1-1

Legal Basis: ARS §8-802 directs the Department of Economic Security to receive reports of dependent, abused or abandoned children.

Rules: Rules pertaining to receiving and screening Child Protective Services (CPS) reports are found in Section R6-5-5502 through R6-5-5504 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 1: Section 1

Hotline Receipt Of Information

Legal Basis

Policy: The department shall accept reports of child abuse, neglect, exploitation or abandonment 24 hours a day, seven days a week.

The department shall operate a statewide, toll-free telephone service specifically for the purpose of accepting reports of child abuse, neglect, exploitation or abandonment.

The Child Abuse Hotline shall be responsible for receiving all reports of child abuse, neglect, abandonment or exploitation. Individuals who contact district offices directly and wish to make a report shall be referred to the Child Abuse Hotline.

Reporters shall be informed of the requirement to identify themselves; however, the Child Abuse Hotline shall accept anonymous reports, if necessary.

Child Abuse Hotline staff shall inform reporting sources that their identity is confidential and released only as required by law. (ARS §8-807)

BEST PRACTICE TIP:
The process of gathering information from reporting sources is enhanced by using standardized questions. These questions ensure that you do not miss the opportunity to gather critical information See Exhibit 1, Hotline Questions

It is important to engage the caller in talking about the strengths, family and community supports of the family as well as the allegations. This will assist the CPS Specialists as they conduct the investigation/safety assessment, allowing them to enter the family's home with both the allegations of harm and possible ways to start the relationship building process. The stronger the family engagement during the investigative/safety assessment process the better the information compiled—and the more effective the CPS Specialist's decisions regarding child safety and risk.

Revision History:
DES(07-2006)

Next

1-2

Legal Basis: ARS §8-802 directs the Department of Economic Security to receive reports of dependent, abused or abandoned children.

Rules: Rules pertaining to receiving and screening Child Protective Services (CPS) reports are found in Section R6-5-5502 through R6-5-5504 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 1: Section 2

Making The Decision To Take A Report

Legal Basis

Policy:

Any incoming communication that meets the criteria for a report shall be taken as a report.

To determine whether an incoming communication meets the criteria for a report for field investigation, consider these questions:

- Does the communication concern a child who is allegedly the victim of physical, sexual or emotional abuse or neglect?
- Does the communication indicate that there is a parent, guardian or custodian that has inflicted or may inflict the abuse or neglect?
- Does the communication indicate that the parent, guardian or custodian permit another person to inflict abuse or neglect on the child?
- Does the communication indicate that the parent, guardian or custodian have reason to know another person might harm the child?
- From the information provided, can the child be located?

The department shall not investigate reports in which a state or federal statute or court order prevents CPS investigation.

Implementation and Procedures Guide

If an incoming communication does not meet the criteria for investigation:

- inform the caller the information will be documented by the child's, parent's and referral source's name and will be reviewed by quality assurance staff within 48 hours;
- refer the caller to a community resource that may be able to address his or her concerns;

If an incoming communication does not meet the criteria for investigation, but:

- concerns a child in the care, custody or control of the department and/or out-of-home provider, document the information and notify the child's case manager and/or licensing specialist, as applicable.

- involves alleged child abuse or neglect by a person other than a parent, guardian or custodian and inflicted without the knowledge of the parent, guardian or custodian, encourage the caller to contact law enforcement *and* follow-up with notification to law enforcement.

If the communication meets the criteria for a report for field investigation:

- Tell the reporting source that a report is being taken;

- Provide the reporter with the name and phone number of the local supervisor,

- Request that the reporter support the verbal report with a written report. [ARS §13-3620(A)]

DOCUMENTATION :

Search CHILDS, Child Protective Services Central Registry (CPSCR), ASSISTS and AZTEC information systems to determine whether there have been previous reports on the family and the status of prior cases. If there have been previous reports on the family, ensure that the report provided to the field includes information on the status of that report.

Enter the information into the CHILDS Case Management Information System.

Document the source name and identifying data, the information reported and the reason the communication is not a report on the Communication Detail window. Complete a Person Detail window for each child and parent.

Document notification of law enforcement.

Revision History:
DES(07-2006)

Previous / Next

1-3

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 1: Section 3

Prioritizing Reports And Response

Legal Basis

Policy: The Child Abuse Hotline shall assign each report a risk level and a Tracking Characteristic, Exhibit 2 (if applicable).

The Child Abuse Hotline shall notify the local office of the receipt of the report and its risk level by telephone for a high risk report or through a CHILDS Alert as soon as possible. The local office and ACYF Group Care CPS specialist shall notify the appropriate law enforcement agency of the report, following district procedures.

Following the guidelines below the hotline worker is to determine and assign the appropriate risk level for the alleged abuse and neglect.

The time frames for investigations are based on the following determinations of high risk, moderate risk and low risk.

If there are extenuating circumstances that either require a faster response time or allow for a slower response, hotline staff have the ability to aggravate or mitigate a report based on Aggravation or Mitigating Factors, Exhibit 3 or the hotline worker can consult with the field regarding aggravation or mitigation or leave this decision up to the field.

: **High Risk Situations**

High Risk Physical Abuse- Severe/life threatening injuries requiring emergency medical treatment and OR parent presents severe physical harm to a child NOW.

The following injuries or situations constitute High Risk Abuse:

- Injuries requiring emergency medical treatment that may include:
  - Head injury with risk of Central Nervous System damage
  - Internal injury
  - Multiple injuries or multiple plan injuries (battering)
  - Severe facial bruises
  - Fractures or bruises in a non-ambulatory child

- Fractures
- Instrumentation injury with risk of impairment
- Immersion burns
- Second and third degree burns
- Parent guardian or custodian provides prescribed/non-prescribed or illegal drugs or alcohol to a child **under the age of six (6)** and the child is exhibiting symptoms of the drug or alcohol
- Child under the age of twenty-four (24) months is shaken (shaken baby syndrome)

§ Child under the age of six (6) observed or reported to be struck in the head, face, neck, genitals or abdomen which could likely cause an injury
§ Physical abuse by a parent, guardian or custodian who has a previous substantiated Priority 1 or High Risk report
§ Parent, guardian or custodian threatens or presents serious bodily harm to a child **NOW**

High Risk Neglect - Severe/life threatening situations requiring emergency intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care**.**

The Following Situations Constitute High Risk Neglect:

- **Delayed or** untreated medical condition which is life threatening or permanently disabling which may include Infant Doe, comatose state or debilitation from starvation or possible non-organic failure to thrive.
- Child of any age who is alone and cannot care for self or for other children due to physical, emotional or mental inability. (This includes a parent, guardian or custodian who is incarcerated or hospitalized.)
- Child under the age of six (6) is alone **NOW**
- Child six (6) to nine (9) years of age is alone for three (3) hours or longer or unknown when parent, guardian or custodian will return
- Imminent harm to child under the age of six (6) due to inadequate supervision by parent, guardian or custodian
- Neglect results in serious physical injury or illness requiring emergency medical treatment. *NOTE: Failure to use child restraints pursuant to ARS § 28-907 are not reports.*
- Imminent harm to child due to health or safety hazards in living environment which may include exposure to the elements
- Child **assessed** as suicidal by qualified mental health professional and parent, guardian or custodian is unwilling to secure needed emergency medical treatment including psychiatric treatment.
- No parent willing to provide immediate care for a child and child is with a caregiver who is unable or unwilling to care for the child NOW or child is left to his or her own resources.

- History of extensive gestational substance abuse to child under three (3) months of age or mother or child tests positive for non-prescribed or illegal drug or alcohol at time of birth
- Child under two (2) months of age displays non-prescribed or illegal drug or alcohol withdrawal symptoms.
- Mother is using cocaine, heroin, methamphetamines or PCP and is breastfeeding a child

High Risk Sexual Abuse - Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven (7) days.

The following situations constitute High Risk Sexual Abuse:

- Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven (7) days
- Child reporting vaginal or anal penetration or oral sexual contact (oral contact with the penis, vulva or anus) within past seventy-two (72) hours AND has not been examined by a medical doctor.

High Risk Response Times
Standard Response Time - SRT: 2 hours
Mitigated Response Time - MRT: 24 hours

: Moderate Risk

Moderate Risk Physical Abuse- Serious/multiple injuries which may require medical treatment and/or a child at risk for serious physical abuse if no intervention is received.

The following injuries or situations are considered Moderate Risk Abuse:

§ Injuries: **That May Require Medical Treatment** which may include:
- þ Multiple injuries or multiple plane injuries
- þ Injuries to torso or extremities
- þ Injuries to child under age one (1)
- þ Fractures
- þ Parent, guardian or custodian provides prescribed/non-prescribed or illegal drug or alcohol to a child **six (6) years of age or older** and the child is exhibiting symptoms of the drug or alcohol
- þ Munchausen's Syndrome by Proxy

- Low Risk injury to child under the age of six (6)

§ Child six (6) years of age or older observed or reported to be struck in the head, face, neck, genitals or abdomen which could likely cause an injury

§ Parent, guardian or custodian **presents serious bodily harm to a child or** fears or threatens to harm child if no intervention received and he or she has a previous **substantiated** report of physical abuse

§ Newborn child (under 3 months of age) born to parents whose parental rights have been previously terminated

Moderate Risk Neglect- Serious/Non-life threatening situations requiring intervention due to the absence of a parent, or a parent who is unable due to physical or mental limitations or is unwilling to provide minimally adequate care.

The following situations constitute Moderate Risk Neglect:

§ Child age eleven (11) to thirteen (13) years of age caring for a child age six (6) or younger for twelve (12) hours or longer

§ Living environment presents health or safety hazards to a child under the age of six (6) which may include human/animal feces, indisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.

§ Due to inadequate supervision **or encouragement** by parent, guardian or custodian **sexual conduct or physical injury occurs between children.** This includes a licensed or certified DES facility or a licensed DHS Level I, II or III Behavioral Health Treatment facility

§ (If the information is on a foster parent, group care facility RTC etc. use the designated questions. If it does not meet the criteria of a report for field investigation, send the information to the licensing specialist and case manager. If the licensing inquiry reveals inadequate supervision the specialist will call back to make a report)

§ No parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child less than ONE (1) WEEK

§ Newborn child (under 3 months of age) born to parents whose parental rights have been previously terminated

Moderate Risk Sexual Abuse - Sexual behavior or attempted sexual behavior occurring 8 days or up to 1 year ago and/or child is exhibiting indicators consistent with sexual abuse.

The following situations constitute moderate risk sexual abuse:

§ Several behavior within the past eight (8) to fourteen (14) days including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor.

§ Attempted sexual behavior or sexual behavior when last occurrence is unknown or when last occurred beyond fourteen (14) days and up to **one (1) year** including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor

§ Parent, guardian or custodian suggests or entices a child to engage in sexual behavior, but there is no actual touching including encouraging a child to view pornographic materials

§ Child is exhibiting physical or behavioral indicators which are consistent with sexual abuse **AND** there are indicators the behavior is caused by parent, guardian or custodian

§ Child is living in the home with a person convicted of a sexual offense against a child

Moderate Risk Emotional Abuse - Child diagnosed by a mental health professional as exhibiting symptoms of emotional abuse caused by a parent.

The following constitutes Moderate Risk Emotional Abuse

§ Child diagnosed by qualified mental health professional as exhibiting severe anxiety, depression, withdrawal or untoward aggressive behavior which could be due to serious emotional damage by parent, guardian or custodian

Moderate Risk Response Times:

SRT: 48 Hours
Aggravated Response Time - ART: 24 Hours
MRT: 72 Hours

Low Risk

Low Risk Abuse - Injuries not requiring medical treatment and/or parent threatens physical harm if no intervention is received.

The following injuries or situations are considered Low Risk Abuse:

§ Injuries **Not Requiring Medical Treatment** which may include:
- þ First degree or cigarette burns
- þ Injury to buttocks or scalp (i.e., hair loss)
- þ Injury to bony body parts (i.e., shins, knees, elbow, etc.)

- Single or small bruises
- Parent, guardian or custodian provides prescribed/non-prescribed or illegal drugs or alcohol to a child and the child is exhibiting symptoms of the drug or alcohol
- Bleeding (i.e., hit in face, bloody nose

§ Parent, guardian or custodian fears, or threatens to harm a child if no intervention is received.

Low Risk Neglect: Situations which may require intervention due to the absence of a parent, or a parent who is unable due to physical or mental limitations or is unwilling to provide minimally adequate care, which includes exploitation of a child.

The following situations constitute Low Risk Neglect:

§ Delayed or untreated medical problem causes child pain or debilitation that is not life threatening AND parent, guardian or custodian is unwilling to secure medical treatment
§ Child under the age of nine (9), who is not alone at the time of the report, but has been left alone within the past fourteen (14) days
§ Parent, guardian or custodian demonstrates an inability to care for a child within the past thirty (30) days including leaving a child with inappropriate or inadequate caregivers
§ Living environment presents health or safety hazards to a child six (6) years of age or older which may include human/animal feces, indisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.
§ Food not provided and child is chronically hungry
§ Significant developmental delays due to neglect
§ Use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities
§ Parent, guardian or custodian is not protecting child from a person who does not live in the home AND who abused **a** child
§ No parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child beyond ONE (1) WEEK UP TO THIRTY (30) DAYS (Reporting source will need to call back if beyond thirty (30) days)

Low Risk Sexual Abuse - Sexual behavior or attempted sexual behavior occurring beyond 1 year and perpetrator currently has access to a child.

The following situations constitute Low Risk Sexual Abuse:

§ Parent, guardian or custodian sexually abused a child in the past **AND** is now living in a home with a child.

§ Attempted sexual behavior or sexual behavior when last occurrence was beyond **one (1) year** including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child and sexual conduct with a minor **and the perpetrator currently has access to the child.**

Low Risk Emotional Abuse - Parent demonstrates behavior which may result in emotional trauma to a child.

The following constitutes Low Risk Emotional Abuse:

§ Parent, guardian or custodian demonstrates behavior or child reports parent, guardian or custodian behavior which is likely to have the effect of **fear** rejection, isolation, humiliation or debasement of a child.

Low Risk Response Times	
SRT	**72 Hours**
ART	**48 Hours**
MRT	**72 Hours Excluding Weekends &Holidays**

DOCUMENTATION :

Document the allegations and the risk level of the report by entering them in the CHILDS Case Management Information System on the Communication Allegation Detail window.

If the response time has been modified due to mitigating or aggravating factors, document the response time on the Report Disposition window to ensure appropriate response.

Revision History:
DES(07-2006)

Previous / Next

1-4

Legal Basis: Not applicable

Rules: Rules pertaining to Initial Response and Methods for Investigation and Alternative Investigation are found in Sections R6-5-5505 through R6-5-5507 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 1: Section 4
Disposition of Reports

Legal Basis

Policy: The department shall make every effort to ensure that all CPS reports assigned to a local office are:

- Assigned for field investigation; or
- Investigated by a CPS Supervisor by means of an alternative investigation.

The department shall not investigate reports in which a state or federal statute or court order prevents CPS investigation.

The department shall ensure that the initial response to a report of child abuse or neglect is accomplished in a timely manner as specified in Hotline Receipt of Information, Chapter 1 Section 3. Initial response to a report may be completed by Child Protective Services, law enforcement or other emergency personnel.

CPS shall initiate the investigation not later than the mitigated response time when the initial response is completed by law enforcement or other emergency personnel.

The initial response shall determine whether a child, who is or may be a victim of abuse or neglect, is currently safe.

A CPS Supervisor may aggravate or mitigate the initial response to a report, based upon case-specific factors.

Time allotted for the department's initial response to a report of abuse or neglect begins when the local office receives the report information from the Child Abuse Hotline by telephone or a CHILDS Alert.

To determine whether to assign the case for an alternative investigation, the following must be true:

- the family has no prior CPS history, and
- a mandated reporting source can confirm that the alleged victim and other children in the home are not current victims of maltreatment, or at risk of imminent harm, and
- the report is unsubstantiated.

If there is any question regarding the appropriateness of alternative investigation, assign the case for field investigation.

Implementation and Procedures Guide:

Review prior reports and case history in the CPSCR and CHILDS Case Management Information System including:

- report narrative;
- identified perpetrators;
- victims;
- investigation finding;
- results of the Child Safety Assessment and Family Strength and Risk Assessment; and
- available hard copy records including any medical, mental/behavioral health, school records and law enforcement reports.

Do not assign a report for investigation where CPS does not have jurisdiction of the case, such as cases involving a state or federal statute or court order prevents CPS investigation. When appropriate, contact and refer the report to the appropriate jurisdiction (tribal jurisdiction, military base, etc.).

The unit supervisor or another staff person acting in a supervisory role will review the report to determine if, based on the allegation information provided, that the report is eligible for Alternative Investigation. Eligibility criteria should always be based on two factors: child safety and the report allegation must be unsubstantiated. The supervisor may make initial contact with the mandatory reporting source to assist in making this determination.

The following do *not* qualify as disposition to alternative investigation:

- court ordered investigations;
- private dependency petitions;

• reports alleging sexual abuse;
• sexual or physical abuse reports, labeled as neglect reports such as sexual conduct or physical injury between children and unknown if parent, guardian or custodian will protect;
• open CPS cases;
• reports previously assigned for field investigation;
• reports involving children in DES care and custody, including children placed in Voluntary Foster Care; and
• reports involving facilities licensed or certified by DES, or a DHS Level I, II or III behavioral health treatment facility.

The CPS Supervisor must then obtain approval from his/her Assistant Program Manager (APM) before dispositioning the report as an Alternative Investigation (AI). If APM approval is obtained the report is ready for an AI disposition. The supervisor or another staff person acting in a supervisory role assigns the report to him/herself as primary case manager. The supervisor or designee may assign a case manager as a supporting case manager.

The assigned CPS unit supervisor or supporting CPS Specialist:

- contacts the "professional mandated reporting source(s)" who is/are involved with the family and that can provide accurate, current information regarding family functioning and stressors;
- the professional mandated reporting source(s) is/are able to confirm that the alleged victim is not a victim of child abuse or neglect; and
- the professional mandated reporting source(s) can confirm the name, age, condition and immediate safety of the other children in the household.

If the professional mandated reporting source(s) cannot provide information that the alleged victim is safe, the safety of the alleged victim must be assessed by in-person interviews with and/or observations of the child victim and caregiver(s).

If at any time a child in the household (including the alleged victim) is considered to be "unsafe" the case shall immediately revert to "field investigation."

The Child Safety Assessment (CSA) and Family Strengths and Risks Assessment (SRA) are not required *unless* the child has been seen and assessed in person by CPS.

A report assigned for field investigation cannot be reverted to alternative investigation status.

Clarify with the CPS Specialist your expectations regarding initial response time and discuss any case-specific concerns.

Determine the initial response time using the following definitions:

- Night: 5:01 p.m. to 7:59 a.m., Monday through Thursday;
- Weekend: 5:01 p.m. Friday to 7:59 a.m. Monday; and
- State holiday: 8:00 a.m. of the holiday to 8:00 a.m. of the following day.

DOCUMENTATION :

***CPS Supervisor*:**

Document case assignment using the Case Assignment window.

Use the Report Disposition window to document:

- the decision to assign the case for field investigation;
- the decision to conduct an alternative investigation; and
- any aggravating or mitigating factors affecting initial response time.

Reports where the department has no jurisdiction to investigate should be dispositioned as No Jurisdiction on the Report Disposition window and document that the report information was provided to the appropriate jurisdiction in the Explain Box.

Use the Report Detail window to document the completion of the initial field response.

Enter the disposition of the report and any aggravating or mitigating factors on the Report Disposition window immediately but no later than ten days of receipt of the report information.

If applicable, document the decision to conduct an alternative investigation or not to investigate a report using the Report Disposition Window Explain Box.

The Assistant Program Manager or designee reviews the decision to conduct an alternative investigation and documents approval or denial of the decision using the Case Notes window designated as Supervisor/Management Contact type. The Assistant Program Manager or designee's review and approval or denial of a decision not to investigate a report must be obtained prior to documentation and included in the Report Disposition Window Explain Box.

Revision History:

DES(07-2006)

Previous

2-1

Legal Basis: ARS §8-802 directs child protective services CPS Specialists to conduct a prompt and thorough investigation of reports received by the department.

ARS §8-800 sets forth the primary purposes of child protective services as to protect children by investigating allegations of abuse and neglect, promoting the well-being of the child in a permanent home, coordinating services to strengthen the family and prevent, and to intervene in and treat abuse and neglect of children.

ARS §8-801 defines protective services as a specialized child welfare program that is administered by the department and investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family.

ARS §8-802 (C) states that a Child Protective Services worker shall promote the safety and protection of children.

ARS §8-803 outlines the rights of the parent, guardian or custodian under investigation by Child Protective Services.

Rules:
Rules pertaining to conducting investigations are found in Section R6-5-5508 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 1

Interviews With The Child, Family And Collateral Contacts

Legal Basis

Policy:
The department has three primary responsibilities when a report is taken:

- Respond according to priority timeframes, to promote the safety and protection of children.
- Determine whether any child in the home is in imminent danger at the present time and if so develop an immediate safety plan to ensure the safety of the child.
- Determine whether the alleged abuse and neglect is substantiated or any other form of abuse and neglect has taken or is likely to take place.

Implementation and Procedure Guide

The Practice of Investigation and Safety Assessments

In responding to reports of abuse and neglect, the department shall respect the legal rights of the parents, guardians or custodians while ensuring the safety of the child. The challenge of the CPS Specialist is to engage the child's family and the child in information gathering and decision making to the greatest extent possible without compromising the safety of the child.

The CPS Specialists must show their CPS Identification card to everyone they interview. When conducting the safety assessment, it is important that the CPS Specialist be courteous and respectful. Ask for permission to enter the home, to sit down, to look in the cupboards and refrigerator and in the various rooms of the home. If the family does not allow access, it may be based as much on fear, as it is on the family “hiding something”. The CPS Specialist’s task is to try to calm the family and to explain why you want to explore the home.

BEST PRACTICE TIP:
The way the investigative CPS Specialist engages the family (or fails to engage the family) can directly impact the willingness of the family to work with other members of the department. The level of trust and integrity that is established between the agency and the family often has a direct relationship on the child being able to remain/reunify with his/her family. It is everyone’s job who comes in contact with the family to build positive relationships.

One way to build this relationship is through engaging in better **understanding the culture and ethnicity** of the family. Cultural competence calls for respecting cultural differences and

recognizing behaviors, values, and beliefs of the cultures of children and families served. This is crucial to the social work belief of "starting where the client is."

For example:
The definition of "family" varies from group to group. While the dominant culture has focused on the nuclear family, African Americans define family as a wide network of extended family, non blood kin and community. Native American Indian families traditionally include at least three generations and multiple parental functions delegated among aunts and uncles, as well as grandparents. Cousins are considered siblings. For the Chinese, the definition of family may include all their ancestors and all their descendants. (McGoldrick, et al.)

The family life-cycle phases also vary for different groups, and cultural groups differ in the emphasis they place on certain life transitions.

Families vary culturally in terms of what behavior they see as problematic and what behavior they expect from children.

Families also differ in their norms around communication and their expectations for how communications in specific situations will occur.

Different cultural groups also vary in their traditional practices and views of adoption.

Also Refer to Continuum of Cultural Competence (Exhibit 4).

Coordination with Law Enforcement

The department shall coordinate its investigations with law enforcement, according to protocols established with the appropriate municipal or county law enforcement agency when:

F The report or the investigation indicated that the child is or may be the victim of an extremely serious conduct allegation;

F The report alleges or the investigation indicates that the child is a victim of sexual abuse; and/or

F A criminal investigation of the alleged child abuse and neglect is in progress or anticipated.

Joint investigations require a shared, cooperative approach and ongoing consultation, collaboration and communication. A joint investigation may include:

- responding with law enforcement;
- making frequent contacts to discuss the status of the case;
- obtaining and sharing information;
- identifying any additional steps needed to ensure the safety of children, and pursuing prosecution as appropriate.

If law enforcement is not able to respond jointly, or expresses that they do not want CPS to respond, the assigned CPS Specialist must still proceed with the investigation within the initial response time to ensure child safety.

If law enforcement has responded to the report, made contacts and interviewed the child and parent, or conducted a child welfare check, the CPS Specialist must respond to the report **prior** to the mitigated response time if the safety of the child **cannot** be confirmed. The response time may be mitigated when contacts can verify:

- § the child is currently safe
- § the child's current whereabouts, and
- § the length of time the child will remain safe.

All reasonable support and assistance shall be provided to staff members who experience violence or the threat of violence while providing child protective services. If information indicates that a situation may be dangerous, notify your supervisor and request an escort from law enforcement. If involved in a dangerous situation while escorted by law enforcement, wait in a safe area and be available to assist in the removal of the child as requested by law enforcement. If unescorted and involved in a dangerous situation, leave immediately and notify law enforcement and your supervisor.

BEST PRACTICE TIP:
The process of partnership with law enforcement requires clear role delineation. Law Enforcement Officers have their roles and responsibilities—and those differ from the roles and responsibilities of CPS Specialists. Ultimately our job is to protect the child by engaging the family so that if possible the child can stay in the home, and if that is not possible and the child has to be removed, the family will make the required changes so that the child can return home rapidly.

Effective Assessment Involves Completion of a Comprehensive Child Safety Assessment
In order to effectively assess safety threats a CPS Specialist must interview all individuals who may have information concerning:

- § whether the reported abuse and neglect or any other form of abuse or neglect, has taken place; and
- § the risk of present or future harm to any child living in the home.

Unless otherwise indicated, the individuals who should be interviewed include:

- § alleged victim of child abuse or neglect;

§ siblings and other children in the home;

§ family members including the alleged abusing/neglecting and non abusing/neglecting spouses or partners (all interviews with the family shall be in person, whenever possible);

- At least one visit shall be made to the child and family's home. During the home visit it is important to respect the family, seek to engage the family by honestly and openly telling the family why we are in the home and using the information that the family and others provide to help determine the immediate safety of the child.

§ Collateral interviews (for example, with school or medical personnel) may be conducted by telephone. Collateral interviews include:

- school personnel;
- child care provider;
- relatives;
- neighbors; and
- others with knowledge of the abuse or neglect, including the reporting source.

When interviewing relatives, neighbors, and others with information regarding the abuse or neglect, share **only information that is necessary** in order to secure additional information about the child and family.

Planning for the First Interaction with the Family

Before going out, gather these forms and publications:

Forms to Be Used as Part of the Process	Forms To Be Given To The Family
Child Safety Assessment, PS-05400 (found in the Forms Registry)	Temporary Custody Notice, CPS-1000A; **if child is removed**
Child Abuse or Neglect Report, PS-020; (found in the Forms Registry)	Voluntary Foster Placement Agreement, FC-008; (found in the Forms Registry)
	Arizona Parent Assistance Program pamphlet
	A Guide to Child Protective Services, PAC-518;

	Consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information, ACY-1125A; **as appropriate**
	Notice of Removal, PS-058; **as appropriate**
	Child Protective Services Request, PS-045; give to family
	Agreement for Child Placement, PS-055. **as appropriate**

Interview with the Family

***Develop a strategy for conducting the interview with the family by making the following decisions*:**

1. Determine who in the family will be interviewed, where, and in what order.

§ In addition to the members of the household, who else is likely to have information that will help you determine whether the child is safe at the present time, whether abuse and neglect occurred, and to what extent there is risk of future harm? Individuals who know the family may be able to support the family during the process and if needed assist the family in creating a safe environment for the child.

§ Consider the advantages and disadvantages of interviewing at school, at home, in the office, or in another safe and neutral location.

BEST PRACTICE TIP:

Seek to interview the child with the family's knowledge in a setting that is safe for the child.

§ When interviewing the child, consider how to conduct the interviews in a way that maximizes your ability to elicit spontaneous responses and to decrease the possibility of coached or rehearsed answers.

2. Determine if interviews with the family should be by appointment or unannounced.

§ From the information available, does it seem likely that the family will cooperate with or be resistant to the investigation?

§ Does the information indicate that the family is relatively stable with strong ties to the

community or are they likely to avoid investigation by leaving before you arrive?

§ Given the particular allegations, how important is it to observe the home environment untouched?

3. Determine if the interview with the family should be conducted alone or should you be accompanied by another staff member, or in case of significant safety concerns, a law enforcement officer.

§ From the information available, what is the likelihood of encountering violent behavior, illegal activities, weapons in the home or the community?

§ How isolated is the family's home?

§ How many people are likely to be present? How many will need to be interviewed?

§ Is there indication that an interpreter will be necessary?

§ Does the situation demand the specialized expertise of another staff member?

The CPS Specialist must explain to the parent, guardian or custodian that they are under investigation. The CPS Specialist must also state that the department has no legal authority to compel cooperation with the investigation or to compel the parent, guardian or custodian to receive services [**ARS §8-803(A)**], but that it is our hope that by working together we can find solutions as they are needed to ensure that their family is as safe and has what it needs.

The CPS Specialist must also tell the parent, guardian or custodian that whether or not they agree to cooperate, or accept the services offered, we have to proceed with the investigation, because our duty to ensure child safety is paramount. Emphasize that we would rather proceed with their support as opposed to without.

The CPS Specialist must tell the parent, guardian or custodian EXPLICITLY that their refusal to cooperate with the investigation or participate in services offered does not in itself constitute grounds for action on our part (including taking temporary custody of their child). [**ARS §8-803 (D)**]

The CPS Specialist must also let the parent, guardian or custodian know that he or she has the right to provide written, telephonic or verbal response to the allegation, including any documentation and that this information will be considered in determining whether the child is in need of protective services, included in the written report of the investigation and in the case record, and used in a court proceeding. [**ARS §8-803(B)**]

The CPS Specialist is required to tell the parent, guardian or custodian that they have the right to participate in the mediation program in the Attorney General's Office, to file a complaint with the Ombudsman-Citizen's Aide and the Family Advocacy Office, and to appeal determinations made

by Child Protective Services. [**ARS §8-803(A); ARS §8-828**]

BEST PRACTICE TIP:
Sometimes when families are scared or mistrusting of our involvement they may come across as antagonistic or angry. We sometimes term this as "non compliant" thinking that this simple statement explains the family's motivations and feelings. Best practice suggests that rather than labeling and viewing the family's behavior as negative, we strive to understand the feelings behind the behavior. Remember that the family has no immediate reason to trust you—trust is built over time. The challenge of being a CPS Specialist is to engage the family and build trust, even when your role includes investigation and possibly child removal. Trust and cooperation is built by listening to what the family has to say, not pre-judging them, and consistently doing what you say you are going to do.

Convey respect for families from the beginning of the casework relationship, rather than communicating acceptance conditional on performance.

Below are some strategies for conveying respect, empathy and genuineness.

Strategy for Conveying Respect

- Demonstrate interest in others through active listening and effective use of questions.
- Treat each person as a unique individual with strengths and needs.
- Explain how each individual's unique potential can be utilized to achieve successful outcomes.
- Elicit input from families.
- Give positive feedback and support for small steps taken toward change.
- Be on time for meetings with families.

Strategies for Conveying Empathy

- Demonstrate active listening and observation skills (nodding, recognizing non-verbal cues) when reaching for the family's experiences.
- Use reflections to test out what the family member has said.
- Ask open-ended questions of the family member to elicit emotions.
- Tune into subtle forms of communication such as a family member's tempo of speech, lowering of the head, clenching of the jaws, or shifting posture.
- Introduce issues of concern by relating them to the needs or concerns of the family member.

Strategies For Conveying Genuineness

- Match verbal responses with nonverbal behavior
- Practice non-defensive communication
- Use self-disclosure appropriately.

Full Disclosure to the Family

Full Disclosure is a critical part of building trust and developing a working relationship to support

child safety, permanence and well-being.

BEST PRACTICE TIP:
Full Disclosure is a fundamental component of engaging families and developing trust. Full Disclosure implies that we tell the family anything that we can about their involvement with the child protection system within what the law allows.
Full Disclosure suggests that we strive to help the family understand the following:

- The specific reasons we have come to their home (required under ARS 8-803)
- The role of the CPS Specialist and our commitment to keeping children safe and helping families. (This may include child removal but it is not what we want to do unless we can find no other way to keep the child safe).
- The specific steps of the investigative/safety assessment process.
- The decision making process-being fully transparent regarding any decisions made.
- How we will communicate the results of any decisions made.

Interviewing the Child Alone
When necessary, a child who is the subject of an investigation or another child who lives in the home may be interviewed prior to law enforcement involvement in order to ascertain their safety.

During an investigation a child may be interviewed without prior parental consent if he or she is:

§ the subject of a CPS investigation;

§ a sibling of the subject of a CPS investigation;

§ a child who lives with the subject of a CPS investigation; or

§ a child who initiates contact with CPS. [**ARS §8-802(C)(4)**]

If a child is interviewed without consent of the parent, guardian or custodian, initiate contact with the parent, guardian or custodian the same day and inform him or her of the child's interview. If he or she cannot be contacted, talk to the reporter as appropriate to find out if they have a means to contact the parent, custodian or guardian. If there is no way to contact the family (and this should be a last resort) leave a copy of A Guide to Child Protective Services, PAC-518, at the home along with your name, address and phone number and a request that he or she contact you.

In other cases, prior written consent must be obtained from the parent, guardian, or custodian. Our goal is to protect the child and to engage the family in the process. It is not helpful to the child to alienate the family during the investigative/safety assessment process.

The alleged abusive/neglectful person shall not be present during the interview of a child who is the subject of an investigation, his or her siblings, or any other child in the household. If appropriate, ask that the parent who is not alleged to have abused or neglected the child to be present for the child interview. The child and his/her siblings, and all other children living in the

home, should be interviewed in a safe and neutral location.

Provide children with information about the CPS process so that they understand to the best of their ability what is happening to them.

Interviews with alleged child victims of sexual abuse may be videotaped if appropriate equipment and trained personnel are available. If equipment and personnel are not available, the interviews shall be audio taped.

If a child is nonverbal, substitute observation for interviewing**.**

Medical examinations are required in proposed substantiated cases with the following allegations:

- Injuries requiring emergency medical treatment;
- Untreated medical condition that is life threatening, or permanently disabling;
- Serious physical injury requiring emergency medical treatment due to neglect; and
- Injuries that may require medical treatment.

Explain to the parents/caregiver the purpose of the medical examination and try to elicit their support and permission for the process. CPS Specialists may obtain a medical examination of the child that has been physically harmed.

If the parent, guardian or custodian is unwilling to secure medical or psychological treatment, arrange for an examination to identify if:

- The child is a victim of an untreated medical condition that is life threatening or permanently disabling, or
- Delayed or untreated medical problem will cause the child pain or debilitation.

The CPS Specialist must:

- Gather information regarding the child’s medical history from the parent.
- Obtain and review the child's medical history and reports from the child's physician.
- Consult with a physician, preferably with expertise in abuse and neglect, in proposed substantiated cases of high or moderate risk medical neglect.
- If indicated, arrange to have children with visible injuries and/or visible indicators of neglect photographed, preferably by law enforcement or a medical professional. If these personnel are not available, photograph the child according to district procedures. Label each photograph with the child's name, date of photograph, date of birth, name of CPS Specialist, and name of the person taking the picture. Photographs of children can

be taken without permission of the parent, guardian or custodian. [**ARS §13-3620(I)**]

- If there is indication that sexual abuse may have taken place, obtain a sexual abuse examination of the child. Schedule the examination immediately if the report involves sexual contact within the past 72 hours and/or the child complains of pain or other symptoms associated with sexual abuse.
- If the parent, guardian or custodian refuses to allow the child to be examined, place the child in temporary custody for up to 12 hours to have the child examined by a medical doctor or psychologist. [**ARS §8-821(E)**]

BEST PRACTICE TIP:
If the parent, guardian or custodian asks to be present during the medical evaluation it is part of your responsibility to carefully consider the request. Your response should be based upon the caregiver's ability and willingness to be supportive to the child without impeding the examination. If you do not believe that the parent, guardian or custodian can be supportive, try to find someone that the child trusts who can be there with them. This is a very traumatic experience for the child; begin to identify and engage supports for the child.

Conclude the investigation by collecting and/or reviewing the following information, if available:

- school records;
- CPS information, reports, records and files from Arizona and other states;
- criminal history records of parent, guardian or custodian, and other household members if there is indication of criminal activity involving a child or that places a child at risk of harm, domestic violence and/or past abuse or neglect of a child; and
- reports from social and mental health service providers or any of the other collateral sources who have worked with the family.

DOCUMENTATION :

Document all contacts and relevant information using the Case Notes window, designated as Investigation type. File written reports and documentation provided by collateral contacts in the hard copy record.

Using the Case Notes window, designated as Supervisory/Management Contact type, document consultation with your supervisor when it is determined that contacting and/or interviewing the reporting source or the parent or other adult who does not reside in the home with the child victim is not necessary.

Document the result of consultations with a physician using the Case Notes window designated as Investigation Type.

Document the child's medical need, examination and child's physician information using the Medical Condition, Practitioner Detail and Examination Detail windows.

Document any written, telephonic or verbal response to the allegation provided by the subject of a CPS investigation using the Case Notes window, designated as Investigation type. File any written response to the allegation and any documentation obtained from the subject of a CPS investigation in the hard copy record. [**ARS §8-803(B)**]

Document on the PS-045 the family's receipt of the PAC-518 containing the American with Disabilities Act statement and notifications of rights.

Document if a joint investigation was not conducted with law enforcement on the Joint Investigation Detail window.

Document coordination of the CPS investigation with law enforcement using the Case Notes window designated as Investigation type when:

- the report or investigation indicated the child is or may be the victim of an extremely serious conduct allegation;
- the report alleges or the investigation indicates that the child is a victim of sexual abuse; and/or
- a criminal investigation of the alleged child abuse and neglect is in progress or anticipated.

Revision History:
DES(07-2006)

Next

2-2

Legal Basis: ARS §8-802 directs child protective services workers to conduct a prompt and thorough investigation of reports received by the department.

ARS §8-800 sets forth the primary purposes of child protective services as to protect children by investigating allegations of abuse and neglect, promoting the well-being of the child in a permanent home, coordinating services to strengthen the family and prevent, and to intervene in and treat abuse and neglect of children.

ARS §8-801 defines protective services as a specialized child welfare program that is administered by the department and investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family.

ARS §8-802(C) states that a Child Protective Services worker shall promote the safety and protection of children.

Rules: Rules pertaining to conducting investigations are found in Section R6-5-5508 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 2

Conducting The Child Safety Assessment

Legal Basis

Policy: In response to reports of child abuse and neglect, the department shall:

- promote the safety and protection of children;
- assess whether any child in the home is in present or foreseeable danger of serious harm; and
- to take sufficient action to control and manager safety threats.

An assessment of child safety shall be completed on all cases where a field investigation is completed. Reassessment of child safety is required at specific intervals during the life of a case.

Implementation and Procedures Guide

Refer to the Child Safety Assessment Protocol (Exhibit 5). The Child Safety Assessment is initiated during initial contact with the family and is continued throughout the investigation.

The purpose of the Child Safety Assessment is to gather sufficient and relevant information to inform a decision about whether the child(ren) is safe or unsafe. A child is unsafe when present or foreseeable danger exists. See Child Safety Assessment Protocol (Exhibit 5) for definitions of present and foreseeable danger. Pertinent information is gathered and analyzed by the CPS Specialist. The foundation for information collection is delineated in the following six questions.

The answers to these six questions provide the assessment data from which the CPS Specialist identifies the presence or absence of threats to child safety and begins to understand how threats may occur within the family. The quality of the safety assessment is totally influenced by the quality and sufficiency of the safety related information collected during the initial assessment. The information assists the CPS Specialist in identifying potential threats to child safety. Analysis of the information is completed in order to determine if the safety factors reach the safety threshold. The assessment and analysis of information collected guides the CPS Specialist's judgment regarding child safety and what actions, if any, should be taken to ensure child safety.

The questions are:

1. If maltreatment did occur, what is the extent of the maltreatment?
    - Type of maltreatment
    - Severity of maltreatment

- History of the maltreatment
- Description of the specific events
- Description of emotional and physical symptoms
- Identification of the child and maltreating caregiver

2. What are the circumstances surrounding the maltreatment?
   - The duration of the maltreatment
   - Caregiver intent concerning the maltreatment
   - Caregiver explanation for the maltreatment and family conditions
   - Caregiver acknowledgment and attitude about the maltreatment
   - Other problems occurring in association with the maltreatment (like substance use or mental disturbance)

3. How does the child function on a daily basis?
   - Capacity for attachment
   - General mood and temperament
   - Intellectual functioning
   - Communication and social skills
   - Expressions of emotions/feelings
   - Behavior
   - Peer relations
   - School performance
   - Independence
   - Motor skills
   - Physical and mental health
   - Functioning within cultural norms

4. What are the disciplinary approaches and typical context used by the caregiver?
   - Disciplinary methods
   - Concept and purpose of discipline
   - Context in which discipline occurs
   - Cultural practices

5. What are the overall, pervasive parenting practices used by the caregiver?
   - Reasons for being a caregiver
   - Satisfactions in being a caregiver
   - Caregiver knowledge and skill in parenting and child development
   - Caregiver expectations and empathy for a child
   - Decision making in parenting practices

- Parenting style
- History of parenting behavior
- Protectiveness

6. How does the caregiver function with respect to daily life management and general adaptation including substance use and mental health functioning?
    - Communication and social skills
    - Coping and stress management
    - Self control
    - Problem solving
    - Judgment and decision making
    - Independence
    - Home and financial management
    - Employment
    - Citizenship and community involvement
    - Rationality
    - Self care and self preservation
    - Substance use
    - Mental health
    - Physical health and capacity
    - Functioning within cultural norms

BEST PRACTICE TIP:
During the safety assessment phase, standardized information gathering and assessment is crucial. Present danger is generally readily identifiable; however, foreseeable danger requires focused professional information gathering and assessment.

See Foundation for Safety Assessment (Exhibit 51) for a description of the safety assessment process and how information gathered and analyzed for each of the questions supports an effective assessment of safety.

As a result of the assessment, identify any family condition, or circumstance that is manifested in such a way that it may become a threat to the child's safety. Determine whether the family condition is (or is emerging) as a threat to child safety by applying the following safety threshold (criteria):

§ Is there a specific, observable **family condition**—behavior, emotion, attitude, intent, perception, situation, etc.?
§ Is the condition **out-of-control** of the caregiver? There appears to be no existing means within the family that can assure the control.

§ Could the condition reasonably have a **severe physical effect** on the child? Severe effect could include serious physical injury, significant pain and suffering, terror or extreme fear, impairment or death etc.
§ Is the severe effect **imminent**? That is, it could happen just about any time within the near future—today, tomorrow or during the upcoming days or weeks?
§ The condition affects a **vulnerable child,** meaning any child who is reliant or dependent on others for protection.

When the safety factors reach the safety threshold, the child is unsafe, and a safety plan is required. See Safety Planning, Chapter 3 Section 1.

To further understand how the identified safety threats are occurring in the family, and to inform safety analysis and planning, the CPS Specialist must also evaluate threats according to the following criteria:

§ **Duration:** length of the threat of danger, how long has it been occurring?.
§ **Consistency:** the frequency of the threat of danger, how often does the threat occur?
§ **Pervasiveness:** the extent of the safety threat. Does it affect family functioning in a significant way?
§ **Influence:** describe anything that stimulates, precipitates or influences the threat of danger. What is the pervasiveness, frequency and duration of this influence?
§ **Continuance:** there is no family member who can control or manage the threat sufficiently to ensure safety of the child. The situation will continue without external intervention.

Complete Child Safety Assessments (CSA).

The Child Safety Assessment must be completed according to the following time frames:

For Child Protection Investigation Cases:

ü Within 24 hours after the worker SEES the alleged child victim(s). If all alleged child victims are not together at the same time as the initial safety assessment is being conducted, and the case manager cannot complete the safety assessment within 24 hours for all children, complete the assessment on those children who are present. Another CSA shall be completed as soon as possible for those alleged child victims who were not present. If other non-involved children are present, the case manager shall include them in the initial safety assessment.
ü Whenever evidence or circumstances suggest that a child may be in danger, including a new report.
ü At the conclusion of the investigation. All children in the home, alleged victims and non-involved children must be included in the assessment.

For In-Home Cases:

ü Prior to supervisory approval when considering to close a case.
ü Whenever evidence or circumstances suggest that a child may be in danger, including a new report or the report is on a non-custodial parent or guardian.

For Out of Home Cases:

- When considering the commencement of unsupervised visits in the home with the parent or guardian.
- Within 24 hours prior to returning a child home. Assess safety in the child's return home environment.
- Prior supervisory approval when considering whether to close a case.
- Whenever evidence or circumstances suggest that a child may be in danger, including a new report or the report is on a non-custodial parent or guardian.

Clarifications as to when the CSA is not conducted:

- **Out of Home Caregivers –** this includes foster, relative, adoptive or non-custodial parent homes unless the caregiver or any member of the household is identified as an alleged perpetrator in a new report.
- **Young Adult Program (YAP) Cases – CSA's are completed:**
  - When considering commencement of unsupervised visits in the home with the parent or guardian;
  - Within 24 hours prior to returning a child home. Assess safety in the child's home environment;
  - Prior to supervisory approval when considering whether to close a case;
  - Whenever evidence or circumstances suggest that the child's safety may be in danger in the home of the out of home caregiver including a report concerning the out of home caregiver.
  - When a teen parent has custody of his/her child, complete the CSA on the teen parent's child in accordance with CSA protocols.
- **Action Requests –** CSA's are not required.
- **Alternative Investigations –** CSA's should not be completed unless the child has been seen by the CPS Specialist.

Child in the Hospital, Incarcerated/Detained

While a child victim may be safe due to hospitalization, incarceration, detention, or temporary placement outside the home, the safety assessment must be conducted based on the child's return home environment.

DOCUMENTATION :

Document the outcome of the child safety assessment process using the Child Safety Assessment, PS-05400.

Written supervisory approval is required for all CSA's. The supervisory signature indicates that the supervisor affirms that sufficient information was gathered and analyzed in a professional manner to justify the safety decisions made.

Revision History:

DES(07-2006)

Previous / Next

2-3

Legal Basis: ARS § 8-821 directs child protective services workers to conduct a prompt and thorough investigation of reports received by the department.

Rules: Rules pertaining to conducting investigations are found in Section R6-5-5508 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 3

Efforts To Locate The Child Victim And Family

Legal Basis

Policy: The department shall make reasonable efforts to locate the child victim and family during an investigation.

Complete reasonable efforts to locate the child and family. Reasonable efforts may include, but are not limited to the following:

- Make at least three attempts to locate the child victim and family through home visits at different times of day during the investigation.
- Request a child welfare check through local law enforcement (a law enforcement child welfare check may substitute for one of the home visits by the CPS Specialist).
- Interview the reporting source or other persons who may have information about the location of the child victim or family.
- Contact the Arizona Parent Locator Service, Finding Missing Parents, Relatives, and Other Significant Persons, and law enforcement for assistance in locating the child and family if the report has been assigned a high risk level of physical or sexual abuse or neglect.
- Review Family Assistance Administration AZTECS database to determine if a current address is available.
- Contact the County Jail and the Department of Correction if the CPS record or other information indicates current or past incarceration.
- If appropriate, contact the child's school or child care provider.
- If appropriate, interview landlords or neighbors.
- Send a certified letter to the home.
- If appropriate, contact other state CPS agencies.

If preliminary information gathered during the investigation indicates the child victim is in present danger and/or foreseeable danger and the whereabouts of the child and family are unknown, consult with the Attorney General's Office regarding filing a petition for a court order

for temporary investigative custody if the child is located. [ARS § 8-821(A)]

DOCUMENTATION :

Document the following using the Case Notes window, designated as Investigation Contact type.

Document consultation with the Office of the Attorney General using the Case Notes window, designated as AG Contact type.

Revision History:
DES(07-2006)

Previous / Next

2-4

Legal Basis: Not applicable

Rules: Rules pertaining to Initial Response and Methods for Investigation and Alternative Investigation are found in Sections R6-5-5505 through R6-5-5507 of the Arizona Administrative Code.

Revision History:

DES(07-2006)

Chapter 2: Section 4

Safety Assessment When There Has Been Three Or More Prior Reports

Legal Basis

Policy: A review of all prior reports and case history shall be completed on a case that involves three or more prior reports with a child, parent, guardian or custodian. This includes foster, adoptive or relative caregivers.

The review should be completed prior to assignment when possible.

Implementation and Procedures Guide:

The supervisor will complete the review of prior reports and case history in the Child Protective Services Central Registry (CPSCR) and CHILDS Case Management Information System. The review should include the following:

- report narrative;
- identified perpetrators;
- victims;
- investigation finding;
- results of the Child Safety Assessment and Family Strength and Risk Assessment; and
- available hard copy records including any medical, mental/behavioral health, school records and law enforcement reports.

Based upon the review, the supervisor should consider the following:

F whether all allegations in previous reports were addressed;
F whether a pattern of cumulative harm to the identified child victim or any other child residing in the home is evident or emerging;
F whether severity of abuse or neglect has increased;
F whether additional sources of information should be contacted, such as school or medical personnel, law enforcement, relatives, and other persons with knowledge about the allegations; and
F whether additional information should be obtained, such as law enforcement records, medical records, school records, mental health records, and other relevant records.

The supervisor should consider assigning the current report to a different CPS Specialist if the last two reports were investigated by the same CPS Specialist.

DOCUMENTATION :

Supervisor must document the outcome of the case review using the Supervisor/Management Case Note type.

Revision History:
DES(07-2006)

Previous / Next

2-5

Legal Basis: The Child Abuse Prevention and Treatment Act (P.L. 104-235), as amended by the Keeping Children and Families Safe Act (P.L. 108-36), requires states to address the needs (including a plan of safe care) of infants identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. The Act further requires states to immediately screen and investigate reports of child abuse and neglect.

ARS § 13-3620(E) requires a health care professional whose routine newborn physical assessment of a newborn infant's health status or whose notification of positive toxicology screens of a newborn infant gives the professional reasonable grounds to believe that the newborn infant may be affected by the presence of alcohol or a substance prohibited by Chapter 34 of this Title to immediately report this information, or cause a report to be made to Child Protective Services. Newborn infant is defined as a newborn infant who is under thirty days of age.

ARS § 8-802(C)(3)(b) requires the department to make a prompt and thorough investigation of the nature, extent and cause of any condition that would tend to support or refute the allegation that the child should be adjudicated dependent and the name, age and condition of other children in the home.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 2: Section 5

Reports Concerning Substance Exposed Newborns

Legal Basis

Policy: The department shall investigate all reports alleging that a newborn infant has been prenatally exposed to alcohol or a controlled substance.

The department shall collaborate with health care professionals and, when available, local substance abuse resources to assist in the investigation, assessment and delivery of quality services for these families.

A newborn infant who has been prenatally exposed to alcohol or a controlled substance or is demonstrating withdrawal symptoms resulting from prenatal drug exposure is considered at high risk of abuse or neglect. The overall drug use (including prenatal drug use) by the parent will be considered in the assessment of the newborn's safety and risk of harm.

Implementation and Procedure Guide

In addition to procedures specified in Interviews With Child, Family and Collateral Contacts (Chapter 2, Section 1), complete the following tasks:

- Immediately gather information concerning the medical condition of the newborn including any complication from the substance exposure and discharge status, and any recommended follow-up medical care.
- Obtain information from the health care professionals regarding their observations of the parental responsiveness to the newborn, visitation, feeding, understanding of the newborn's special needs or any other information to assist in the safety assessment.
- Advise the health care professional an assessment of the newborn's safety and risk of harm in the home environment is being completed and request he/she notify CPS prior to the newborn's discharge from the hospital.

If the newborn is hospitalized at the time of the report, visit the newborn's home environment **prior** to the newborn's discharge. If it is not possible to visit the home prior to discharge, visit the home on the day of the newborn's discharge, but no later than the Mitigated Response Time.

The CPS Specialist needs to actively engage a team in planning for a substance abused newborn.

The Coordination of SEN Cases (Exhibit 7) requires involvement with substance abuse services and medical professionals. If needed, consult with a community and/or contract substance abuse professional to gain clinical expertise and advice regarding severity of drug usage, signs and symptoms, behavioral indicators and motivation for treatment.

BEST PRACTICE TIP:
The Substance Abuse Behavioral Indicator Checklist will be of value to the process of completing the investigation/safety assessment. Substance Abuse Indicator Checklist (Exhibit 6).

Complete an assessment of the newborn's safety using the **Child Safety Assessment,** PS05400, found in the Forms Registry, and Exhibit 5, Child Safety Assessment and Protocol.

If the child is assessed as unsafe, complete a Safety Plan. A Safety Plan may include an In-Home or Out-of-Home Plan.

- An In-Home Safety Plan should include:
  - an identified non-substance abusing alternative caregiver in the home; or
  - at least one reliable, non-substance abusing adult who has regular contact with and care of the newborn.

Assess the alternative caregiver's capacity to care for the newborn. At a minimum, the assessment should include:

- any history of substance use;
- the protective capacity of the alternative caregiver; and
- any history of criminal activity or child abuse or neglect indicating that the newborn's health or safety would be at risk of harm if placed in the caregiver's home and/or by the alternative caregiver.

- An Out-of-Home Safety Plan is required when an In-Home Safety Plan can not ensure the newborn's safety. The Out-of-Home Safety Plan may include:

  - temporary placement by the parent with a relative or other significant person;
  - community placement;
  - voluntary foster care;
  - filing an out-of-home dependency petition

BEST PRACTICE TIP:

If a safe and willing kinship caregiver can be identified to go into the home and care for the child, this is preferable to removing the child. Family engagement, building trust and helping the family see that the CPS Specialist wants what is best for them will assist in identifying appropriate kinship providers.

Engage the family in completing a family assessment using the PS05401, Family Centered Strengths and Risks Assessment Interview and Documentation Guide, (Exhibit 16), the Family-Centered Strengths and Risks Assessment Rating Reference, (Exhibit 17), and the Strengths and Risks Assessment window to determine the level of risk and needs of the newborn, and to determine the appropriate intervention. Use the Guide/Instructions to Assessing Risk Factors for Substance Exposed Newborns, (Exhibit 8) to assist in this assessment. This Guide should be used in totality as no single factor alone should determine the level of risk or intervention.

Provide the parent with a copy of the Arizona Families F.I.R.S.T. brochure, Arizona Families F.I.R.S.T (Exhibit 9). Also, inform the parent that his/her participation in the substance abuse assessment and treatment, if recommended, is expected in order to assist CPS in the assessment of the family and will be used as a framework for intervention.

Refer the parent to Arizona Families F.I.R.S.T or other substance abuse resource to begin the engagement and assessment of the parent's substance abuse dependence and treatment needs. Ensure the referral contains accurate information to assist the provider in contacting the parent within 24 hours excluding weekends and holidays, and as much information available regarding the parent's substance use.

Ensure that the parent signs the ACY-1125AFORNA, *Consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information* for release of information with the Arizona Families F.I.R.S.T. provider or other substance abuse resource. This consent will enable the substance abuse provider to share information regarding clinical concerns, client engagement, severity of the addiction, recovery environment, treatment recommendations, identifying co-occurring issues and potential for relapse.

Determine what further action shall be taken. At a minimum, the case must be opened for services to ensure the newborn's continued safety and the family's participation in services. While the case is open for services, maintain face-to-face contact with the parent and newborn (and alternative caregiver, if applicable) in the home at least once a month in order to determine whether:

- progress is being made towards alleviating the risk of abuse and neglect; and
- the newborn continues to remain safe in the home.

Coordinate with the Arizona Families F.I.R.S.T provider or other substance abuse resource to expedite the engagement and assessment process and to obtain results of outreach and assessment conducted. See Roles and Responsibilities in the Coordination of SEN Cases, (Exhibit 7).

If the Arizona Families F.I.R.S.T provider or other substance abuse resource informs the CPS Unit Supervisor that the family has refused or discontinued treatment, reassess safety and risk factors. Determine the appropriate level of intervention based on the outcome of the reassessment. Further intervention may include:

- placement with relatives outside the home;
- voluntary foster care;
- filing a dependency petition requesting In-Home Intervention;
- filing an in-home dependency petition; and/or
- filing an out-of-home dependency petition.

If the Arizona Families F.I.R.S.T provider or other substance abuse resource reports a new allegation of abuse or neglect, ask the provider to make a report to the Child Abuse Hotline.

To determine whether it is appropriate to close the case, determine whether the parent:

§ recognizes the safety and/or risk factors that caused the child to be unsafe or at risk of harm;
§ has taken steps to change the behavior or conditions that place the child at risk of harm and that these steps are sufficient to lead you to believe that the child will be safe at home in the foreseeable future;
§ is involved with extended family members, community support networks or service providers who will help the family maintain these changes over time; and
§ knows how and where to access help if problems arise in the future.

If the parent placed the newborn with an alternative caregiver, determine whether the caregiver:

§ needs follow-up services to continue to meet the newborn's needs; and
§ is aware of available financial and non-financial services and eligibility requirements, and, if necessary, assist the caregiver:

- o to complete applications for services; and/or
- o to access needed services through the department or community resources.

The Child Protective Services case may be closed when:

- the family is able to care for the newborn safely without department involvement; or
- the family no longer wishes to participate in voluntary services and the safety and risk factors are not severe enough to warrant filing an in-home or out-of-home dependency petition.

Prior to closing the case at **investigation or ongoing status**, convene a case conference with the family and Arizona Families F.I.R.S.T provider or other substance abuse resource (other service providers or professionals working with the family may be included) to ensure that the family understands:

- the child's safety must be maintained;
- the case status;
- recommended services;
- the need for successful completion of treatment and other recommended services; and
- failure to participate in treatment will result in reassessment of safety and risk factors and revision of the case plan.

DOCUMENTATION :

Document the outcome of the assessment of newborn's safety using the Child Safety Assessment Summary Window.

Document the outcome of the Family Assessment using the Strengths and Risks Assessment window. See the Family-Centered Strengths and Risks Assessment Introduction and Instructions, (Exhibit 15) for further instructions.

Revision History:
DES(07-2006)

Previous / Next

2-6

Legal Basis: The Indian Child Welfare Act of 1978 (P. L. 95-608) requires states to adhere to certain standards and procedures when Indian children are involved in involuntary child custody proceedings in state court. An involuntary proceeding includes the removal of an Indian child from the child's parent, guardian or Indian custodian, or an action for foster care placement of or the termination of parental rights to an Indian child.

The Act defines an Indian child as an unmarried person who is under the age of eighteen and is either a member of an Indian tribe or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

The Act requires notice be provided to the parent or Indian custodian and the Indian child's tribe by registered mail with return receipt requested, of the pending dependency proceedings and of the right to intervene.

ICWA mandates that in any state court proceeding for the foster care placement of, or termination of parental rights to an Indian child, the Indian custodian of the child and the Indian child's tribe shall have the right to intervene at any point in the proceeding.

Rule: Rules pertaining to a child for Indian Child Welfare Act (ICWA) purposes are found in 25 Code of Federal Regulations (CFR) 23.

The Child Safety Assessment and the Family Centered Strengths and Risk Assessment is completed in the same way as with any other child.

See Chapter 18 policies and procedures for serving Native American Children and their families.

Revision History:
DES(07-2006)

Chapter 2: Section 6

Reports Involving Native American Children

Legal Basis

Revision History:
DES(07-2006)

Previous / Next

2-7

Legal Basis: Arizona's mandatory child abuse reporting law requires that a report shall be made to CPS when there are "reasonable grounds to believe there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant." [**ARS §13-3620(A)**]

Rules: Federal rules concerning Infant Doe reports are set forth in the Federal Register, 45 CFR Part 1340, Child Abuse and Neglect Prevention and Treatment Program: Final Rule.

Revision History:
DES(07-2006)

Chapter 2: Section 7

Reports Involving Infant Doe Reports

Legal Basis

Policy: The department shall promptly notify health care facilities concerning Infant Doe reports.

The department shall coordinate with hospital-based Infant Care Review Committees regarding Infant Doe reports. However, the department shall make an independent determination regarding the necessity for CPS intervention.

The infant's current quality of life due to a handicap or disability shall not be considered in determining if Child Protective Services has grounds for action.

Infant Doe requirements shall apply to any child under one year of age. They may also be applied to children older than one year who have been continuously hospitalized since birth, who were born extremely prematurely or who have a long term disability.

Respond to Infant Doe reports within the time frames specified in the CPS Response System (Chapter 1, Section 3).

Follow procedures previously specified for responding to CPS reports, with the following exceptions:

§ Notify the Program Manager of the report verbally. He or she will notify the ACYF Program Administrator. Follow-up with a written Unusual Incident Report, J-309.

§ Coordinate the investigation with the Division of Developmental Disabilities, if appropriate.

§ Engage independent medical consultation. Consult with the Program Manager regarding authorization of payment for the consultation.

§ Request and review medical records, in consultation with a medical consultant. If the hospital refuses to make medical records available, consult with your supervisor and the Attorney General's Office.

§ If necessary, take temporary custody of the infant to obtain independent medical consultation.

§ After consultation with your supervisor and with the Attorney General's Office, file a

dependency petition, if

- the medical examination will take more than 12 hours; or
- there is unresolvable disagreement between parent or guardian plans regarding treatment and the recommendations of the Infant Care Review Committee; or
- the hospital has no Infant Care Review Committee and there is irresolvable disagreement between the parent or guardian, the child's physician and/or the independent medical consultant; or
- it appears that nutrition, hydration, appropriate medication or medical treatment is being withheld.

Revision History:
DES(07-2006)

Previous / Next

2-8

Legal Basis: ARS §8-802 directs the department to receive reports of dependent, abused or abandoned children.

Rules: Rules pertaining to receiving and screening Child Protective Services (CPS) reports are found in Section R6-5-5502 through R6-5-5504 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 8

Reports Concerning Munchausen Syndrome By Proxy (MSBP)

Legal Basis

Policy: Confirmed or suspected cases of Munchausen's Syndrome By Proxy (MSBP) shall be investigated and managed using a multidisciplinary team (MDT) comprised of involved professionals, including the assigned CPS Specialist, the supervisor, the treating medical doctor, a psychiatrist, Attorney General staff, and law enforcement.

An MSBP expert shall be consulted at all critical decision making points in a case where MSBP is suspected or confirmed (for example, diagnosis, treatment, removal, placement and visitation decisions).

An allegation of abuse or neglect based on a diagnosis of MSBP shall not be substantiated unless the diagnosis has been confirmed by:

- The treating medical doctor which is based on medical records or the current condition of the child; and the opinion of a psychiatrist that the alleged perpetrator presents psychological characteristics and motivation consistent with MSBP; or
- Direct or circumstantial evidence that the alleged abusive parent/caretaker caused the medical condition of the child; or
- A confession from the perpetrator; or
- Video surveillance tapes which show the perpetrator taking some action which induces the medical condition of the child, combined with other medical evidence of unexplained illness in the child.

To assess if there is reason to suspect MSBP, consider the following questions:

- Does the child have a history of unexplained illnesses, with multiple doctor visits, hospitalizations, medical procedures, or surgeries?
- Have any other children in the family had undiagnosed illnesses beyond the normally expected frequency or degree of seriousness?
- Has a medical doctor reported that MSBP is suspected or confirmed?
- Is there direct or circumstantial evidence that the parent/caretaker induced illness in the child?
- Has the parent/caregiver confessed to exaggerating or inducing illness in the child?
- Have video surveillance tapes revealed that the parent/caregiver took some action to cause illness in the child?
- Does absence of the parent/caregiver result in a decrease of symptoms or recovery in the child?

Implementation and Procedure Guide

Assess the child's immediate safety as described in Completing the Child Safety Assessment (Chapter 2 Section 2).

If MSBP is suspected or confirmed, provide emergency intervention to ensure the child's safety.

If MSBP is suspected or confirmed:

- Consult with an Assistant Attorney General to identify an MSBP expert.
- Obtain recommendations from the MSBP expert regarding diagnosis, treatment, removal, placement, visitation, and other critical case management decisions.
- Convene an MDT comprised of involved professionals, including the assigned CPS Specialist, the supervisor, the treating medical doctor, a psychiatrist, Attorney General Staff, and law enforcement within ten work days from the date of initial response to the CPS report.
- Provide copies of the social history, medical, and any other relevant information, including the recommendations of the MSBP expert, to other professionals involved in the case and serving on the MDT.
- Obtain recommendations from the MDT regarding diagnosis, treatment, removal, placement, visitation, and other critical case management decisions.

In all cases where a diagnosis of MSBP is confirmed, the child victim must be voluntarily or involuntarily removed from the alleged perpetrator's care. Develop a safety plan to ensure the child's safety in accordance with Chapter 3, Section 1.

When considering placement of the child with a non-abusive parent, extended family member or other significant person, carefully assess the perspective caregiver's ability and willingness to protect the child from the alleged perpetrator, including his or her perception of whether the suspected abuse did, or could have, occurred.

Assess the danger of parental contact to the child and determine if a no contact order should be requested. Ensure that visitation, including visitation in a hospital setting, is closely supervised by one or more persons who have been instructed to observe all physical contacts between the parent/caregiver and the child.

Gather information as described in **Chapter 2, Section 1,** and through the following means

- § Obtain all available medical records on the child from birth to present, and any other relevant medical records on siblings or other family members.
- § Personally interview all previous medical providers for the child victim.
- § Interview family members and other persons with knowledge of the family, to obtain a detailed social history on all children, parents, grandparents, and other significant family members.
- § Interview persons separately.
- § When appropriate, cooperate with hospital and law enforcement personnel to arrange and monitor video surveillance of the child and perpetrator.

Arrange for a psychiatrist familiar with MSBP to evaluate the parent/caregiver, provide a report with recommendations, and participate as a member of the MDT.

Obtain diagnostic opinions from all medical doctors and psychiatrists assessing or treating the family. At minimum, obtain one diagnostic opinion from the treating medical doctor and one from the psychiatrist who evaluated the alleged perpetrator.

If a diagnosis of MSBP is confirmed, continue cooperating with law enforcement and the child's and family's treatment team to obtain additional information and observations which would support or refute the diagnosis of MSBP.

Include the Assistant Attorney General in all decision-making aspects of the case**.**

File motions, if necessary, to expedite acquisition of all medical records, restrict or disallow visitation, or to compel the perpetrator or other family members to participate in assessment or treatment services.

Invite all members of the MDT to all case plan staffings and involve the team in decisions

regarding the permanency goal, the child's placement, visitation, services provision, risk assessment, and reassessment.

DOCUMENTATION :

Document the Safety Assessment on the Safety Assessment window.

Document the Safety Plan using the Child Safety Assessment, Part 5 (PS-054).

Document all contacts and relevant information using the Case Notes window, designated as Investigation type.

Document the Visitation Plan using the Visitation window.

Revision History:
DES(07-2006)

Previous / Next

2-9

Legal Basis: Not applicable

Rules: Rules pertaining to procedures for investigation of out-of-home provider found in Section R6-5-5516 of the Arizona Administrative Code.

Revision History:

DES(07-2006)

Chapter 2: Section 9

Reports Concerning Out-of-Home Care Providers

Legal Basis

Policy: Procedures governing investigations of reports concerning an out-of-home placement are aimed at ensuring the health and safety of children while respecting the rights of providers.

All reports of abuse or neglect concerning an out-of-home care provider shall be investigated by a CPS Specialist. This includes investigations of reports involving the following placement settings:

- unlicensed non-relatives;
- unlicensed relatives;
- licensed family foster homes;
- certified adoptive homes; and
- DES certified child care homes.

The out-of-home care provider shall be notified within six hours when a child has been interviewed or removed.

Implementation and Procedures Guide:

Follow the procedures for CPS investigations, as previously described in this chapter.

In addition, implement the following special procedures:

- Notify or ensure that the following individuals are notified of the report and the plans for investigation within eight working hours of receipt of the report:
  - the parent(s) or legal guardian of each child in the home;
  - the CPS Specialist and/or CPS Specialist's supervisor for each child in the home (The Child Abuse Hotline will notify these individuals through a CHILDS Alert.);
  - the attorney and/or guardian ad litem and CASA for each child in the home; and

- the provider's OLCR/Family Home Licensing liaison or certification specialist and/or supervisor, including public or private licensing agencies.

- Complete the Unusual Incident Report, J-309 and process according to form instructions.
- Conduct an opening conference with the out-of-home care provider, licensing specialist and/or child's CPS Specialist in order to clarify the allegations and process of investigation.
- Provide a copy of the PAC-616, Investigation of DES Licensed Foster Home Homes, to licensed foster and foster-adoptive parents.
- Videotape or audiotape all interviews of children, out-of-home care providers and the alleged abusive person regarding allegations of sexual abuse of foster children in the home. If any individual refuses to be taped, note this in the case record.
- Complete the investigation within five working days. If it is necessary to extend the investigation, notify each child's parent(s) or legal guardian, out-of-home provider and all involved staff of the reason for the delay and the anticipated date for completion.

In an emergency situation where abuse or neglect has occurred, remove the child without consultation. Notify the following individuals within 24 hours of the removal:

- the child’s CPS Specialist and/or supervisor;
- the provider’s OLCR Family Home Licensing liaison and/or supervisor, if applicable;
- the Office of Licensing, Certification and Regulations (OLCR) representative;
- the Program Manager or designee; and
- the Assistant Attorney General if the child is placed in the physical custody of the provider.

Follow the procedures outlined in Chapter 6, Section 14 if the out-of-home caregiver disagrees with the removal of the child and requests a case conference.

If the findings indicate that the report is unsubstantiated:

- Verbally notify each child's parent(s) or legal guardian, out-of-home care provider, and staff of the investigative findings **within eight working hours**.
- Provide written notification of the investigation findings **within three working days**.
- Inform the OLCR/Family Home Licensing liaison of any licensing concerns **within three working days**.

- Complete the written report of the investigation and findings **within ten working days** after completion of the investigation.

If the findings indicate that the department intends to substantiate the report:

- Inform each child's parent(s) or legal guardian, attorney or guardian ad litem, out-of-home care provider and staff of the proposed substantiated findings **within eight working hours** after completing the investigation.
- **Within five working days** after completing the investigation, convene a case conference that includes the following individuals:
  - the out-of-home care provider;
  - the CPS Specialist and his or her supervisor;
  - each child's CPS Specialist and his or her supervisor;
  - the Assistant Attorney General responsible for licensing;
  - the Office of Licensing, Certification and Regulations (OLCR) representative;
  - the OLCR/Family Home Licensing liaison or certification specialist and supervisor, if applicable; and
  - the Program Manager or designee.

The out-of-home care provider may bring a person representing his or her interests. The provider must waive his or her right of confidentiality prior to this person's participation in the case conference. Personally identifying information shall not be disclosed to persons not authorized to receive information pursuant to ARS §8-807.

In addition, invite each child's parent(s) or legal guardian to attend. Other staff members, law enforcement, or legal counsel may be invited to participate, as necessary.

At the case conference:

- Discuss the proposed substantiated investigation findings.
- Discuss and determine any agency recommendations regarding licensing.
- Provide the out-of-home care provider an opportunity to discuss the findings of the CPS investigation and licensing issues.

Be aware of the following responsibilities for follow-up:

- If the case conference results in a licensing recommendation other than revocation, OLCR/ Family Home Licensing liaison sends the licensed out-of-home provider a letter discussing any licensing issues within three days of the case conference.
- If the recommendation of the case conference is to revoke the license of a provider, offer the provider the option of voluntary withdrawal from the program.
- If revocation is required, the OLCR Program Administrator or designee sends the provider a letter within four weeks of the case conference, after consultation with an Assistant Attorney General.
- If the case conference confirms a proposed substantiated finding, notify the Protective Services Review Team of the finding within one day of the case conference.

DOCUMENTATION :

In addition to the requirements for documentation of CPS investigations, described above, document the following using the Case Notes window:

- notification of each child's parent(s) or legal guardian, case manager and/or supervisor, and OLCR Family Home Licensing liaison or certification specialist and/or supervisor, of the report and the plans for investigation;
- the opening conference with the out-of-home care provider or the reason that the conference did not occur;
- in cases of alleged sexual abuse, the refusal of any party to have his or her interview audiotaped or videotaped; and
- any reasons for extending the investigation beyond the required five day time frame.

File a copy of the Unusual Incident Report, J-309, in the hard copy record.

If the report is unsubstantiated:

- Document the verbal and written notification of parent(s), legal guardian, out-of-home care provider and staff of the finding;
- Send a copy of the confidential written report of the investigation to each child's CPS Specialist, the provider’s OLCR/ Family Home Licensing liaison or certification specialist and/or supervisor and Program Manager; and
- File the original report in the hard copy record.

If the department intends to substantiate the report:

- Send a copy of the confidential written report of the investigation to each child's CPS Specialist, the provider's OLCR/Family Home Licensing liaison or certification specialist and/or supervisor and Program Manager; and
- File the original report in the hard copy record.

Revision History:
DES(07-2006)

Previous / Next

2-10

Legal Basis: Not applicable

Rules: Rules pertaining to procedures for investigations in a Licensed Child Welfare Agency are found in Section R6-5-5515 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 10
Reports Concerning Licensed Child Welfare Agencies

Legal Basis

Policy: The ACYF CPS Group Care CPS Specialist shall be responsible for investigations in licensed child welfare agencies. All reports of abuse or neglect concerning licensed child welfare agencies shall be investigated by a CPS Specialist.

The ACYF CPS Group Care Specialist may investigate reports jointly with district CPS personnel.

Agencies shall have the right to:

- be in formed of the investigation and nature of the allegation, to receive a description of the investigation process, and to be in formed of staff and children who will be interviewed, except when the administrator is the alleged abusive person or when prior notice may jeopardize the safety of the child;
- seek legal counsel at any time during the investigation process;
- have the opportunity to present and discuss information relevant to the investigation before a determination is made;
- be given a status report on the progress of an investigation not completed within 21 days;
- written notice of investigation findings;
- receive a redacted copy of the CPS report and a redacted copy of the written report of the CPS investigation [**ARS §8-802(C)(7)(a)**]; and
- have their licensing record fully cleared if allegations are unsubstantiated and to be assured that licensing staff will communicate the unsubstantiated findings when public inquiries are made.

Implementation and Procedures Guide:

ACYF Group Care CPS Specialist:

Follow the procedures for CPS investigations as previously described.

In addition, implement the following special procedures:

- Identify who will participate in the investigation. Participants may include the local CPS office, law enforcement, or representatives of other agencies.
- Notify the following of the report:
    - the child welfare agency within two hours of receipt of the report during a regular working day (or no later than 10:00 a.m. the following morning);
    - the agency administrator, unless an unannounced visit is planned;
    - law enforcement; and
    - the local CPS office, if a joint investigation is planned.
- Complete the Unusual Incident Report, J-309, and process according to form procedures.
- Plan visits to minimize disruption to the agency, whenever possible. If the visit is unannounced, notify the agency administrator or designee immediately upon arrival.
- Audiotape or videotape interviews with children, agency staff, and alleged abusive person(s). If any individual refuses to be taped, note this in the record.
- Conduct an exit conference before leaving the agency:
    - to review the investigation and clarify procedures;
    - to offer the agency the opportunity to submit for consideration the facility's internal investigation report within ten days; and
    - if applicable, to discuss the content of a Corrective Action Plan.

If the report is determined to be unsubstantiated:

- Send written notice of the investigation findings to all parties who were notified of the investigation within five working days after the completion of the investigation.
- Document the investigation and findings in the agency's CPS case record.

If the department intends to substantiate the report:

- Convene an internal case conference to discuss the proposed investigation findings. Participants may include the ACYF Field Operations Manager, ACYF Group Care CPS Specialist, OLCR licensing specialist, CPS Unit Supervisor, district CPS Specialists,

other DES staff, the CPS Specialist(s) of the children affected, an Assistant Attorney General and others, as appropriate.

- Notify the Protective Services Review Team of the proposed substantiated finding within one day of the case conference.

If licensing issues arise as result of the investigation or case conference, the OLCR Licensing Specialist will notify the agency in writing within ten working days of the conference, sending copies to:

- the OLCR Community Care Licensing Unit Manager;
- the child's CPS Specialist and/or child welfare agency or court-ordered representative authorized to act on behalf of the child; and
- the ACYF Program Manager.

DOCUMENTATION :

Send a redacted copy of the CPS report and a redacted copy of the written report of the CPS investigation to the administrator of the child welfare agency **within 15 working days** after completion of the investigation. If the administrative head is the alleged abusive person, send the above reports to the agency's board of directors.

Send an unredacted copy of the written report of the CPS investigation to the child's CPS Specialist **within 15 working days** after completion of the investigation.

Document the investigation and findings in the agency's CPS case record.

Maintain all records of the investigation and case conference in the agency's CPS record.

File a copy of the Unusual Incident Report, J-309 in the agency's CPS record.

Revision History:
DES(07-2006)

Previous / Next

2-11

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 2: Section 11

Reports Concerning a DCYF Employee

Legal Basis

Policy: Investigations of reports of abuse or neglect of a child by a DCYF employee and/or reports alleging an employee's child is the victim of abuse or neglect shall be conducted in a manner that will protect the rights of the employee and ensure the safety of the child.

Any report alleging the abuse or neglect of a child by a DCYF employee or any report alleging an employee's child is the victim of abuse or neglect shall be referred directly to the Program Manager of the district in which the abuse or neglect occurred.

The Program Manager may request that a CPS Specialist from an adjoining district be assigned to investigate the report.

CPS reports on other DES staff (for example, Job Services, FFA) shall be investigated according to standard procedures. If a CPS Supervisor is concerned about any perceived conflict, he or she may consult with the Assistant Program Manager or Program Manager.

Revision History:
DES(07-2006)

Previous / Next

2-12

Legal Basis: ARS §8-802(C)(9) requires the department to enter an investigation finding within 21 days of the date that the department received the initial report information.

ARS § 8-807(P) permits the department to summarize the outcome of the investigation to the person who reported the suspected child abuse or neglect.

ARS § 8-811(K) requires the department to provide the parent, guardian or custodian who is the subject of the investigations, *and* the person who reported the suspected child abuse of neglect if that person is the child's parent, guardian or custodian with a copy of the outcome of the investigation at one of the following times;

- when the report is unsubstantiated;
- when the report is "proposed substantiated perpetrator unknown";
- after the time to request a hearing on a proposed substantiated finding has lapsed without the department receiving a request for the hearing; or
- after a final administrative decision has been made on the proposed substantiated finding.

ARS §13-2907.02 states that a person who knowingly and intentionally makes a false report of child abuse or neglect knowing the report is false or a person who coerces another person to make a false report of child abuse or neglect knowing the report is false is guilty of a class 1 misdemeanor.

ARS §13-3620.01 states that a person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect, or a person acting with malice who coerces another person to make a false report of child abuse or neglect is guilty of a class 1 misdemeanor. A person who knowingly and intentionally makes a false report that a person has violated this provision is guilty of a class 1 misdemeanor.

ARS §8-201.01(1) states that a child who, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner shall not, for that reason alone, be considered to be an abused, neglected or dependent child.

ARS §8-201.01(2) states that a child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered to be an abused, neglected or dependent child for that reason alone.

ARS §8-819 states the department, when determining whether a child has been neglected, shall consider:

§ the drug or alcohol abuse by the child's parent, guardian or custodian;
§ the use by the mother of a dangerous drug, a narcotic drug or alcohol during pregnancy if the child, at birth or within a year after birth, is demonstrably adversely affected by this use. A dangerous drug or narcotic drug has the same meaning as prescribed in ARS §13-3401.

Rules: Rules pertaining to Investigation Findings are found in Sections R6-5-5509 and R6-5-5510 of the Arizona Administrative Code.

Rules pertaining to summarizing the outcome of the investigation to the person who reported the suspected child abuse or neglect are found in Section R6-5-5607(C) of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 12

Determining Whether Maltreatment Occurred

Legal Basis

Policy: The department shall enter an investigation finding within 21 days of the date that the department received the initial report information [**ARS §8-802(C)(9)**].

The department shall notify the parent, guardian or custodian, who is the alleged perpetrator (alleged abuser) of the investigation finding in writing.

The department shall notify the reporting source who is the parent, guardian or custodian of the investigation finding in writing at one of the following times:

- when the report is “unsubstantiated”; or
- when the report is “proposed substantiated perpetrator unknown”; or
- after the time to request a hearing on a proposed substantiated finding has lapsed without the department receiving a request for the hearing; or
- after a final administrative decision has been made on the proposed substantiated finding.

The department shall advise the parent, guardian or custodian of his or her right to appeal a proposed substantiated finding before entry of the finding into the CHILDS Central Registry and of the right to receive a redacted copy of the report.

If the investigation indicates the probability that the reporting source knowingly made a false report, the CPS Specialist shall consult with the Attorney General's Office regarding referral to law enforcement.

Substantiation

The Substantiation Guidelines (Exhibit 11) are provided to assist workers in making a decision regarding substantiation of abuse or neglect.

To determine if a report is substantiated, the CPS Specialist must consider the following questions:

- Are there facts which provide a reasonable ground to believe that abuse or neglect occurred?
- Has any parent, guardian or custodian admitted being abusive or neglectful?

- Did the parent, guardian or custodian have reason to know another person would abuse or neglect the child? How did they know?
- Did the parent, guardian or custodian allow another person to abuse or neglect the child? How and when?
- Did the child provide age appropriate description and details of abuse or neglect?
- Did the child identify the person who caused the abuse or neglect?
- Are there any witnesses? What did they see? Did they document what they saw?
- Did you observe physical or behavioral signs of abuse or neglect? Are these signs consistent with the account provided by the child, witnesses or the alleged abusive parent, guardian or custodian?
- What do the reports of medical professionals, psychologists or other professionals indicate? Review all conflicting professional opinions with a Multidisciplinary Team (including a physician) with 48 hours.
- Is there a diagnosis by a medical doctor or psychologist that the child is suffering serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior that is the result of behavior by the parent, guardian or custodian?
- To what extent is the information provided by members of the family consistent?
- Is there a prior history of child abuse or neglect? Does the current report involve the same abusive parent, guardian or custodian and child?
- Do the family dynamics (such as domestic violence or substance abuse) contribute to the child abuse or neglect?

To determine if a report is substantiated and the perpetrator is unknown, the CPS Specialist should consider the following additional questions:

- Have you thoroughly considered all of the evidence?
- After thorough consideration of the evidence, is the perpetrator unknown?
- Is there substantial risk of harm to the child? How?

To determine if a report finding is unable to locate, ask yourself these additional questions:

- Were reasonable efforts made to locate the child victim?
- Is the location of the identified child victim unknown despite reasonable efforts to locate the child?
- Is there insufficient evidence to conclude that the child was abused or neglected without interviewing or observing the child?

BEST PRACTICE TIP:
While the need to substantiate whether or not abuse or neglect occurred, it is only the first step in the process. Once having decided that harm to a child occurred or may occur, the next step—and possibly the most important—is to find a way to engage the family in services and supports so that the child will not be harmed again.

To determine the credibility of information, consider the following questions:

- Is the child able to provide consistent descriptions or details about the abuse or neglect?
- Is the child known by others to be truthful?
- Is the information corroborated by other independent evidence?
- Was the information provided at the same time as the incident or immediately after?
- Does the information contain sufficient detail?
- •Was the information consistent throughout the investigation?
- •Does the source of information have a motive to lie?
- Was the information prepared in the official course of business? (i.e. reports from police, emergency medical personnel, physicians).
- Is the reporting source related to the alleged abusive parent, guardian or custodian or have an interest in the outcome of the investigation?
- Is the reporting source of the information willing to sign a statement/affidavit or testify in a court proceeding?

To determine if the reporting source knowingly made a false report, ask yourself the following questions:

- Is there a likelihood of financial gain or other benefit to the reporting source?
- Has the reporting source admitted making a false report? To whom?
- Has the reporting source made a prior report where the evidence indicated the report to be false?
- Is there a history of family disputes?
- Are custody issues being decided concurrently with the report?
- Was the report made to harass, embarrass, intimidate or harm another?
- Have statements been made during the investigation which indicate retaliation?

Implementation and Procedure Guide

Review Substantiation Guidelines (Exhibit 11) and apply the Legal and Applied Definitions for each category of abuse and neglect prior to determining whether child abuse or neglect occurred.

When determining whether a child has been neglected, consider:

- § the drug or alcohol abuse by the child's parent, guardian or custodian;
- § the use by the mother of a dangerous drug, a narcotic drug or alcohol during pregnancy if the child, **at birth or within a year after birth**, is demonstrably adversely affected by this use. A dangerous drug or narcotic drug has the same meaning as prescribed in **ARS §13-3401**.

It is not an act of neglect if:

- § the child suffers from a disability or chronic illness and services are unavailable to treat the child's disability or chronic illness, or
- § the child, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner for that reason alone, or
- § the parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of such medication for that reason alone.

It is not an act of physical or emotional abuse if, for that reason alone:

- § the child, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner, or
- § the parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of such medication.

Consult with and obtain the approval of the supervisor to determine the outcome of the investigation and investigation finding. Consult with the Protective Services Review Team (PSRT) Specialist when there is uncertainty or questions regarding whether the evidence supports the finding.

Enter the finding and tracking characteristic if applicable in the Investigation Allegation Findings window and/or Investigation Tracking Characteristic Findings window **within 21 days** of the date that the department received the initial report information.

Enter a finding of "proposed substantiated", after an investigation, when there is probable cause to support a finding of abuse or neglect. (Probable cause means facts which provide a reasonable ground to believe that abuse or neglect occurred). Upon supervisory approval, CHILDS will alert PSRT of this finding.

PSRT will provide written notification of the proposed substantiated finding, to the parent, guardian or custodian who is the alleged perpetrator (alleged abuser), using the Notification - Proposed Substantiated Finding PS05000.

Enter in the CHILDS Central Registry a finding of "proposed substantiated perpetrator deceased" after an investigation when there is probable cause to support a finding of abuse or neglect, and

the abusive parent, guardian or custodian dies prior to entry of the finding. This finding will remain in the CHILDS Case Management Information System and is not subject to the appeals process. No notification is necessary as the perpetrator is deceased.

Enter in CHILDS a finding of “proposed substantiated perpetrator unknown” after an investigation when there is probable cause to support a finding of abuse or neglect and the abusive parent, guardian or custodian can not be identified.

Enter in CHILDS a finding of unsubstantiated, after an investigation, when there is not probable cause to support a finding of abuse or neglect. This finding will remain in the CHILDS Case Management Information System.

Provide written notification of “unsubstantiated” finding or “proposed substantiated perpetrator unknown” to the parent, guardian or custodian who is the alleged perpetrator (alleged abuser), using the Notification - Unsubstantiated Finding PS05200, **within five days** of completing the investigation.

Provide written notification of unsubstantiated or proposed substantiated perpetrator unknown finding, to the parent, guardian or custodian who is the reporting source, using the Notification - Reporting Source PS05100, after verifying the person is a parent, guardian or custodian *and* the person is identified as the reporting source on the CPS report. This finding will remain in the CHILDS Case Management Information System and is not subject to the appeals process.

Enter a finding of "unable to locate" when:

- the child victim cannot be located; and
- there is insufficient evidence to conclude that the child was abused or neglected without interview or observing the child.

The finding of “unable to locate” will remain in the CHILDS Case Management Information System and is not subject to the appeals process.

Once you have determined that a reporting source made a false report, consult with (and obtain approval of) your supervisor and the Attorney General's Office prior to referring a reporting source to law enforcement for knowingly making a false report.

DOCUMENTATION :

CPS Specialist

Using the Case Note window designated as Investigation Contact type, record all information obtained from persons interviewed, and correspondence received. Describe:

- the type of abuse or neglect that occurred;

- physical description or condition of the child;
- the shape, size, color, location of injuries;
- the substantial risk of harm to the child;
- physical condition of the home;
- statements from the psychologist or physician that the child is exhibiting severe anxiety, depression, withdrawal or untoward aggressive behavior which is caused by the parent, guardian or custodian;
- evidence of sexual activity involving a child;
- the reasons the information obtained and/or the persons providing the information are or are not credible;
- all facts obtained during the investigation that indicate the original report was made by a person who knew the allegation was false at the time the report was made;
- the reasonable efforts made to locate the child and family; and
- reasons why the perpetrator is unknown.

Document the report finding on the Investigation Allegation Findings window and/or Investigation Tracking Characteristic Findings window **within 21 days** of the date that the department received the initial report information. [**ARS §8-802(C)(9)**] For "proposed substantiated" findings, enter the Finding Statement using the Investigation Allegation Findings Explain window.

Using the Case Notes window designated as Supervisory Contact type, document consultation and approval of your supervisor about a false report and referral to law enforcement.

Using the Case Note window designated as AG Contact type, document consultation with and approval of the Attorney General's Office to refer a person determined to have made a false report to law enforcement.

Using the Case Note window designated as Key Issue Contact type, document the referral of a reporting source who made a false report to law enforcement.

Document a false report by adding the Tracking Characteristic *FR* (False Report Indicated) on the After Investigation Allegation Finding Detail window.

Document services offered or provided to the family using the Investigation Allegation Findings Explain window.

File a copy of the Notification letters in the case record.

CPS Supervisor

Review the case record to ensure that the evidence supports the finding. If additional information is necessary to support the finding, return the case to the CPS Specialist to obtain the additional information. Review and approve or modify the proposed finding **within five days** of completion of the investigation. For "proposed substantiated" findings, ensure that the Finding Statement and services offered or provided to the family are documented on the Investigation Allegation Findings window.

For "proposed substantiated" findings concerning an out-of-home care provider or child welfare agency, review and approve or modify the proposed finding within one day of completion of the investigation or the case conference.

Revision History:
DES(07-2006)

Previous / Next

2-13

Legal Basis: Not applicable

Rules: Rules pertaining to assessment of risks are found in Section R6-5-5512 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 2: Section 13

Assessing The Risk Of Future Harm: Use Of The Family Centered Strengths And Risks Assessment

Legal Basis

Policy: Within 45 days of case opening or prior to closing the case at investigation, whichever occurs first, the worker must engage the caregivers and children within the family in interviews to identify relevant information about the family's history and functioning in each domain associated with risk of future maltreatment, including:

- History of Abuse/Neglect in the Family
- Parenting Skills and Expectations
- Substance Abuse Issues
- Mental Health Issues
- Physical Impairments
- Basic Needs (Food, Clothing, Shelter)
- Employment
- Health Issues
- Family Violence Issues
- Social and Economic Issues
- Social Supports

Every one of the eleven domain areas must be explored with the family.

Implementation and Procedure Guide

The strengths and risks assessment is a family centered process for gathering information about the family as well as to engage the family in the process of identifying their own strengths, protective capacities and needs using the PS05401, Strengths and Risks Assessment Interview and Documentation Guide (Exhibit 16), and the Family Centered Strengths and Risks Assessment Rating Reference, (Exhibit 17). These tools provide options for non-confrontational, solution focused, open-ended questions related to each risk domain. Ask as few or as many questions as necessary to assess the family's functioning in each of the life domains. See the Family Centered Strengths and Risks Assessment Instructions (Exhibit 15) for additional information on completing the family centered assessment.

BEST PRACTICE TIP:
A comprehensive family assessment is a "process," not the completion of a "tool." The tools

are helpful in documenting needs or in stimulating the conversation about assessment issues. The engagement of family members in a discussion that is individualized to their situation is vital. Simply completing a form will not capture all that is needed for comprehensive assessment.

If necessary, conduct additional interviews with extended family members and other significant persons in order to complete the strengths and risk assessment process.

BEST PRACTICE TIP:
CPS Specialists must systematically gather information and continuously evaluate the needs of children and parents/caregivers as well as the ability of family members to use their strengths to address their needs.

A comprehensive assessment:

- Recognizes patterns of parental behavior over time;
- Examines the family strengths and protective capacities to identify resources that can support the family's ability to meet its needs and better protect the children;
- Addresses the overall needs of the child(ren) and family that affect the safety, permanency and well being of the child(ren);
- Considers the contributing factors such as domestic violence, substance abuse, mental illness, chronic health problems and poverty; and
- Incorporates the information gathered into a plan for intervention.

Complete the Strengths and Risks Assessment window.

The issues identified during the assessment must include:

- assessment of *risks* in each of the life domains and the family's overall level of risk;
- identification of the *protective capacities of the family* that mitigate risk;
- identification of *strengths* that the family may build upon to enable them to care for their child safely;
- identify of the critical *risk factors* that must be addressed in order for the family to care for their child safely;
- determination of acceptable *outcomes or objectives* related to each risk factor, which, if achieved, would enable the child to live safely with the parents without department involvement;
- determination of the level of intervention and service needs of the family; and
- identification of any additional considerations or concerns that may impact on decision making in the case.

BEST PRACTICE TIP:
The continuous assessment of families' ability to address their needs is important; recognizing strengths can help families realize their capacity to change. In addition, the identified protective capacities can assist in mitigating the identified risk factors.
Strengths are those positive qualities or resources present in every family. Protective capacities are the resources and characteristics of the family members that can directly contribute to the protection and development of the children. It is important to note that the assessment of protective factors is not simply a listing of the positive qualities and resources; the protective factors must offset the risks related to abuse/neglect. The protective factors often have to be activated to play a relevant role within the service plan.

Protective Capacities might include:

- § Supportive family
- § Willingness by the parents to accept responsibility
- § Willingness of parents to change behavior
- § Understanding of child needs and developmental stages
- § Physical and emotional health of parents
- § Capacity to form and maintain healthy relationships
- § History of effective problem solving
- § Communication skills
- § History of effective parenting in the past

The strengths and risk assessment, in conjunction with the findings of the safety assessment/ investigation shall serve as:

- the basis to evaluate risk of present or future harm to the child;
- the level and type of intervention required by a family;
- whether to close or open a case for services; and
- as the basis for service planning.

The assessment process should be directly linked to the creation of the case plan.

Comprehensive assessment information must be updated whenever major changes in family circumstances occur and at points of key decision-making on a case. These include:

- § Decisions about in-home services
- § Placement decisions
- § Reunification decisions
- § Decisions related to changing the service plan (or case goal)

- § Adolescent permanent placement decisions
- § Formal reviews of progress including court reviews
- § Termination of Parental Rights decisions
- § Case closure

A systematic re-assessment of needs and strengths provides useful documentation on progress, risk reduction, justification of permanency decisions or requests which may be needed to inform the family, worker, supervisor or the court.

The Strengths and Risks Assessment window is not required when:

- Action Request Communications: Communications that do not require an investigation, but may require an action by CPS. These specific communications are contained in the CPS Response System, Tracking Characteristics (Exhibit 2)**.**
- Border Cases: A case involving a child whose family does not reside within the US and the department's involvement is limited to returning the child to his/her family in coordination with the Border Patrol and/or INS and the case is being closed. In this type of case, the family is not available to complete the Strengths and Risk Assessment.
- False (Malicious) Reports: After investigation, evidence indicates the reporting source knowingly and intentionally made a false (malicious) report, and the investigation results in no identified safety concerns or indication of risk. To determine if the reporting source knowingly and intentionally made a false report and should be referred to the County Attorney, refer to Determining Whether Maltreatment Occurred (Chapter 2 Section 9) .
- Transitional Independent Living Program: Closing a case involving a youth age 18 or older who has signed a voluntary foster care agreement.
- Alternative Investigations: if the child and/or family was not seen.

DOCUMENTATION :

Complete an assessment of present or future risk of harm to the child using the Strengths and Risks Assessment window. Using the Explain box, summarize the identified risks and protective factors identified during the assessment and the justification for the overall level of risk. Protective capacities as well as identification of future risk must be documented.

Revision History:
DES(07-2006)

Previous

3-1

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) sets forth federal case plan requirements.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 3: Section 1

Safety Planning

Legal Basis

Policy: When a Child Safety Assessment concludes that a child is unsafe, the department shall develop a safety plan to ensure the child's safety. The department shall determine the level of intervention necessary to manage the safety threats; identify safety services and supports that will enable the child to remain at or return home safety, or indicate the need for out-of-home care.

If the Child Safety Assessment concludes that the child is safe, safety intervention is not required.

If the Child Safety Assessment concludes that the child is unsafe, a safety intervention is required. To ensure that a sufficient safety plan is created, determine the level of intervention necessary to manage the identified safety factor (threat).

Evaluate the appropriateness of an In-Home Safety Plan using the following criteria:

- The caregivers are residing in the home which is an established residence.
- The home environment is calm and consistent enough for safety actions; safety services; and safety service providers can be in the home and be safe.
- The caregivers are willing:
  - to accept an in home option as the continuing safety plan;
  - for safety services to be deployed within the home according to the continuing safety plan;
  - to be cooperative with those who are participating in carrying out the continuing safety plan (i.e., safety service providers) within the home;
  - and agreeable to the designated tasks and time frequencies as set forth in the continuing safety plan;
  - and agreeable to expectations set for them within the continuing safety plan.

Evaluate the appropriateness of an Out-of-Home Safety Plan as the only option to ensuring the child's safety using the following criteria:

- Safety threats, as analyzed, are so extreme or occurring within the family in such a way so as to prevent In-Home Safety Plan.
- A child is out of control so as to prevent an In-Home Safety Plan.
- The nature of the home environment is chaotic, unpredictable or dangerous so as to prevent an In-Home Safety Plan.
- The caregivers are unwilling to accept an in-home option for the continuing safety plan;

are unwilling to accept people, resources or safety services that are available for a continuing safety plan.

- The caregivers' willingness to accept an in-home option for the continuing safety plan cannot be confirmed or relied upon.

Implementation and Procedures Guide

If the Child Safety Assessment concludes that the child is unsafe, a safety intervention (plan) is required. See Chapter 2 Section 2 Completion of the Child Safety Assessment.

The determination that a child is unsafe does not mean that the child must be removed from the home. Often a child can be made safe by the child's non-offending parent or caregiver, by the help and supports of family members and community supports.

> **BEST PRACTICE TIP:**
> Whenever possible, children should remain with their families. At times, a safety plan is required in order for the child to remain safely at home. Safety plans are most effective when jointly created with families and specifically address what action the child, child's family including kin will take if, at any time, the child's safety is in jeopardy. Safety plans that are developed with the child's parent(s) and involve kin provide a built-in support system for children and their families. In order to engage the child's parents, they must trust and believe that the CPS Specialist wants to help, to support them in caring for their own children. The most effective safety planning occurs when the family is fully engaged in the safety planning process.
>
> Family members can serve as a tremendous source of support to one another. The more successful you are in engaging the family; the more successful you will be in learning about "kin" during the safety assessment. Kin includes individuals who are related by blood and non-relatives who have a close relationship with the family.

Consult your supervisor prior to developing the safety plan with the family.

About Safety Planning

Safety Plans are actions taken to control and manage impending danger, have an immediate effect, be immediately accessible and available and contain safety services and actions only, not services designed to effect long-term change. It must be sufficient to ensure safety.

Safety Plans are effective when they meet the following specified criteria:

§ They are a written arrangement with the parent(s) and those who will help maintain safety (safety monitor) and the CPS Specialist.
§ They clearly specify the impending danger identified from a standardized set of safety factors (threats) and individually describe how they are seen within each family.

§ They identify how each impending danger safety factors (threats) will be managed and also specify:
- Who will perform what types of safety actions?
- What is the suitability of this person (s)?
- Under what circumstances will they perform the safety actions (i.e. location, who else will be there,)?
- What time frames (frequency, duration, and exact times and days) will the safety actions occur?
- The availability and accessibility of safety providers at the times the threats are present and need managing.
- A communication plan among participants.

Safety Plans are representative of the least intrusive/restrictive intervention. This means the most intrusive options are used only after all least intrusive options have been determined to be insufficient to assure safety.

- CPS maintains responsibility and accountability for the sufficiency of the safety agreement.
- Specifics related to governance of the safety agreement are stated clearly.
- Oversight and administration of the safety agreement is stated and is the responsibility of CPS.

About Safety Services

Safety services are designed to control and manage safety threats, not to effect long-term change. Safety services may include:

§ In-home to out-of-home placement (partial to total);
§ An evaluation of the protective role of parents (non-protective to significant);
§ Protective role of others (friends, relatives, others);
§ Safety service arrangements which can be very limited or quite extensive;
§ Types of supports that vary from informal supports such as relatives to neighbors, church members, paraprofessionals to professionals supports;
§ Clarification of parental access to child. It may be that, in order to ensure safety, the offending parent can have no access, or, perhaps, liberal supervised access is fine; and
§ Separation (temporary to permanent).

Develop the safety plan with the family including the child, if age appropriate. The safety plan should directly relate to the safety factors (threats) identified in the Child Safety Assessment.

Consider these questions in developing a safety plan:

- Is there a parent or other responsible adult at home who is willing and able to ensure the child's safety at this time?
- If not the caregiver, is there someone else who is close to the family who can be engaged to ensure the child's safety at this time?
- What types of safety services or supports can be provided to enhance the child's safety at home while the family addresses safety factors that necessitate DES involvement?
- If physical conditions in the home are hazardous and are determined to impact child safety, are there any community supports or individuals on whom the caregiver can rely to address these concerns?

An In-Home Safety Plan should not be developed when:

- there is no reliable, identified person within the family that can help to control and manage the safety factors (threats);
- the non-abusive parent has not demonstrated an ability to protect the child;
- the person identified as a safety monitor is employed and is not readily available;
- the caregiver does not recognize the safety threats and is not motivated to change; or
- the parent has separated from the maltreating parent as an action taken to ensure the child's safety, but has not demonstrated behavior to indicate that he/she will remain separated while the safety plan is in effect.

Safety Monitor

A safety monitor may be utilized to assist the CPS Specialist in ensuring child safety. The use of a safety monitor does not relieve the CPS Specialist of his/her responsibility for oversight and administration of the safety plan or continued assessment of the child's safety. Engage the family and ask their assistance in identifying appropriate individual(s) who can assist in ensuring the child's safety. When safety monitors are identified, assess their ability to use judgment and take actions that are and will continue to be protective of the child. Areas to consider include whether the individual:

- ü has demonstrated the ability to protect the child in the past (with or without CPS involvement) while under similar circumstances and family conditions;
- ü believes the child's report of maltreatment and is supportive of the child;
- ü is capable of understanding the specific threat to the child and the need to protect the child;
- ü displays concern for the child and the child's experience and is intent on emotionally protecting the child;
- ü has a strong bond with the child and that he/she is clear that the number one

priority is safety and well-being of the child;

- ü is physically able to intervene and protect the child;
- ü does not have significant individual needs which might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.;
- ü is emotionally able to carry out a plan and/or to intervene to protect the child (not incapacitated by fear of maltreating person);
- ü has adequate knowledge and skill to fulfill caregiving responsibilities and tasks. (This may involve considering the caregiver's ability to meet any exceptional needs that the child might have.);
- ü has asked, demands and expects the maltreating adult to follow the conditions of the safety plan and can assure that the plan is effectively carried out;
- ü consistently expresses belief that the maltreating person is in need of help and that he or she supports the maltreating person getting help. (This is the individual's point of view without being prompted by CPS.);
- ü while having difficulty believing the other person would maltreat the child, the individual describes the child as believable and trustworthy'
- ü has adequate resources necessary to meet the child's basic needs;
- ü is cooperating with the CPS Specialist's efforts to provide services and assess the specific needs of the family; and
- ü does not place responsibility on the child for the problems of the family.

In addition, obtain information to determine the safety monitor and members of his/her household are appropriate for this role, including completing a search for prior CPS involvement and a criminal records check with the Department of Public Safety. If an out-of-home safety plan is created, an assessment of the safety monitor's home should also be completed.

Once the safety plan is complete, review with the supervisor is essential. We want to make certain that the plan is sufficient to assure safety, that is, a prudent judgment is made by the CPS Specialist and supervisor that the degree of intrusiveness and level of effort represented in the safety plan will be reasonably effective in protecting a child.

Safety Planning is an ongoing part of the role of the CPS Specialist. If a safety plan is developed, it must be incorporated into the child's case plan. See Developing the Family Centered Case Plan (Chapter 9 Section 1).

DOCUMENTATION :

Document the safety plan using the **Child Safety Assessment**, Part 5, PS05400.

Provide a copy of the Safety Plan to the parent or caregiver and the person responsible for

carrying out the plan, if other than the parent.

Revision History:
DES(07-2006)

Next

3-2

Legal Basis: ARS §8-800 sets forth the primary purposes of child protective services as to protect children by investigating allegations of abuse and neglect, promoting the well-being of the child in a permanent home, coordinating services to strengthen the family and prevent, and to intervene in and treat abuse and neglect of children.

ARS §8-801 defines protective services as a specialized child welfare program that is administered by the department and investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family.

ARS §8-802(C) states that a Child Protective Services Worker shall promote the safety and protection of children.

ARS §8-821 establishes that CPS may take temporary custody of a child if probable cause exists to believe that the child is:

§ a victim suffering or will imminently become a victim of abuse or neglect that can not be mitigated through any safety plan;

§ suffering serious physical or emotional injury that can only be diagnosed by a medical doctor or psychologist;

§ physically injured as a result of living on premises where dangerous drugs or narcotic drugs are being manufactured.

ARS §8-821 also states that, if a child is taken into temporary custody, the child's sibling shall also be taken into temporary custody only if reasonable grounds independently exist to believe that temporary custody is clearly necessary to protect the child from suffering abuse or neglect.

ARS §8-821 states that a child who is taken into temporary custody for medical or psychological diagnosis must be returned within 12 hours, excluding weekends and holidays, unless the examination reveals abuse or neglect.

ARS §8-823 states that if a child is taken into temporary custody the Child Protective Services Worker shall provide written notice within six hours to the parent or guardian of the child unless:

§ the parent or guardian is present when the child is taken into custody, then written and verbal notice shall be provided immediately;

§ the residence of the parent or guardian is outside the state and notice cannot be provided within six hours, then written notice shall be provided within 24 hours;

§ the residence of the parent or guardian is not ascertainable then reasonable efforts shall be made to locate and notify the parent or guardian of the child as soon as possible.

ARS §8-514 requires the department to place a child in the least restrictive placement available, consistent with the needs of the child. The order of placement preference is: with a parent; grandparent; in kinship care with another member of the child's extended family, including a person who has a significant relationship with the child; in licensed foster care; in licensed therapeutic foster case; in a group home; or in a residential treatment facility. The placement preference for an Indian child is in accordance with the Indian Child Welfare Act.

ARS §8-514.02 authorizes the department to place a child with a parent or relative.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 3: Section 2

Providing Emergency Intervention

Legal Basis

Policy: If a child is in danger of imminent abuse or neglect, the department shall provide emergency intervention to ensure the child's safety.

The department shall engage the child's family to the greatest extent possible in planning for voluntary interventions that minimize department intrusion while ensuring the safety of the child.

The following circumstances indicate imminent harm and require emergency intervention:

- No caregiver is present and the child cannot care for him or herself or other children.
- A child has severe or serious non-accidental injuries or another condition that requires immediate medical treatment.
- A child requires immediate medical treatment of a life-threatening medical condition or a condition likely to result in impairment of bodily functions or disfigurement, and child's caregiver is not willing or able to obtain treatment.
- A child is suffering from nutritional deprivation that has resulted in malnourishment or dehydration to the extent that the child is at risk of death or permanent physical impairment.
- The home environment has conditions that endanger the child's health or safety, such as human or animal feces, undisposed garbage, exposed wiring, access to dangerous objects, or harmful substances that present a substantial risk of harm to the child.
- The child was physically injured as a result of living on premises where dangerous drugs or narcotic drugs are being manufactured.
- A doctor or psychologist has determined that a child's caregiver is unable or unwilling to provide minimally adequate care.
- A doctor or psychologist has determined that a child's caregiver has emotionally damaged and the child is exhibiting severe anxiety, depression, withdrawal, or aggressive behavior due to the emotional damage; and the caregiver is unwilling or

unable to seek treatment for the child.

þ The physical or mental condition of parent, guardian or custodian endangers the child's health or safety.

þ There is reason to believe that a caregiver is engaged in sexual conduct with a child, or has allowed the child to participate in sexual activity with others.

þ The newborn child was left with a Safe Haven provider.

þ A Family Strengths and Risks Assessment identifies other circumstances that place a child at imminent risk of harm requiring removal. The assessment shall include identification of family strengths and risk factors; and an evaluation of all facts and circumstances surrounding a child and family situation, including the following:

- whether a law enforcement official or medical professional expresses concern about risk to the child victim if the child victim returns to or remains in the home;
- the alleged abuser's behavior towards the child victim;
- other adults in the households behavior towards the child victim;
- whether the child victim resides with a parent or other adult who is willing and able to protect the child;
- whether the parent, guardian or custodian is abusing alcohol and/or drugs and how this behavior places the child at risk or abuse or neglect;
- whether the child at birth, or within a year of birth, is demonstrating adverse affects as a result of the mothers use of dangerous drugs or alcohol during pregnancy;
- the conditions of the home environment and whether those conditions threaten the child victims safety or physical health;
- whether there has been a pattern of maltreatment, particularly a pattern of incidents of increasing severity;
- the nature and severity of the alleged maltreatment;
- whether DES is able to provide services to the child or family to alleviate conditions or problems that pose a risk of maltreatment, without the need of removal;
- whether the childs caregiver refuses access to a child or declined an offer of in-home services;
- the familys strengths and risk factors;
- the childs current physical and mental condition; and
- whether the child victim has injuries that require immediate medical

treatment

BEST PRACTICE TIP:
While it is always valuable to have the perspectives of other professionals, it should be the CPS Specialists assessment in conjunction with the supervisor that determines if child removal must occur. Information provided by other professionals is considered in the CPS Specialists assessment. Sometimes the community believes that removal is in the best interest of the child; however, we can often protect children while they remain with their family or with a person who has a significant relationship with the child..

Implementation and Procedure Guide

There are a variety of emergency interventions that may be appropriate. Review all conflicting medical opinions within 48 hours:

- § with a Multidisciplinary Team, including a physician, or
- § base intervention on the most serious diagnosis if a Multidisciplinary Team is not available.

It is the responsibility of the CPS Specialist to engage the child's family to the greatest extent possible in discussions about the childs safety and planning for voluntary interventions that minimize intrusion in the life of the family. Alternatives that should be considered include:

1. **In-Home Solutions**
   a. *Ensuring availability of needed services*
2. **Kinship Care Options**
3. **Leaving Home And Going To A Safe Place**
4. **Community Placement**
5. **Voluntary Foster Care Placement**
6. **Temporary Custody with Parental Knowledge**
7. **Emergency Removal Without Caregiver Knowledge**

As you are making a decision about which option is best for this child and family, ask yourself the following questions:

1. IN-HOME SOLUTION

- § Can the specific safety concerns identified in the safety planning be successfully removed or modified by making specific, immediate changes in the living environment - for example:
  - o Identifying an individual such as a grandparent, another member of the child's extended family including a person who has a significant relationship with the child or neighbor who can come into the home to support the family and maintain the

child safety;

- Ensuring that the family receives emergency food, clothing, shelter, utilities or other necessities; or
- Removing the alleged abusive person from the home;
- Connecting the caregiver to services that have been helpful in the past and to individuals who are supportive of the caregiver.

§ Are immediate services available to the caregiver that prevent or eliminate the need for removal?

- If so, can the parent get to the services? Confirm that the caregiver has made a connection with someone who can assist in the delivery of these services.

§ What makes you believe that these interventions will make the child safe?

2. KINSHIP CARE OPTIONS

§ Can the parent, guardian or custodian identify a grandparent, another member of the child's extended family including a person who has a significant relationship with the child who is willing and able to care for the child immediately, at least on a short-term basis? See Chapter 6, Section 2, Finding Missing Parents, Relatives and Other Significant Persons; and Relative Search Best Practice Guide (Exhibit 12).

§ Have you engaged the caregiver to the extent that you believe he/she will follow through with the agreement to place the child with a grandparent, another member of the child's extended family including a person who has a significant relationship with the child?

§ Do you believe that the grandparent, another member of the child's extended family including a person who has a significant relationship with the child is willing and able to protect the child from imminent abuse or neglect?

BEST PRACTICE TIP:
Case plan staffings, Family Group Decision Making or some type of family meeting is effective in identifying possible kin caregivers. It is always best if the family is involved early in the process and is active in helping to decide placement options. While it may take more time in the beginning, family involvement will save the CPS Specialist time as the case moves forward.

Even during instances of emergency removal of a child, placement with kin is the preferred option. In those instances, prior to placement:

§ Complete Central Registry, CHILDS Case Management Information System background and emergency history check by the Department of Public Safety (DPS), on all individuals in

the home age 18 or older.

§ Complete a preliminary home study using as a guide the Outline for Assessment for Kinship Foster Care or Significant Person Placement, CT01100, found in the Court Document Detail.

§ Determine if there is any information which would preclude the grandparent, another member of the child's extended family including a person who has a significant relationship with the child from providing a safe, nurturing environment for the child; and

§ Complete the Agreement for Child Placement, PS055.

3. LEAVING HOME AND GOING TO A SAFE PLACE

Sometimes the only solution is for the caregiver who is trying to protect the child to leave and go to a safe situation.

§ Can the parent, guardian or custodian and the child leave home and go to a safe situation for at least a short period of time such as a relative or friends home?

§ Is there a shelter available that can provide temporary housing if no friend or relative can be identified?

§ If this is an option, the CPS Specialist needs to help the caregiver determine how employment or school issues will be managed?

4. COMMUNITY PLACEMENT

§ Can the parent, guardian or custodian place the child in a community placement while the department completes its investigation?

§ Is a community placement available in the community?

§ Is the parent, guardian or custodian willing to follow through with the agreement to place the child in a community placement?

§ Is the parent, guardian or custodian willing to comply with any conditions to a community placement as specified by CPS such as:

- o not removing the child from the community placement without CPS approval; or
- o not permitting contact with a prohibited person?

§ Is the parent, guardian or custodian willing to cooperate with the requirements of the organization/agency providing the community placement?

5. VOLUNTARY FOSTER CARE PLACEMENT

If there are no other voluntary alternatives, you may need to consider a voluntary foster care placement. See Providing Voluntary Foster Care Services (Chapter 4, Section 1).

§ Based on your conversations with the parent, guardian or custodian, do you think that the parent, guardian or custodian would place the child voluntarily until such time as the parent, guardian or custodian can create a safe living environment?

§ Do you think that is it likely that the parent, guardian or custodian will be able to resolve the identified safety factors within the 90 days of the voluntary foster care period?

If no voluntary emergency intervention can ensure the child's safety, consult with your supervisor and with legal counsel when possible before removing the child from the home.

6. TEMPORARY CUSTODY WITH CAREGIVER KNOWLEDGE

Consider the following questions:

- Is temporary custody the only option to ensure the child's safety?
- Do you believe, based on your interactions, that you must remove the child immediately and that no other available option is appropriate and/or acceptable to the caregiver?

Provide to them:

- the Temporary Custody Notice, CPS-1000A; and
- A Guide to Child Protective Services, PAC-518.

If the child was removed from a setting other than the home of a parent, guardian or custodian, fill out the Notice of Removal, PS-058. Give one copy to an appropriate individual at the place of removal.

7. EMERGENCY REMOVAL WITHOUT CAREGIVER KNOWLEDGE

In emergency situations, a child may have to be removed *without* prior consultation if failure to do so would be a danger to the child or yourself.

If emergency removal of a child is necessary and prior consultation with a supervisor is not possible, notify the supervisor within two hours if the removal occurred during regular working hours or by 8:30 a.m. the next morning if removal occurred after regular hours.

The following reasons may require removal of a child without caregiver knowledge:

- Immediate need for medical or psychological examination; or
- Provision of emergency out-of-home placement due to immediate threat of harm to the child;
- Identity or whereabouts of caregiver are unknown.

BEST PRACTICE TIP:
If the emergency removal of a child is necessary, consider what the experience is like for the child. Are there special items that can go with the child? Does the child understand what is happening? Can an opportunity be provided for the child to say goodbye to siblings (if they are not being removed?) If there are two individuals involved in the process of removing the child, can one of the individuals sit in the back seat with the child? During the ride try to stay in constant communication with the childNEVER forget how scared the child or youth is.

If the child was removed from a setting other than the home of a parent, guardian or custodian, fill out the Notice of Removal, PS-058. Give one copy to an appropriate individual at the place of removal. Proceed with verbal and written notice of parents, guardians or custodians.

Parental Notification
If a child is taken into temporary custody when the caregiver is not present the CPS Specialist must do the following:

- Attempt to notify the parent, guardian or custodian immediately either in person or by phone;

BEST PRACTICE TIP:
If it is possible, the conversation with the parent should occur in person. They need to understand what has happened, that their child has been taken into temporary custody and the next steps of the process need to be fully explained. Having this conversation in person helps build the relationship between the family and the CPS Specialist. The following are strategies for conveying respect, empathy and genuineness:

Strategies for Conveying Respect

- Convey respect for families from the beginning of the casework relationship, rather than communicating acceptance conditional on performance.
- Demonstrate interest in others through active listening and effective use of questions.
- Treat each person as a unique individual with strengths and needs.
- Explain how each individuals unique potential can be utilized to achieve successful outcomes.
- Elicit input from families.
- Give positive feedback and support for small steps taken toward change.
- Be on time for meetings with families.
- Ensure privacy and honor guidelines of confidentiality during family sessions.

Strategies For Conveying Empathy

- Demonstrate active listening and observation skills (nodding, verbal utterances, recognizing non-verbal cues).
- Use reflections to test out what the family member has said.
- Ask open-ended questions of the family member to elicit emotions.

§ Tune into subtle forms of communication such as a family members tempo of speech, lowering of the head, clenching of the jaws, or shifting posture.
§ Introduce issues of concern by relating them to the needs or concerns of the family member.

Strategies For Conveying Genuineness

§ Match verbal responses with nonverbal behavior.
§ Practice non-defensive communication.
§ Use self-disclosure appropriately.

Source: Adapted from New York State Office of Children and Family Services Supervisory CORE Curriculum, developed by SUNY
National Resource Center for Family Centered Practice and Permanency Planning 1999.

F Provide the parent, guardian or custodian with written and verbal notification of the removal within six hours if he or she lives in or is incarcerated in Arizona or within 24 hours if he or she lives, or is incarcerated out-of-state. [ARS §8-823(A)]

F Verbally inform him or her of the reason for temporary custody;

F If it is necessary to notify the parent, guardian or custodian at their place of employment and he or she is not available, discreetly leave your name, phone number and department name (DES), and request a return call.

F Notify the parent, guardian or custodian in writing by delivering or express mailing the Temporary Custody Notice, CPS-1000A, and A Guide to Child Protective Services, PAC-518

§ If available, write the date, time and place of the Preliminary Protective hearing on the Temporary Custody Notice, CPS-1000A.

§ If the date, time and place of the Preliminary Protective Hearing are not available at the time the Temporary Custody Notice is served, provide written notice of this information to the parent or guardian within 24 hours of filing the dependency petition. [ARS §8-823(B)(7)]

F CPS Specialists must send a copy of the Temporary Custody Notice, CPS-1000A, to:

§ any divorced, non-custodial parent, regardless of the specific arrangements of the divorce agreement; and

§ any man alleged to be the child's father, whether or not his name appears on the birth certificate and whether or not allegations that he is the father are confirmed.

BEST PRACTICE TIP:

Sometimes caregivers will not provide information about a non-custodial parent because of the history between the couple during their marriage. However, they may believe that the non-custodial parent is a better option than foster care. Continue to ask the questions about the non-custodial parent, understanding that as the process goes on the caregivers attitude may change.

F If the address of the parent, guardian or custodian is not known, make reasonable efforts to obtain it by contacting relatives, friends, and/or employers. If the address cannot be obtained, initiate a search for missing parent with the Arizona Parent Locator Service according to district operating procedures. Refer to Chapter 6: Section 2, Finding Missing Parents, Relatives and Other Significant Persons.

EMERGENCY REMOVAL OF SIBLINGS

The childs sibling shall also be taken into temporary custody *only* if reasonable grounds independently exist to believe that temporary custody is clearly necessary to protect the child from suffering abuse or neglect. [ARS §8-821(A)] If siblings are removed the CPS Specialist must make EVERY POSSIBLE ATTEMPT to place them together.

BEST PRACTICE DISCUSSION:

CPS Specialists offer a variety of reasons for separating siblings in family foster care. Although these reasons may have merit, studies indicate that the practice often delivers negative messages and results in problems for children in the long run. There is almost always an alternative.

"It's bard to find families who will accept a sibling group. Separating the children gives them a better chance of finding a permanent family should adoption become the plan, because most families adopt just one child at a time."

First, CPS Specialists need to thoroughly explore the kinship care options for all children entering care. Research shows that kinship families are usually more likely than unrelated foster families to care for sibling groups. Even among unrelated foster families, most are already fostering more than one child. Foster families with a full house cannot be expected to take two, three, or more siblings all coming into care at the same time. Many communities are now recruiting and training foster families specifically for sibling groups. It can be done.

"These kids come from troubled backgrounds. Their combined problems may be too much for one set of parents. "

CPS Specialists hope that if they place children separately, each child will receive a generous share of attention and nurturing from one foster family, and this will develop the child's highest potential. But even a needy child does not necessarily benefit from being the only child in a family.

"Some siblings just can't get along with each other. Why put everyone through that?"
Sibling rivalry and jealousy remain major causes for separation in family foster care and adoption. But siblings in functioning families are not separated permanently just because they fight. Siblings who remain together learn how to resolve their differences and develop durable relationships.

"The children are so unhappy about being removed from their biological family that they would probably band together to sabotage any placement.
This kind of teamwork on the part of the children may call for equally strong teamwork among foster parents, biological parents, CPS Specialists, and other helpers. It's a challenge, but not an insurmountable one.

"The older sibling has become the caregiver for the other children. If we separate the children, the caregiving child can relax and they younger ones can learn to trust adults. "
Relationships of this kind can be a source of great strength for children. Foster parents can use them constructively to help siblings develop new roles and expectations.

"Sometimes siblings come into care at different points in time. If we can't place the other siblings in the same foster home as the first one, we place them in different homes to preserve the first placement."
This is a dilemma. Nevertheless, if we value the lifelong relationships of the family of origin, we will thoroughly assess the pros and cons of placing the siblings together. Most children who are placed in out-of-home care eventually return to their birth families. Even when we need to find new parents for children, we need not and should not destroy the connections among siblings.

Kathy Barbell
(Casey Family Programs)

OBTAINING THE CHILDS MEDICAL INFORMATION

Obtain medical information about the child from the parent, guardian or custodian including:

- whether the child has a medical need or chronic illness that requires special care or treatment; and
- the name and telephone number of the childs physician.

If possible, obtain the parent's, guardian's or custodian's authorization to provide emergency medical care for the child. If the parent, guardian or custodian refuses or is unavailable, consult with a supervisor regarding authorization for procedures.

If the child has a medical need or chronic illness, make all reasonable efforts to contact the childs physician or the physician who most recently examined or treated the child to:

- Confirm the diagnosis of the medical need or chronic illness.
- Obtain information on the daily care and treatment required to meet the childs medical need or chronic illness.
- Request that the physician participate in the Removal Review Team conference.

A Temporary Notice, CPS-1000A and a Notice of Removal, PS-058 shall be left with a Safe Haven provider if the name and address of the parent is unknown. Obtain a medical examination for a newborn left at a Safe Haven that is not a hospital or outpatient treatment center.

RETURNING THE CHILD HOME PRIOR TO FILING A DEPENDENCY

- A child who is taken into temporary custody for medical or psychological diagnosis must be returned within 12 hours, excluding weekends and holidays, **unless the examination reveals abuse or neglect.** [ARS §8-821(E)]

- A child who is taken into temporary emergency custody because he or she is a victim or it is determined that the child will imminently become a victim of abuse or neglect or was physically injured must be returned to the parent within 72 hours, excluding weekends and holidays, **unless a dependency petition is filed.** [ARS §8-821(G)]

PRELIMINARY PROTECTIVE HEARING

A Preliminary Protective hearing will be held on each case in which a child has been removed and a dependency petition filed. The court will hold the hearing no less than five days and not more than seven working days after removal, excluding Saturdays, Sundays and state holidays. (ARS §8-824)

DOCUMENTATION :

File one copy of the Temporary Custody Notice, CPS-1000A, and/or the Notice of Removal, PS-058, in the hard copy record.

Provide one copy of the Temporary Custody Notice, CPS-1000A, to the juvenile court judge, according to district procedures.

Complete the following windows in CHILDS when a temporary custody notice has been issued:

1. Removal Status
2. Removal Settings
3. Legal Status
4. Custody Notices

If the parent, guardian or custodian places the child with a relative or non-relative or in a community placement, document the placement on the Placement/Location Detail window.

Using the Case Notes window, designated as Investigation Contact type document:

- § verbal and written notification of and reason for the child's removal to the parent, guardian or custodian;
- § a parent, guardian or custodians refusal to sign the Temporary Custody Notice CPS-1000A;
- § all reasonable efforts to contact with the childs physician or the physician who most recently examined or treated a child who has a medical need or chronic illness, and
- § the daily care and treatment required to meet the childs medical need or chronic illness.

Document the results of the emergency DPS criminal history records check, Central Registry and CHILDS Case Management Information System check using the Case Notes window, designated as Investigation Contact Type.

File one copy of the notice of the date, time and place of Preliminary Protective hearing in the hard copy record if the date, time and location of the hearing was not available at the time the Temporary Custody Notice was served.

Submit the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing as described in Laws, Legal Processes, and Liability (Chapter 19). This report must be submitted to the juvenile court not later than the day before the hearing.

In addition, fill out and append the Verification, CT04600, found in the Court Document Detail. Submit the Verification to the Attorney General's Office for filing with the dependency petition.

Document the child's out-of-home placement using the Service Authorization Request and Service Authorization Provider Match windows and by following the procedures outlined in Providing Out of Home Services to Children Under a Dependency Petition (Chapter 6).

Document the childs medical need or chronic illness, examination and childs physician information using the Medical Condition, Practitioner Detail and Examination Detail windows.

Revision History:
DES(09-2006)

Previous / Next

3-3

Legal Basis: ARS §8-822 requires that the department "review each removal of a child which is expected to result in a dependency petition to assess options other than continued out-of-home-placement, including in-home services to the family".

ARS §8-828 requires the department to establish the Family Advocacy Office. Upon request the Family Advocacy Office shall immediately review the removal of a child prior to the filing of a dependency petition.

Rules: Rules pertaining to Removal Review are found in Section R6-5-5514 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 3: Section 3

Reviewing Emergency Removals

Legal Basis

Policy: Upon request, the Family Advocacy Office shall immediately review the removal of the child prior to the filing of a dependency petition.

The department shall conduct a Removal Review Team conference within 72 hours of a child's removal from home, excluding weekends and holidays, when the removal is expected to result in the filing of a dependency petition. The review shall determine whether the removal was necessary, if there are alternatives to continued out-of-home placement of the child or if continued out-of-home placement is necessary and, therefore, a dependency petition must be filed. [ARS §8-822]

In determining whether continued out-of-home placement is necessary, consider these questions:

- § Does the child's home situation still present imminent risk of harm?
- § If so, can the safety factors that led to the child's removal be successfully removed or modified by providing specific, measurable, immediate actions/interventions?
  - o What actions must take place?
  - o Is the parent, guardian or custodian willing and able to take the necessary actions?
  - o Can the parent, guardian or custodian place the child with a relative or friend who will ensure the safety of the child in lieu of placement by the department?
  - o Is the parent, guardian or custodian willing to place the child in a community placement, if available?
  - o Is the parent, guardian or custodian willing to place the child in voluntary foster care?

Implementation and Procedure Guide

There will be times when, upon learning of the emergency removal of their children, the parents, guardians or custodians will ask for an immediate review of the child's removal. In this instance

it is the responsibility of the CPS Specialist to inform the family that the Family Advocacy Office (Exhibit 14) will, upon request of the parent, guardian or custodian, review the removal of their child before the department files a dependency petition. This review shall evaluate all the facts and circumstances that indicate imminent harm or risk of imminent harm and need for removal. Alternatives to the child's removal shall also be considered.

The Family Advocacy Office (FAO) shall accept for review all requests by the parent, guardian or custodian received within 72 hours of the date and time that the Temporary Custody Notice (TCN) was served. If review of the removal has not been conducted by the Removal Review Team, include the FAO Specialist in the Removal Review Team.

If the removal is expected to result in the filing of a dependency petition, convene the Removal Review Team to review the child's removal.

At a minimum, the **Removal Review Team Membership** shall consist of:

- the CPS Specialist who conducted the investigation and/or the CPS Specialist who will file the dependency petition;
- § the supervisor of the CPS Specialist,
- § two members of the Foster Care Review Board, and
- § the child's physician if the child has a medical need or chronic illness. If the child's physician is not available, the CPS Specialist must locate a physician who is familiar with children's health care. (ARS §8-822)

If the child is or may be Indian, the district ICWA liaison should be included in the Removal Review. Other qualified professionals, including an uninvolved ACYF Assistant Program Manager or CPS Supervisor, Family Group Decision Making staff (FGDM), counselor, therapist, psychologist or psychiatrist or tribal social services representative may be included in the Removal Review.

Contact the designated Foster Care Review Board members according to district protocols. If the Foster Care Review Board can not provide two members to participate in the conference, proceed with the review.

If the child has a medical need or chronic illness, make reasonable efforts to contact the child's physician or the last physician who examined or treated the child, to:

- o confirm the diagnosis of the medical need or chronic illness,

- obtain information on the daily care and treatment required to meet the child's medical need or chronic illness, and
- request that the physician participate in the Removal Review Team conference.

If all reasonable efforts were made to contact the child's physician and the physician is not available, contact the CMDP Medical Director to ascertain whether he/she can participate in the Removal Review Team or for the name of a physician who is familiar with children's health care. Request that the physician participate in the Removal Review Team conference.

If a Family Advocacy Office Specialist requests participation in the Removal Review Team conference, verify that this person is a staff member by calling the Family Advocacy Office. Once identity is confirmed, include the person the conference.

Prior to Convening the Team

If received prior to the review, provide to the Removal Review Team any verbal, telephonic or written response to the allegations made by the parent, guardian or custodian.

Convening of the Removal Review Team

Convene a Removal Review Team conference within 48 hours from the date and time the parent, guardian or custodian was served the Temporary Custody Notice, CPS-1000A. The Removal Review Team conference may be in person or by telephone.

BEST PRACTICE TIP:
The better the family's capacities, coping skills and past successes are understood by the CPS Specialist, the more effective the CPS Specialist will be in helping the family to craft a plan that will effectively keep children safe in their own home.

With the Removal Review Team, identify the basis for the removal, whether the removal meets imminent harm criteria and, consider all options for protecting the child while minimizing intrusion into the family. Alternatives to keeping the child in care may include:

- returning the child to the home with a safety plan in place, with or without a dependency petition;
- assisting the parent, guardian or custodian in placing the child temporarily with a relative or friend;
- assisting the parent, guardian or custodian in placing the child in a community placement, if available.
- placing the child with a relative or friend and filing a dependency petition; and
- placing the child in voluntary foster care.

Actions Resulting From the Removal Review Team Meeting

If the majority of the Removal Review Team participants agree that the removal was necessary and that none of the alternatives can adequately assure the safety of the child, take the necessary steps to file an out of home dependency petition.

If the majority of the Removal Review Team participants do not agree that the removal was (is) necessary, return the child to the parent, guardian or custodian. If the child has not been removed, do not remove the child. However, if the Child Safety Assessment indicates that the child is unsafe and an in-home safety plan cannot assure the child's safety, consider other available alternatives to assure the child's safety, including filing an in-home dependency petition. If consensus cannot be reached concerning continued out-of-home placement or service options, consult with the Assistant Program Manager to reach a decision concerning placement or services.

DOCUMENTATION :

Document the Removal Review Team conference and the Team's recommendations using the Removal Review Findings and Removal Review Detail windows.

Document any disagreement concerning continued out-of-home placement or services using the Case Notes window designated as Case Conference type. Attach a copy of the case note to the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing.

If a child is released from temporary custody before a dependency petition is filed, update the Removal Status, Legal Status and Provider Service Authorization windows to reflect the child's change in status.

Revision History:
DES(07-2006)

Previous

4-1

Legal Basis: ARS §8-801(4) allows for the provision of voluntary services by defining "protective services" as a program which investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home and to coordinate services to strengthen the family."

ARS §8-802(C)(8) requires the department to offer to the family of any child found to be in need of protective services those services designed to correct unresolved problems which would indicate reason to adjudicate the child dependent.

ARS §8-816 describes and outlines the services available in the Family Builders Program, which provides a variety of community-linked family preservation and support services to assist families to prevent and remedy conditions or circumstances that cause child abuse or neglect."

The federal Family Preservation and Family Support Act of 1994 (P.L. 103-66), renamed Promoting Safe and Stable Families by the Adoption and Safe Families Act of 1997 (P.L. 105-89), provides for a capped entitlement to states to provide family preservation services, and community-based family support services aimed at promoting family strength and stability and enhancing parental functioning.

Rule: Not applicable

Chapter 4: Section 1

In-Home Services

Legal Basis

Policy: The department will offer voluntary services for those families in which:

§ a CPS report has been received;

§ steps have been taken to assure, to the greatest extent possible, that all children are currently safe and will remain safe in the home.

§ a CPS Investigation and Family Strengths and Risks Assessment have indicated that one or more children in the home is at risk of abuse and neglect; and

Whenever possible, it is best to provide services on a voluntary basis, where the family is willing to access services that can improve the outcomes for the family. While the availability of services may be limited due to resource constraints, it is important to try to gain family support for voluntary involvement with the agency.

When a decision has been made to provide voluntary services to a family it is important and required that CPS Specialists and/or the contract providers have face-to-face contact with parent (s) residing in the same household and children in the home at least once a month in order to determine:

- whether the children continue to remain safe in the home; and
- the services and supports are being effective in alleviating the risk of abuse and neglect

To determine whether provision of voluntary services is appropriate, consider these questions:

F Are there community or extended family resources available that can help the parent address these concerns without DES involvement? Is the parent willing to use them?

F In conversations with the caregiver, do they acknowledge that there a need for support for their family?

F Based on your conversation with the caregiver, does he/she appear both willing and able to make changes in behavior and/or home environment to reduce the

potential for harm to the children?

- Has the parent received services from the department in the past? If so, what was the result?
- Is the parent willing to accept voluntary services from DES?
- What steps can be taken to ensure that the children will remain safe while voluntary services are provided?

Implementation and Procedure Guide

Request in home support services as outlined in your District's operating procedures.

If services are provided through a Family Support, Preservation and Reunification In-Home service provider, the contracted provider will complete a family centered service plan. This family centered service plan will meet the case planning requirements for this family.

Request ACYF-funded services (Chapter 9 Section 14) using the Request for Services, PS-067.

Request Behavioral Health Services for Title XIX-(Chapter 9 Section 12) for eligible children and adults through the Regional Behavioral Health Authority (RBHA).

It is critical that workers are particularly thorough in documentation of all services provided to the family. If removal of a child later becomes necessary, this documentation is the basis for the federally-required judicial determination that reasonable efforts were made to prevent the child's removal from home. (P.L. 96-272)

DOCUMENTATION :

Ensure the Service Authorization Request window and Service Authorization Provider Match windows are completed.

File a copy of the PS-067 in the hard file.

Document the decision to provide voluntary services by completing the Determination of Case Status Window.

Revision History:

DES(07-2006)

Next

4-2

Legal Basis: Not applicable

Rules: Not applicable

Chapter 4: Section 2

Voluntary Placement By A Parent

Legal Basis

Policy: Parents who are receiving voluntary child protective services from the department may place a child temporarily with a relative, friend or in a community placement in order to assure the child's safety.

CPS Specialists shall have face-to-face contact with the child, caregiver and parent(s) at least once a month to ensure that the child is safe while the family resolves risk factors that prevent the child from being cared for safely at home.

CPS Specialists shall determine whether the proposed caregiver has a history of child abuse or neglect.

Implementation and Procedure Guide

Prior to developing or approving a plan that includes a child's voluntary placement with a relative or friend by a parent:

- § conduct a search of the Child Protective Services Central Registry (CPSCR) and CHILDS Central Registry to determine whether the proposed caregiver has a history of child abuse or neglect;

- § complete a criminal history check with the Department of Public Safety (DPS);

The case plan must be developed within 21 days of case opening and must include the involvement of family members, the caregiver and the CPS Specialist.

The case plan must include:

- § follow-up services needed by the relative, friend or alternate caregiver to continue to meet the child's needs;
- § provision of information to the caregiver about available financial and non-financial services and eligibility requirements;
- § provision of assistance to the caregiver in completing the necessary applications for services; and/or
- § helping the caregiver to access needed services through department or community

resources.

The case plan must be formally reviewed at a minimum every six months thereafter.

BEST PRACTICE TIP:
A case plan is at best only a hypothesis of what will be effective to help the family in meeting their goals. While the policy requires that the plan be formally reviewed every six months, best practice suggests that the plan is **reviewed every time the CPS Specialist meets with the family**. This practice ensures that the plan remains effective in meeting the family needs. When the family indicates that services are not helpful, the plan should be re-evaluated and additional/new services provided that will be more helpful to the family. The case plan should evolve as information about how the family can best meet their goals becomes known.

DOCUMENTATION :

Document the parent's placement of the child using the Placement/Location Detail window and Case Plan Tasks window. Use the Explain Box to document the voluntary placement.

Revision History:
DES(07-2006)

Previous / Next

4-3

Legal Basis: ARS §14-5104 allows a parent or legal guardian to enter into a written agreement with a designated substitute caregiver to assume typical day-to-day responsibility for care and supervision of a child, such as educational activities and medical treatment. The written agreement is a "delegation of powers by parent or guardian"; also referred to as a parental Power of Attorney. The term of the agreement can not exceed six months. The parent or guardian can not delegate the power to consent to marriage or adoption of the minor. The agreement may be revoked at any time by either the parent/guardian or the substitute caregiver.

ARS §8-802(C) requires a "protective services worker" to offer to the family of any child found to be in need of protective services those services designed to correct unresolved problems which would indicate reason to adjudicate the child dependent.

Rules: Not applicable

Chapter 4: Section 3

Facilitating A Power Of Attorney

Legal Basis

Policy: The department may facilitate and assist the parent or guardian in formally delegating parental responsibility to a substitute caregiver only when:

- The parent or guardian has the legal authority to delegate parental responsibility.
- The parent or guardian has the ability to make effective decisions concerning his/her child's safety including choosing an appropriate substitute caregiver.
- The substitute caregiver is willing and able to care for the child for a specified period of time.
- An assessment of the substitute caregiver indicates that the caregiver's home is a safe and appropriate placement for the child.
- The parent or guardian and substitute caregiver will abide by the terms of the agreement (including not revoking the agreement prematurely or without informing the department), and accept department monitoring.
- The circumstances preventing the parent's or guardian's ability to provide a safe, nurturing home for the child are likely to be resolved within the specified period of time.

"Facilitation" includes not only assisting the family in completion of the Power of Attorney (POA), but also the department's awareness that a POA is in place.

A parental Power of Attorney is intended to be a **temporary solution to a family crisis** and should not be used as a permanent alternative to continued custody by the parent or guardian. It is part of the case plan developed to assure the child's immediate and short-term safety, and shall not be used as a long-term alternative to ensure a child's safety.

The Power of Attorney is intended to enable the substitute caregiver to obtain services for the child, consent to medical and behavioral health treatment, consent to educational and recreational activities, and to demonstrate his or her authority to have temporary care and custody of the child.

In addition to the above policy requirements for the Power of Attorney, consider the following:

§ Does the child have a positive relationship with the substitute caregiver or, if age appropriate, agree with the placement?

§ Does the child have special medical or behavioral health needs? If so, will the substitute caregiver be able to meet these needs?

§ Will the placement disrupt the child's education? Does the child have special educational needs which can be met in the proposed placement?

§ Will extended family members support and cooperate with the case plan including the parental Power of Attorney?

§ Does the other parent object to the parental Power of Attorney?

§ Will the substitute caregiver require supportive services (such as child care, applications for TANF or AHCCCS, or counseling, etc.) in order to care for the child, and, if so, how will those services be provided?

§ Should a formal visitation agreement, including sibling visitation and access to other family members, be included in the case plan?

BEST PRACTICE TIP:
Visitation between the child and his or her family is fundamental to the child's well being. If there is any concern that the child and family will not have consistent and frequent visitation due to the caregiver behavior, careful consideration should be given to whether or not this is the best temporary placement for the child. The CPS Specialist should convey to the caregiver that the child needs to see his/her family and the emotional pain and trauma that may occur when a child is separated from his/her family.

Implementation and Procedure Guide

If there are circumstances or risk factors that prevent the parent or guardian from caring for the child safely at the end of the specified period of time, a parental Power of Attorney is not appropriate.

To determine whether the parent or guardian has legal authority to delegate parental powers, inquire whether any court including juvenile or tribal court has entered paternity, custody, guardianship, visitation or support orders concerning the child.

If no custody order exists, the custodial parent may delegate his/her parental powers. If a custody order exists, determine if the order requires consent by the other parent. A parent with joint custody may delegate his/her parental powers.

Assess the parent's or guardian's capacity to make effective decisions concerning the child's safety including choosing an appropriate substitute caregiver. Identify behavioral characteristics that indicate the parent or guardian understands that the child needs protection and the alternatives to ensure the child's safety, and is capable of participating in case planning.

Assessment of the Caregiver

Assess the substitute caregiver's willingness and ability to care for the child for the specified time period and whether the caregiver's home is a safe and appropriate placement for the child, using the Outline for Assessment for a Substitute Caregiver, PS06800, found in Forms Registry. The assessment (home study) of the substitute caregiver and caregiver's home must include:

- the substitute caregiver and any other adult in the home completing the Checklist for Assessment of Kinship Foster Care and Significant Person Placement; FSC-1015AFORNA;

- a search of the CPS Central Registry and CHILDS Case Management Information System, and CHILDS Central Registry to determine whether the substitute caregiver or any other adult in the home has a history of child abuse or neglect;

- a criminal history check with the Department of Public Safety for the substitute caregiver and any other adult in the home to determine whether the caregiver or any other adult in the home has a criminal history indicating that the child's health and safety would be at risk of harm if placed in the home; and

- any information or observation which would preclude the substitute caregiver from

providing a safe, nurturing environment for the child.

Review the results of the assessment (home study) with your supervisor. Obtain supervisory approval of the child's placement with the substitute caregiver.

If the substitute caregiver can provide a safe, nurturing environment for the child, have the parent and caregiver complete and sign the Power of Attorney and Delegation of Parental Powers, PS06900, found in Forms Registry.

Inform the caregiver that he/she must immediately notify the CPS Specialist or the Child Abuse Hotline of any attempt by the parent or another individual to revoke the parental Power of Attorney. The safety plan shall include an action step that the substitute caregiver will immediately notify the CPS Specialist or the Child Abuse Hotline of any attempt by the parent or another individual to revoke the parental Power of Attorney.

Determine the follow-up services needed by the substitute caregiver to continue to meet the child's needs.

Inform the substitute caregiver about available financial and non-financial services and eligibility requirements. If necessary, assist the substitute caregiver to complete applications for services and/or access needed services through department or community resources.

If there are safety or risk factors that may prevent the parent or guardian from safely caring for the child at the end of the specified period of time, open the case for services and develop a case plan in accordance with Case Planning and Case Management. (Chapter 9)

Cases are to remain open through the duration of the POA (up to six months) or until the POA terminates and the child is safely returned to the parent and the identified safety and risk factors identified are adequately addressed. If the POA expires or is revoked; reassess the child's safety if in the parent's home by completing the Child Safety Assessment.

While the case is open for services:

§ Monitor the child's placement with the substitute caregiver through face-to-face contact with the child and caregiver at least once a month to ensure the child's safety; and

§ Maintain monthly face-to-face contact with the parent. Obtain supervisory approval for exceptions to monthly face-to-face contact with the parent or guardian. For more information about exceptions, see Planning and Implementing Services and Supports Necessary to Achieve the Goal (Chapter 9 Section 4).

If the safety and risk factors cannot be remedied within the duration of the POA, consult with the supervisor about further actions to ensure the child's continued safety.

DOCUMENTATION :

Document all of the information obtained during the assessment of the substitute caregiver and the caregiver's home using the Case Notes window.

Document supervisory approval of the placement of the child with the substitute caregiver.

File a copy of the signed Power of Attorney and Delegation of Parental Powers, PS06900, in the case record.

Revision History:
DES(07-2006)

Previous / Next

4-4

Legal Basis: ARS §8-806(C) authorizes the department to provide voluntary foster care placement for children for a period not to exceed 90 days and no more than two periods within 24 consecutive months.

ARS §8-806(D) directs the department to accept a voluntary placement agreement:

- **Only** if the department can provide the necessary services that are likely to remedy the circumstances that bring the child into care within the 90 day placement period; and
- The department plans to the return the child to the parent, guardian or custodian at the end of the 90 day period or the parent, guardian or custodian will arrange a safe alternative placement for the child after the voluntary placement.

ARS §8-806(I) directs the department to:

- **Develop a case plan** in concert with the child's parent, guardian or custodian **within 10 days of the voluntary placement** that sets forth the services necessary to promote the safety of the child upon return of the child to the parent, guardian or custodian or the alternative placement;
- Provide or contract for the services specified in the case plan or to assist in accessing community resources to provide the services; and
- Share the plan with the out-of-home care provider.

ARS §8-806(J) requires the department to inform the parent, guardian or custodian or alternate placement of available financial and non-financial services and eligibility requirements before returning the child. The department must also assist the parent, guardian, custodian or alternative placement to complete the necessary applications.

ARS §46-134(A)(2)(c)(ii) authorizes the department to pay for voluntary foster care in an out-of-home placement.

Voluntary placement of Native American children is governed by the Indian Child Welfare Act, 25 U.S.C. §1901 et seq.

Rules: Not applicable

Chapter 4: Section 4

Providing Voluntary Foster Care Services

Legal Basis

Policy: Voluntary foster care is a time-limited service that may be provided for a child as an alternative for the family to keep their child safe. A case plan must be developed with the family aimed at resolving safety and/or risk factors that must be addressed in order for the child to live safely at home.

Placement under a voluntary foster care agreement shall be with a licensed out-of-home care provider.

A parent's decision to place a child in voluntary foster care does not constitute grounds for abandonment, abuse or dependency nor may it be used in a judicial proceeding as an admission of criminal wrong-doing. [ARS §8-806(G)]

Voluntary Foster Care Agreements shall not:

- exceed 90 days;
- be consecutive ("back-to-back") placement agreements;
- be utilized more than twice within 24 consecutive months, [ARS §8-806(C)];
- be accepted for a child without the written, informed consent of the parent, legal guardian or legal custodian. [ARS §8-806(E)]
- be accepted for a child who is age 12 or older and not developmentally disabled without the written informed consent of the child, unless the department determines that voluntary placement is clearly necessary to prevent abuse. [ARS §8-806(F)]

For Native American children, the parent's consent must be:

- recorded before a judge; and
- accompanied by the judge's certification that the terms and consequences of the consent were fully understood by the parent or guardian and that the explanation was either understood in English or interpreted into a language that the parent or custodian

understood. (25 U.S.C.§1901 et seq.)

The Voluntary Foster Agreement may be used when:

- the child can be sufficiently protected while in voluntary foster care.
- based on the Child Safety Assessment and the Strengths and Risks Assessment, the identified safety and/or risk factors that prevent the child from living at home safely **can be remedied within 90 days or less**, or the parent, guardian or custodian can arrange an alternative safe placement for the child after the voluntary foster care placement;
- less restrictive alternatives - such as placement with relatives, friends, community placements or provision of in-home support services will not allow the child to remain safely at home;
- the case plan is family reunification or other parent, relative or significant person placement; See Relative Search Best Practice Guide (Exhibit 12);
- the parent, guardian or custodian is willing and able to cooperate with a case plan and abide by the terms of the voluntary foster care agreement; and
- the child is age 12 or over and not developmentally disabled, and is willing to consent to voluntary placement, unless placement is clearly necessary to prevent abuse.

BEST PRACTICE TIP:
The voice of youth in care can often be lost. It is critical that the child is part of the planning process at all times, and especially when the family is voluntarily placing the child somewhere other than his or her home. Sometimes youth will not want to move because it will impact their schooling and school activities; often it means that they are separated from their brothers and sisters. When voluntary placement occurs, the issues that matter to a young person must be considered.

Implementation and Procedures Guide

Consult with the supervisor to ensure that the case circumstances meets the criteria for voluntary foster care.

Engage the family in a discussion about safety planning utilizing a voluntary foster care agreement. During this discussion, inform the parent, guardian or custodian:

- that he/she retains **Parental Rights and Responsibilities Under Voluntary Foster Care.** These include:
  - legal custody of the child;
  - the right to reasonable visitation;
  - the right to consent to medical treatment; and
  - the right to participate in educational decisions and to sign special education consents.

- that his/her decision to place a child in voluntary foster care does not constitute grounds for abandonment, abuse or dependency nor may it be used in a judicial proceeding as an admission of criminal wrong-doing.

- that any time beyond 60 days of the child's initial out-of-home placement will be considered for termination of parental rights purposes if:
  - a dependency petition is filed;
  - the child is made a ward of the court; and
  - the dependency action results in the termination of parental rights based on length of time the child has been in out-of-home placement.

- may be assessed for contribution for full or partial cost of foster care.

Paperwork Involved in Voluntary Placement

If the determination is made that voluntary foster care placement is appropriate:

F Explain the terms of Voluntary Foster Placement Agreement, FC-008, to the parent, guardian or custodian and to any child who is over age 12 and not developmentally disabled. Determine, in cooperation with the parent, guardian or custodian the length of placement **up to 90 days** and specify this on the form.

F Complete the Voluntary Foster Placement Agreement, FC-008, found in the Forms Registry. Have the parent, guardian or custodian and child, if appropriate, sign the form.

F If the child who is age 12 or over and not developmentally disabled, refuses to

sign the Voluntary Foster Placement Agreement, FC-008, document the reasons for proceeding with the placement in the case record using the Case Notes window.

F Distribute the Voluntary Foster Placement Agreement, FC-008 as follows:

§ Give one copy to the parent, guardian or custodian.

§ Give one copy to the child, if age 12 or over and not developmentally disabled.

§ Send one copy to the ACYF Parental Assessment Specialist, Site Code 940A, **within five working days.**

§ Keep the original in the child's hard copy record.

F Complete the Parental Assessment Financial Statement, FC-009, found in the Forms Registry, and determine the amount that the parent or guardian will be assessed for the cost of the child's care. Have the parent or guardian sign the form.

F Distribute the Parental Assessment Financial Statement, FC-009 as follows:

§ Give one copy to the parent, guardian or custodian.

§ Send one copy to the ACYF Parental Assessment Specialist, Site Code 940A, **within five working days.**

§ Keep the original in the child's hard copy record.

Report any changes in address, finances or case status on the Parental Assessment Financial Statement, FC-009, and forward to the ACYF Parental Assessment Specialist, Site Code 940A.

Place the child in a licensed out-of-home care placement that meets the child's individualized assessed needs. See Selecting an Out-of-Home Care Provider, (Chapter 6, Section 5).

If the child is or may be Native American, follow the procedures outlined in Voluntary Consent for Foster Care Placement of a Native American Child, (Chapter 18 Section 4).

Case Plan Development

Develop an individualized case plan within 10 working days of placing a child in voluntary foster care. The case plan must address the safety and/or risk factors that prevent the child from living

safely at home and provisions for contact and visitation between the child and family. Provide a copy of the case plan to the parent, child aged 12 or older and not developmentally delayed, and the out-of-home caregiver.

To the fullest extent possible, ensure the involvement of the parents, children, out-of-home care providers and when appropriate, extended family members in the case planning process. See Best Practice Tips on Facilitating a Family Centered Meeting (Exhibit 18). Chapter 9 provides further direction on case plan development.

Make referrals to all services outlined in the plan *within two working days* of placing the child in voluntary foster care. Services may be provided through the department or referral to community resources.

Meet with the family within 30 days of taking a child into voluntary foster care (and monthly thereafter) to review the case status, progress toward the case plan goal and continued appropriateness of voluntary foster care. If the family is able to rapidly correct the situation, then the child must be returned to their home. Voluntary foster care cannot be prolonged when the risk factors have been mitigated.

BEST PRACTICE TIP:
A case plan that is developed for the family has much less chance of being successfully implemented than a plan developed in concert with the family A case plan is only a hypothesis of what will be effective to help the family in meeting their goals. Critical to the success of voluntary placement is the provision of services and supports that will change the family dynamics or current situation. Best practice suggests that the plan is **reviewed every time the CPS Specialist meets with the family**. This practice ensures that the plan remains effective in meeting the family's needs. When the family indicates that services are not helpful, the plan should be re-evaluated and additional/new services provided that will be more helpful to the family. The plan is a document that must evolve as information about how the family can best meet their goals becomes known.

Monitor the child's out-of-home placement through monthly face-to-face contact with the child and caregiver in the caregiver's home to ensure that the child is safe.

If the child runs away from the voluntary placement, follow procedures found in Chapter 6 Section 20, Locating Children on Runaway Status**.**

Upon the child's return to out-of-home care, follow procedures found in Chapter 6 Section 20, Locating Children on Runaway Status. In addition to these procedures:

- Convene a case conference, within seven days**,** to include the parent, guardian or custodian and the out-of-home care provider to discuss continuance or termination of the Voluntary Foster Placement Agreement.
- Do not end date the Removal Status or terminate CMDP coverage unless the Voluntary Foster Placement Agreement is terminated.

Expiration of the Voluntary Placement Agreement
Within 10 working days prior to expiration of the Voluntary Foster Placement Agreement:

- Reassess the child's safety using the Child Safety Assessment;
- **Convene a case plan staffing** to determine whether:
  - the child may be safely returned home; or
  - the parent, guardian or custodian has arranged an alternate safe placement with a relative, non-custodial parent, or other custodian; or
  - filing an In-Home Intervention (Chapter 5, Section 2), or In-Home Dependency Petition (Chapter 5, Section 3) or Out of Home Dependency Petition (Chapter 6, Section 1) is necessary to ensure the child's safety.

BEST PRACTICE TIP:
The quality of the case staffing is dependent upon the planning that occurs prior to the meeting. While all CPS Specialists are busy, this is time well spent. The preparation ensures that the right people attend, that the atmosphere is set for the family's and child's voice to be heard. The most effective case staffings occur when the family really believes that their presence makes a difference. The least effective case staffings occur when the family believes that the plan is already written before they get there, and what they say has little value.

Before the child returns home or is placed in an alternate safe placement:

- Ensure that the child is provided an opportunity to talk about his/her feelings about going home or going to an alternate placement.
- Determine the follow-up services needed by the parent, guardian, custodian, or alternate caregiver to meet the child's needs.
- Inform the parent, guardian, custodian or alternate caregiver about available financial and non-financial services and eligibility requirements.

þ Assist the parent, guardian, custodian or alternate caregiver to complete the necessary applications for services.

þ Access needed services through department or community resources.

BEST PRACTICE TIP:
Prior to placing a youth in foster care, ensure that you have asked the youth about people who matter to him/her. Youth are the best resource for kinship care placements.

Revocation of the Voluntary Placement Agreement

A parent or the department may revoke a Voluntary Placement Agreement **within 72 hours** written notice. If a parent revokes a Voluntary Placement Agreement, the CPS Specialist shall, **within 72 hours**, excluding weekends and holidays:

- return the child to the custody of parent, guardian or custodian; or
- file a dependency petition if there is reason to believe that the child would be in imminent danger if he or she returns home.

DOCUMENTATION :

Document the case conference to review the case status to determine whether voluntary foster care is appropriate using the Case Notes window designated as Supervisory type.

Ensure that the child is enrolled in CMDP by completing the Removal Status window with the date of placement with the licensed out-of-home care provider as the Removal Start Date.

Document the case plan staffing using the Case Notes window designated as Staffing type.

Document explanation of the terms and conditions of the Voluntary Foster Placement Agreement using the Case Notes window designated as Parent/Caretaker Contact type.

Document the removal on the Removal Status window.

Document the reasons for proceeding with placement when a child who is age 12 or over and not developmentally disabled refuses to sign the Voluntary Foster Placement Agreement, FC-008, using the Case Notes window.

Document the meeting with the parent, custodian or guardian held 30 days after placement to review the case status using the Case Notes window designated as Parent/Caretaker Contact type.

If the child runs away from Voluntary Placement, document all information related to the runaway of a child including the DR number, notification of all parties and specific attempts to locate the child using the Case Notes window.

Document the end of the voluntary placement by end dating the removal on the Removal Status window and the legal status on the Legal Status window.

Following the child's return to the parent, guardian, or custodian, or alternate caregiver, end date the removal on the Removal Status window and update the Legal Status window.

Revision History:
DES(07-2006)

Previous / Next

4-5

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 4: Section 5

Terminating Voluntary Child Protective Services

Legal Basis

Policy: Voluntary child protective services shall be terminated when:

§ the family is able to care for its children safely without DES involvement; or

§ the family no longer wishes to participate in voluntary services and risk factors are not severe enough to warrant a dependency action; or

§ a dependency action must be filed to ensure the safety of the child.

A Voluntary Child Protective Services case may be closed when:

þ The parent recognizes the factors that caused the child to be at risk of harm.

þ The parent has taken steps to change the behavior or situation that places the child at risk.

þ These steps are sufficient to lead you to believe that the child will be safe at home in the foreseeable future.

þ The parent is involved with extended family members, community support networks or service providers who will be able to help the family maintain these changes over time.

þ The parent knows how and where to access help if problems arise in the future.

þ The child been placed, as arranged by the parent, guardian or custodian, in an alternate, safe, permanent, legal placement with a relative, on-custodian parent, or other custodian.

§ The follow-up services needed by the relative, non-custodial parent or alternate caregiver to continue to meet the child's needs have been established.

Terminate voluntary child protective services and file a dependency petition when:

- The child would be unsafe at home or in a placement made by the parent and that no additional supports or interventions can assure the child's safety.
- The parent is unwilling or unable to take concrete actions to change the behavior or situation that led to CPS involvement with the family.
- There is a family member, community support network or service provider who can assist the family in keeping the child safe only through court intervention.

Conduct a case plan staffing to assess the progress made in addressing the risk factors that led to DES involvement with the family. If the assessment indicates that:

- identified safety and risk factors have been adequately addressed, outcomes have been achieved and the child appears to be safe at home, close the case.
- the family refuses to participate in voluntary services and grounds for a dependency action do not exist, close the case.
- the child appears to be unsafe in his or her current situation, follow the procedures for filing an In-Home Intervention (Chapter 5, Section 2), or In-Home Dependency Petition (Chapter 5, Section 3) or Out of Home Dependency Petition (Chapter 6, Section 1) to ensure the child's safety.

Prior to case closure:

- Ensure that the parent, guardian, custodian or the caregiver is aware of available financial and non-financial services and eligibility requirements.
- Assist the parent, guardian, custodian or caregiver to complete the necessary applications for services.
- Access needed services through department or community resources.
- Ensure that the parent has extended family members or community support networks that can assist him or her if difficulties arise.
- Ensure that the parent knows how and under what circumstances to seek help in the future.

DOCUMENTATION :

Document the decision to terminate voluntary child protective services and close the case.

Document the case plan staffing using the Case Notes window designated as Staffing type.

Revision History:
DES(07-2006)

Previous

5-1

Legal Basis: Not applicable

Rules: Rules pertaining to ongoing services and case closure are found R6-5-5511 through R6-5-5513.

Revision History:
DES(07-2006)

Chapter 5: Section 1

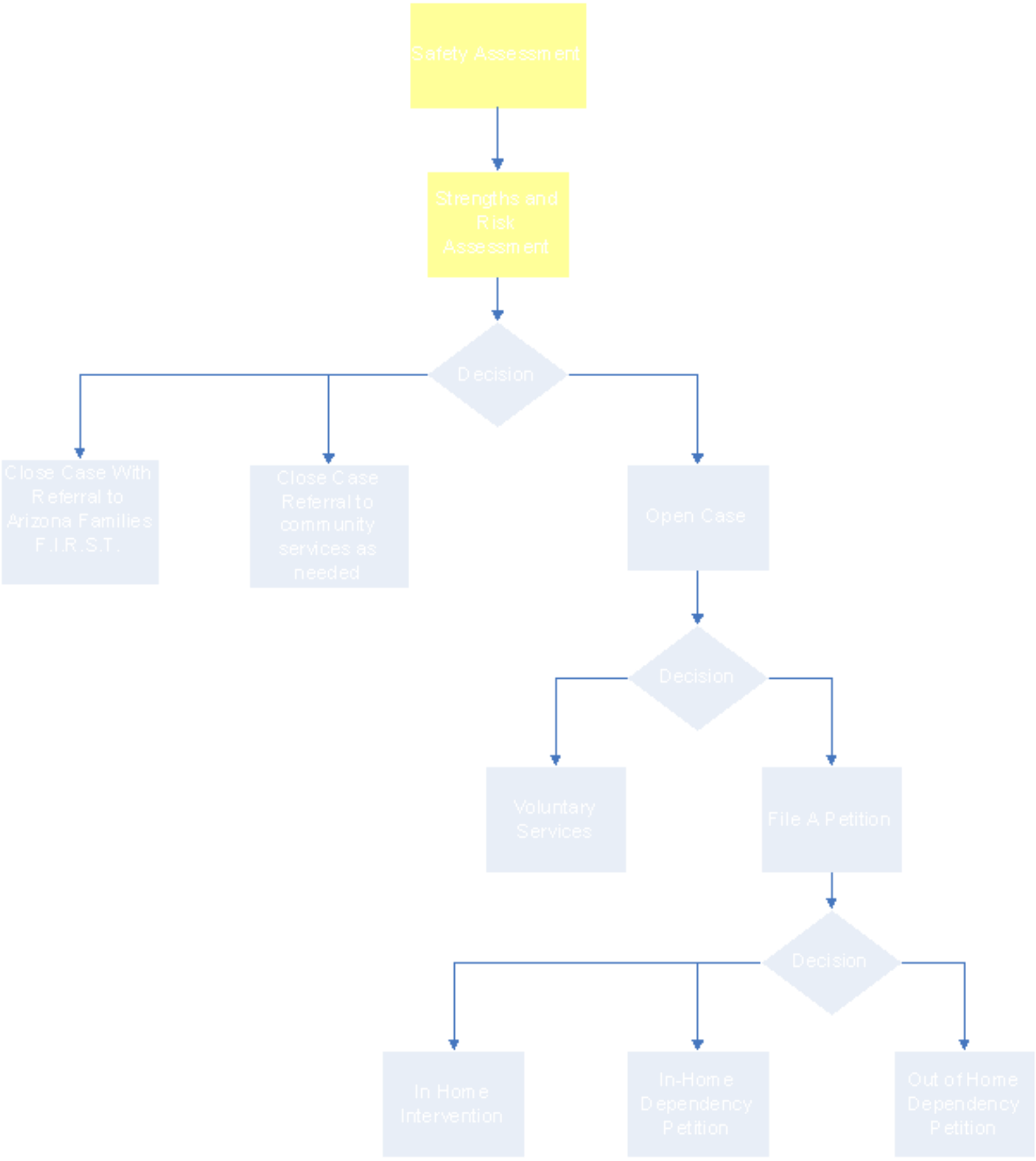
Determining Whether To Open The Case For Ongoing Services

Legal Basis

Policy: Based on the results of the CPS safety assessment/investigation and the results of the Strength and Risk Assessment, the department shall determine whether to 1) close the case 2) offer voluntary child protective services or 3) open a case for ongoing services. If the case is going to be open for ongoing services the worker must determine if the services can be provided through a voluntary relationship with DES, if a petition for in-home intervention is sufficient or if an In home or Out of Home Dependence Petition must be filed.

The existence of present or future risk of harm to any child in the family unit and if services and supports can mitigate the identified risks are the primary factors for CPS Specialists to consider when determining whether a case should be open for ongoing services.

See the following chart for the decision making process.



Whether or Not To Close A Case or Open for Services

To determine whether to close a case following investigation and assessment, consider these

questions:

§ Are there no risk factors that are severe enough to warrant ongoing department involvement to assure safety of the child?

§ Does the family refuse to participate in voluntary services and are there no risk factors severe enough to warrant a dependency action?

§ Are some risk factors present, but the family has acknowledged them and is receiving support and services from extended family or community resources?

§ Has the family moved and its whereabouts are unknown and have reasonable efforts to locate the family been made?

If the case is to be closed:

§ Obtain management approval when severe or serious injury to a child has been substantiated.

§ Refer the family to any community resources that may be able provide support or services, if need arises, now or in the future.

§ Make certain that the family knows that they can contact DES in the future if they need help.

If the case is to be closed and CPS Specialist is considering a referred to Families F.I.R.S.T. consider these questions:

§ Are there prior CPS reports in which substance abuse contributed to child abuse or neglect?

§ Is there a history of prenatal substance abuse? How long?

§ Are there current or prior reports of Substance Exposed Newborns (SEN)?

§ Has substance abuse treatment been provided in the past? If so, who participated and how long?

§ Is the family willing to participate in the Arizona Families F.I.R.S.T. Program?

§ Will participation in the Arizona Families F.I.R.S.T. Program reduce risk factors and enable the child to reside safely in the home without continued department involvement?

If the decision is made that a case cannot be closed then it must be open for services.

To determine whether to open a case for <u>voluntary services</u> *or* <u>to recommend the filing of a dependency action</u> consider the issues below after completing the Strengths and Risk Assessment.

§ Are there unresolved risk factors contributing to subsequent reports? If so,

§ Does the parent agree that these risk factors exist and is the family willing to work with the agency to resolve the issues?

§ Does the family require services to address potential abuse or neglect issues that they cannot access without DES involvement?

§ Are there services that the department could provide on a voluntary basis (either directly or through referral to a community agency) to help the family address the risk factors which led to the child's abuse and neglect?

If the answers to the above questions are yes, open a case for Voluntary Services (Chapter 4).

BEST PRACTICE TIP:
In order to determine if the services can be provided on a voluntary nature, assess how motivated the family is to cooperate. Do they see the need? Do they agree that the children in the family are in need of additional food, clothing, supervision, etc.? Do they understand the concept of risk? The CPS Specialist cannot assume that terms that are familiar to child welfare are familiar to every family. The CPS Specialist should practice full disclosure and describe both the process and terms and make the considerations of risk very transparent to the family.

To determine whether to provide in-home services, consider these questions:

§ If the family is unwilling to accept services voluntarily or appears unable to benefit from voluntary services, are there grounds for a dependency action?

§ If the child is currently in the parent's, guardian's or custodian's home, can he or she remain there safely with the continuation or provision of services or supports?

§ If the child is not currently at the parent's, guardian's or custodian's home, can he or she return home safely with the provision of additional services or supports?

BEST PRACTICE TIP:
While it is not always possible, it is best if the CPS Specialist can find a way to keep the child safe in their own home. Foster care should not be used when an in-home solution can be identified. It is very important to remember that removing a child from their home always creates trauma. Sometimes we have no choice in order to ensure child safety, but we must never forget that foster care holds its own set of issues and problems for children. The way to prevent unnecessary placement is to complete a comprehensive assessment of the family using the Strengths and Risk Assessment. By identifying the strengths and protective capacities of the family that can mitigate risk, by fully understanding how the family has effectively coped in the past, and by learning about the supports on which the family can draw, CPS Specialists will be in a position to effectively identify in-home options whenever they are possible.

If no services or supports can ensure the child's safety at home at the present time, then out-of-home care must be provided.

Implementation and Procedure Guide

In offices in which Child Protective Services Investigation is separate from Ongoing Services, transfer the case as soon as possible, but no later than 45 days after receiving the case for investigation.

If the case is not transferred within 30 working days and a case plan staffing is due within ten working days, the investigation worker shall conduct the staffing prior to the transfer.

Inform the client about the transfer, identifying the new case manager, if assigned.

Closing a Case When a Referral is Made to Families F.I.R.S.T.
Prior to closing a case which has been referred to the Arizona Families F.I.R.ST. Program:

§ Ensure that the completed PS-067, Referral for Services, has been sent to the Arizona Families F.I.R.S.T. Provider,

§ Forward a copy of the PS-067 to the Substance Abuse Treatment Program Specialist at Site Code 940A.

§ Obtain the Arizona Families F.I.R.S.T. provider notification that the family refused to participate in substance abuse treatment. This notification should be received within five (5) days from the date of the referral to the Arizona Families F.I.R.S.T. provider, or

§ Obtain the Arizona Families F.I.R.S.T. provider notification that the family accepted and completed a service plan for substance treatment. (This notification should be approximately fourteen (14) days from the date of the referral to the Arizona Families F.I.R.S.T. Program provider).

§ Obtain supervisory approval for case closure when substance abuse contributed to the substantiation of prior reports of severe or serious injury or neglect.

DOCUMENTATION :

Prior to case closure or transfer, ensure that the following windows are completed:

- Child Safety Assessment Summary
- Family Strengths and Risks Assessment
- Joint Investigation Detail (if applicable)
- Report Detail
- Investigation Detail

- Investigation Allegation Findings
- Investigation Tracking Characteristic Findings
- Determination of Case Status

Document the results of the investigation within 30 days of receipt of the report in the Case Note window, designated as Investigation Type.

Document the results of the supervisor consultation in the Case Note window type Supervisor Contact type.

Document the determination of case status by completing the Determination of Case Status window.

Document the family's decision to accept or refuse services on the Child Protective Service Request and Summary of Clients Rights and Responsibilities, PS-045.

Update CHILDS to reflect any changes in the case status.

File a copy of the PS-067 in the hard copy record.

File the notification from the Arizona Families F.I.R.S.T. Provider in the hard copy case record.

Revision History:
DES(07-2006)

Next

5-2

Legal Basis: ARS §8-802(C)(5) requires child protective services workers to conduct a prompt and thorough investigation of the nature, extent and cause of any condition that would tend to support or refute the allegation that the child should be adjudicated dependent.

ARS §8-201(13) defines a dependent child to include a child whose parent is unwilling or incapable of providing proper and effective parental care and control of the child. The definition is broad enough to include a child whose parent, guardian or custodian is capable of providing care *only* with departmental intervention to provide services and Juvenile Court oversight.

ARS §8-891(A) creates an alternative to an adjudicated dependency that allows a child to remain in the home when short term (up to one year) intervention appears likely to resolve risk issues, and the parent, guardian or custodian agrees to a case plan and to participation in services.

ARS §8-803 discusses the requirement to provide all verbal or written responses to the allegation and any documentation provided by the subject of a CPS investigation to the court prior to a hearing or trial relating to the dependency petition.

Rules: Rules pertaining to conducting investigations, making a determination that the child is in need of protective services, providing protective services and alternatives to involuntary removal of the child are found in the Arizona Administrative Code Sections R6-5-5508, R6-5-5510, R6-5-5511 and R6-5-5513, respectively.

Revision History:
DES(07-2006)

Chapter 5: Section 2

Petitioning for In-Home Intervention

Legal Basis

Policy: If voluntary services are not an option there are three paths the case can take: 1) petitioning for in-home intervention, 2) filing an in-home dependency petition, 3) filing an out of home dependency petition.

The difference in the three paths identified above is depicted in the following chart:

In Home Intervention	In Home Dependency Petition	Out of Home Dependency Petition
The court stays the finding at the initial court hearing.	The court makes a finding of dependency—and the child remains in the home.	The court makes a finding of dependency and the child is removed from the home.
The CPS Specialist writes an initial report to the court (the Report to Juvenile Court for In-Home Intervention) — and unless a party requests a hearing, there is no court hearing for 12 months.	There is a court hearing every 90 days.	There is a court hearing every 90 days.
Indicate “In-Home Intervention Requested” on the Dependency Petition Worksheet.	Indicate In Home Dependency on the Dependency Petition Worksheet	Indicate Out of Home Dependency on the Dependency Worksheet

Serve the Notice Requesting In-Home Intervention to the parents (including the non-custodial parent), guardian or custodian.	Serve the In-Home Dependency Notice to the parent (including the non-custodial parent), guardian or custodian	Serve the Out of Home Dependency Notice to the parent (including the non-custodial parent), guardian or custodian

The department may recommend the filing of a petition requesting In-Home Intervention when:

- The Child Safety Assessment indicates that the child is safe or an in-home safety plan is in place.
- The child is at a moderate or higher level of risk of harm and short-term services (up to one year) are required to resolve the identified risk factors.
- There is reason to believe that the parent, guardian or custodian will *only* follow through with services with court oversight.

Consider filing a dependency petition requesting In-Home Intervention when *all* of the following are true:

- The child has not been removed from the home.
- The Child Safety Assessment indicates the child is safe or an in-home safety plan is in place.
- The Family Centered Strengths and Risks Assessment identifies moderate risk factors that appear likely to be resolved through short-term (up to one year) in-home intervention. These risk factors may include substance abuse, domestic violence, physical abuse, chronic neglect, lack of supervision, or failure to obtain necessary treatment for a medical condition of the child.
- There is reason to believe that the family will follow through with services, due to prior history or other indicators, with minimal court oversight.
- The parent, guardian or custodian agrees to the in home intervention case plan in writing and to full participation in services.
- The child is at risk of harm due to the inability or unwillingness of the parent, guardian or custodian to provide food, clothing, shelter or medical care; or the parent, guardian or custodian is unable to provide proper care, control and supervision of the child.

Do not consider filing a dependency petition requesting In-Home Intervention:

- if the family does not fully agree with the in-home intervention plan;
- if the child's health and safety can not be maintained in the home;
- if protective services are unlikely to remedy the risk factors that place the

child at risk of abuse or neglect; or

- if it is necessary to remove one or more children from the home.

BEST PRACTICE TIP:
Whenever possible, identify extended family members or community resources to support the family's participation in services and to assist in monitoring the child's safety. The more support provided to the family, the greater the likelihood that they will be successful.

Implementation and Procedure Guide

Review and discuss the case circumstances with your supervisor, including the likelihood of resolving the risk factors through In-Home Intervention.

Develop and implement the case plan in accordance with **Case Planning and Case Management** (Chapter 9).

Legal Issues
Consult with the Office of the Attorney General to determine whether there is sufficient evidence to file a petition for in-home intervention and maintain the child safely in the home. Also, discuss the duration of the petition (up to one year or less).

If so advised by the Attorney General's Office that there is sufficient evidence, prepare the Dependency Petition Worksheet, CT00900, found in the Court Document Detail, and submit it to the Attorney General's Office, following district operating procedures. Indicate "In-Home Intervention Requested" on the Dependency Petition Worksheet.

Serve the Notice Requesting In-Home Intervention, CPS-1017AFORNA, to the parents (including the non-custodial parent), guardian or custodian.

If necessary, conduct an extensive and documented search for missing parents. If you are unable to identify or locate a parent after conducting a diligent search, complete an Affidavit of Unknown Residence, CT00600, found in the Court Document Detail, and submit it to the Attorney General's Office prior to the Initial Dependency Hearing.

Prepare the report to Juvenile Court for the Initial Dependency Hearing (also known as a 21-Day Hearing) using the Report to Juvenile Court for In-Home Intervention, CT05500, found in the Court Document Detail. Provide all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation. Submit the report to the Court and the Attorney General's Office at least five working days prior to the hearing with the following attachments:

- Proposed Case Plan as documented in the Permanency Goals window, Case Plan Tasks window, and the Case Plan Agreement window.

- Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in Court Document Detail.
  - ü Ensure that the child's school name and address are recorded on the FC-064-A.
  - ü Include on the FC-064-A the name and address of any juvenile probation officer of a child and any RBHA case manager of a parent or a child.

- Reports from service team members if applicable and available.

Send the report to the attorneys and/or guardians ad litem representing the parents, guardians and child in the Dependency Petition, with all of the above attachments except Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A.

Send the report to other individuals given "interested party" status by the Court, to the parents, guardians and child, if age 12 or older and not represented by an attorney; to any juvenile probation officer; to any parent's or child's RBHA case manager. Include the Proposed Case Plan as the only attachment.

When the Parents Successfully Complete the Requirements in the In-Home Intervention Case Plan

If the parent, guardian or custodian successfully completes the in-home intervention case plan, contact the Attorney General's Office to file a motion to dismiss the Petition. Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the report to the Attorney General's Office. A hearing on the motion to dismiss is not required; although, the Court may set a hearing. Distribute the Addendum Report as described above.

Consult with the Attorney General's Office if there is a reason to extend the In-Home Intervention order. The Attorney General's Office will file a motion to extend the order prior to the In-Home Intervention Review Hearing.

If the petition is not dismissed prior to the In-Home Intervention Review Hearing, complete an Addendum Report, CT00200. Ensure that the report contains the following information:

- the services offered and provided;
- parent's participation and progress in services;

- description of how each identified risk factor has been resolved; and
- need (and reason) for an extension of In-Home Intervention Services.

Submit the report to the Court and the Attorney General's Office at least ten working days prior to the hearing with the following attachments:

- Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in Court Document Detail.
  - ü Ensure that the child's school name and address are recorded on the FC-064-A.
  - ü Include on the FC-064-A the name and address of any juvenile probation officer of a child and any RBHA case manager of a parent or a child.

- Reports from service team members if applicable and available.

Send the report to the attorneys and/or guardians ad litem representing the parents, guardians and child in the Dependency Petition with all of the above attachments except Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A.

Send the report to other individuals given "interested party" status by the court, to the parents, guardians and child, if age 12 or older and not represented by an attorney; to any juvenile probation officer; to any parent's or child's RBHA case manager.

When the Parents Do Not Fullfill the Agreements in the In-Home Intervention Case Plan
If after the Court orders In-Home Intervention, the parent, guardian or custodian does not comply with the case plan including participation in services, reassess the child's safety using the Child Safety Assessment to determine if the child is safe in the home.

If the child is unsafe and an In-Home Safety Plan can ensure the child's safety:

- þ Complete a Safety Plan.
- þ Determine whether the level of risk has increased by completing a reassessment of the family's strengths and risks using the Strengths and Risk Assessment.
- þ Contact the assigned Assistant Attorney General to file a motion to rescind the In-Home Intervention order and proceed to adjudication.
- þ Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the repot to the Attorney General's Office. Distribute the Addendum Report as described above.

If the child is unsafe and the child's safety can not be maintained in the home:

- þ Complete an Out-of-Home Safety Plan.

- Take temporary custody of the child.
- Serve a Notice of Removal to the parent, guardian or custodian.
- Contact the Attorney General's Office to file a motion to rescind the In-Home Intervention order and a motion to Change Physical Custody.
- Notify the child's guardian ad litem.
- Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the report to the Attorney General's Office. Distribute the Addendum Report as described above.

DOCUMENTATION :

Document consultation with the supervisor using the Case Notes window, designated as Supervisory Contact type.

Document consultation with the Attorney General's Office using the Case Notes window, designated as AG Contact type.

File a copy of the Dependency Petition along with any court order for In-Home Intervention in the case record.

Document the child's legal status as In-Home Intervention in the Legal Status window.

Revision History:
DES(07-2006)

Previous / Next

5-3

Legal Basis: ARS §8-802(C)(5) requires child protective services workers to conduct a prompt and thorough investigation of the nature, extent and cause of any condition that would tend to support or refute the allegation that the child should be adjudicated dependent.

ARS §8-201(13) defines a dependent child to include a child whose parent is unwilling or incapable of providing proper and effective parental care and control of the child. The definition is broad enough to include a child whose parent, guardian or custodian is capable of providing care *only* with departmental intervention to provide services and Juvenile Court oversight.

ARS §8-891(A) creates an alternative to an adjudicated dependency that allows a child to remain in the home when short term (up to one year) intervention appears likely to resolve risk issues, and the parent, guardian or custodian agrees to a case plan and to participation in services.

ARS §8-803 discusses the requirement to provide all verbal or written responses to the allegation and any documentation provided by the subject of a CPS investigation to the court prior to a hearing or trial relating to the dependency petition.

Rules: Rules pertaining to conducting investigations, making a determination that the child is in need of protective services, providing protective services and alternatives to involuntary removal of the child are found in the Arizona Administrative Code Sections R6-5-5508, R6-5-5510, R6-5-5511 and R6-5-5513, respectively.

As described in Determining Whether to Open a Case for Ongoing Services, (Chapter 5, Section 1) if the decision is made to open a case and a petition is to be filed, there are three options: petitioning for in-home intervention, filing an in-home dependency petition or filing an out of home dependency petition.

Revision History:
DES(07-2006)

Chapter 5: Section 3

Filing An In-Home Dependency Petition

Legal Basis

As described in Determining Whether to Open a Case for Ongoing Services, (Chapter 5, Section 1) if the decision is made to open a case and a petition is to be filed, there are three options: petitioning for in-home intervention, filing an in-home dependency petition or filing an out of home dependency petition.

Policy: The department shall consider providing services through an in-home dependency petition when:

- The Child Safety Assessment indicates that the child is safe or an in-home safety plan is in place.
- The child is at risk of harm and short-term services (up to one year) are required to resolve the identified risk factors.
- There is reason to believe that the parent, guardian or custodian will *only* follow through with services with court oversight.

Consider filing a dependency petition requesting In-Home Intervention when *all* of the following are true:

- The child has not been removed from the home.
- The Child Safety Assessment indicates the child is safe or an in-home safety plan is in place.
- The Family Centered Strengths and Risks Assessment identifies moderate risk factors that appear likely to be resolved through short-term (up to one year) in-home intervention. These risk factors may include substance abuse, domestic violence, physical abuse, chronic neglect, lack of supervision, or failure to obtain necessary treatment for a medical condition of the child.
- There is reason to believe that the family will only follow through with services, due to prior history or other indicators, with court oversight.

- The parent, guardian or custodian agrees to a case plan and participation in services.
- The child is at risk of harm due to the inability or unwillingness of the parent, guardian or custodian to provide food, clothing, shelter or medical care; or the parent, guardian or custodian is unable to provide proper care, control and supervision of the child.

Do not consider filing a dependency petition requesting In-Home Intervention:

- if the child's health and safety can not be maintained in the home;
- protective services are unlikely to remedy the risk factors that place the child at risk of abuse or neglect; or
- if it is necessary to remove one or more children from the home.

Implementation and Procedure Guide

Review the results of the Child Safety Assessment and the Strengths and Risks Assessment.

Assess the type and level of protective services and supervision needed to ensure the child's continued safety and to remedy the identified risk factors. If possible, identify extended family members or community resources to assist in monitoring the child's safety and to support the family's participation in services.

Review and discuss the case circumstances with your supervisor, including the likelihood of resolving the risk factors through In-Home Intervention.

Develop and implement the case plan in accordance with Case Planning and Case Management (Chapter 9).

Consult with the Office of the Attorney General to determine whether there is sufficient evidence to file a dependency petition and maintain the child safely in the home. Also, discuss the duration of the petition (up to one year or less). If so advised by the Attorney General's Office that there is sufficient evidence, prepare the Dependency Petition Worksheet, CT00900, found in the Court Document Detail, and submit it to the Attorney General's Office, following district operating procedures. Indicate "In-Home Intervention Requested" on the Dependency Petition Worksheet.

Serve the Notice Requesting In-Home Intervention, CPS-1017AFORNA, to the parents (including the non-custodial parent), guardian or custodian.

If necessary, conduct an extensive and documented search for missing parents. If you are unable to identify or locate a parent after conducting a diligent search, complete an Affidavit of Unknown Residence, CT00600, found in the Court Document Detail, and submit it to the Attorney General's Office prior to the Initial Dependency Hearing.

Prepare the report to Juvenile Court for the Initial Dependency Hearing (also known as a 21-Day Hearing) using the Report to Juvenile Court for In-Home Intervention, CT05500, found in the Court Document Detail. Provide all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation. Submit the report to the Court and the Attorney General's Office at least five working days prior to the hearing with the following attachments:

- Proposed Case Plan as documented in the Permanency Goals window, Case Plan Tasks window, and the Case Plan Agreement window.
- Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in Court Document Detail.
    - ü Ensure that the child's school name and address are recorded on the FC-064-A.
    - ü Include on the FC-064-A the name and address of any juvenile probation officer of a child and any RBHA case manager of a parent or a child.

- Reports from service team members if applicable and available.

Send the report to the attorneys and/or guardians ad litem representing the parents, guardians and child in the Dependency Petition, with all of the above attachments except Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A.

Send the report to other individuals given "interested party" status by the Court, to the parents, guardians and child, if age 12 or older and not represented by an attorney; to any juvenile probation officer; to any parent's or child's RBHA case manager. Include the Proposed Case Plan as the only attachment.

After the Court orders In-Home Intervention and the parent, guardian or custodian does not comply with the case plan including participation in services, reassess the child's safety using the Child Safety Assessment to determine if the child is safe in the home. If the child is unsafe and an In-Home Safety Plan can ensure the child's safety:

- complete a Safety Plan;

BEST PRACTICE TIP:
Safety plans are most effective when jointly created with families and specifically address what

the child, child's family including kin will do if at any time, the child's safety is in jeopardy. Safety plans that are developed with the child's parent(s) and involve kin provide a built in support system for children and their families. In order to engage the child's parents, they must trust and believe that the CPS Specialist wants to help, to support them in caring for their own children. The most effective safety planning occurs when the family is fully engaged in the process.

- Determine whether the level of risk has increased by completing a reassessment of the family's strengths and risks using the Strengths and Risk Assessment.
- Contact the assigned Assistant Attorney General to file a motion to rescind the In-Home Intervention order and proceed to adjudication. Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the repot to the Attorney General's Office. Distribute the Addendum Report as described above.

If the child is unsafe and the child's safety can not be maintained in the home:

- Take temporary custody of the child.
- Serve a Notice of Removal to the parent, guardian or custodian.
- Contact the Attorney General's Office to file a motion to rescind the In-Home Intervention order and a motion to Change Physical Custody.
- Notify the child's guardian ad litem.
- Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the report to the Attorney General's Office. Distribute the Addendum Report as described above.

If the parent, guardian or custodian successfully completes the in-home intervention case plan, contact the Attorney General's Office to file a motion to dismiss the Petition. Complete an Addendum Report following the format found in the Court Document Detail, CT00200, and submit the report to the Attorney General's Office. A hearing on the motion to dismiss is not required; although, the Court may set a hearing. Distribute the Addendum Report as described above.

Consult with the Attorney General's Office if there is a reason to extend the In-Home Intervention order. The Attorney General's Office will file a motion to extend the order prior to the In-Home Intervention Review Hearing.

If the petition is not dismissed prior to the In-Home Intervention Review Hearing, complete an Addendum Report, CT00200. Ensure that the report contains the following information:

- the services offered and provided;
- parent's participation and progress in services;

- description of how each identified risk factor has been resolved; and
- need (and reason) for an extension of In-Home Intervention Services.

Submit the report to the Court and the Attorney General's Office at least ten working days prior to the hearing with the following attachments:

- Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in Court Document Detail.
  - ü Ensure that the child's school name and address are recorded on the FC-064-A.
  - ü Include on the FC-064-A the name and address of any juvenile probation officer of a child and any RBHA case manager of a parent or a child.

- Reports from service team members if applicable and available.

Send the report to the attorneys and/or guardians ad litem representing the parents, guardians and child in the Dependency Petition with all of the above attachments except Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A.

Send the report to other individuals given "interested party" status by the court, to the parents, guardians and child, if age 12 or older and not represented by an attorney; to any juvenile probation officer; to any parent's or child's RBHA case manager.

DOCUMENTATION :

Document consultation with the supervisor using the Case Notes window, designated as Supervisory Contact type.

Document consultation with the Attorney General's Office using the Case Notes window, designated as AG Contact type.

File a copy of the Dependency Petition along with any court order for In-Home Intervention in the case record.

Document the child's legal status as In-Home Dependency in the Legal Status window.

Revision History:
DES(07-2006)

Previous / Next

5-4

Legal Basis: The federal Adoption and Safe Families Act of 1997 (P.L. 105-89) amended the Family Preservation and Family Support Act (P. L. 103-66) by renaming it, *Promoting Safe and Stable Families*. This law governs services to promote family strength and stability, parental functioning and child protection.

ARS §8-514.02 allows for the provision of in-home services under a dependency by stating that the department "may place a child with a parent or relative."

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 5: Section 4

Providing In-Home Services Under a Dependency

Legal Basis

Policy: When the court has granted a dependency petition, the department shall provide services that minimize intrusion into family life to the greatest extent possible while ensuring the health and safety of the child.

With the court's approval, the department may provide in-home services under a dependency if such services can adequately ensure the child's health and safety while the family addresses safety and risk factors that necessitate DES involvement.

Case planning and case management requirements described in Case Planning and Case Management, (Chapter 9) shall apply to families receiving in-home services under a dependency petition.

CPS Specialists shall have face-to-face contact with the child and parent(s) in the home at least once a month:

- to ensure that the child remains safe in the home; and
- to work with the family on addressing safety and risk factors that prevent them from caring for the child safely without DES involvement.

Implementation and Procedure Guide

To provide in-home services to families under a dependency:

- Review court orders carefully to make sure that all requirements of the court are met.
- Develop a proposed case plan jointly with the family. Meet all requirements related to periodic reassessment and revision of case plans.
- Review and update the Child Safety Assessment and Family Strengths and Risk Assessment, if necessary, whenever the case plan is revised.
- Complete the Family Relationships window.
- Visit the child and family in the family home at least monthly.
- Provide services and/or refer the family to services that will address risk factors that prevent the family from ensuring the child's health and safety without DES involvement.
- Monitor the family's progress in achieving the outcomes specified in the case plan.

When providing in-home services under a dependency, do not:

- Present the case for review by the Foster Care Review Board;
- Develop an Out-of-Home Care Plan or Visitation Agreement;
- Complete any other tasks associated solely with out-of-home placement.

DOCUMENTATION :

Document all contacts and visitation with the child(ren) and family members using the Case Notes window, designating the appropriate type. Document face-to-face contacts using the Case Notes window and by selecting the In Person Contact Type radio button.

Highlight the names of all parties present using the Contact With list on the Case Notes window. Select the "In Placement Contact" when the child and parent are seen together or separately in the parent's home.

Document the decision to provide in-home services under a dependency petition using the Determination of Case Status window.

Document the Proposed Case Plan by completing the following windows associated with the Case Plan Directory: Permanency Goals, Case Plan Tasks and Case Plan Agreement. Confirm the information on the Notification window.

Document the periodic reassessment of the case and the revised case plan by completing the following windows associated with the Case Plan Directory.

If new safety or risk factors have been identified since the last assessment, use the Child Safety Assessment and the Family Strengths and Risk Assessment window.

Revision History:
DES(07-2006)

Previous

6-1

Legal Basis: ARS §8-802 enables the department to file dependency petitions.

ARS §8-842 requires that the hearing on an initial dependency petition must be set within 21 days of its filing.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6: Section 1

Filing an Out-of-Home Dependency Petition

Legal Basis

Policy: The department shall recommend the filing of a dependency petition when a child is at risk of imminent or potential abuse or neglect and cannot be protected through the use of voluntary protective services or an in-home dependency petition.

The Attorney General's Office is responsible for deciding whether to file a dependency petition in cases of abuse or neglect, based upon information and recommendations provided by the CPS Specialist and CPS Supervisor.

If a child has been removed from home on an emergency basis, a dependency petition shall be filed within 72 hours, excluding Saturdays, Sundays and holidays, or the child shall be returned to the parent's custody. [ARS §8-802(D) and ARS §8-821(G)]

To determine whether out-of-home care is appropriate, consider these questions:

- Does the parent lack extended family members, friends or community support networks that can provide sufficient support for the parent and protection for the child to enable the child to stay safely at home at this time?
- Are there no available community services that can ensure the child's health and safety in the home at this time?
- Are the parent(s) unwilling or unable to participate in services or interventions that will enable the child to stay safely at home at this time?
- Does the child's risk of maltreatment at home outweigh the traumatic effects of removal from home?

To decide whether to recommend filing an out of home dependency petition, consider these questions:

- Does the Family Strengths and Risks Assessment indicate that there are significant risk factors that prevent the family from ensuring the child's health and safety at the present time?
- Does the severity or chronicity of the maltreatment or the vulnerability of the child (due to age, health or special needs) increase the level of concern about the child's safety?

- Are there any extended family members who could assure the health and safety of the child without necessitating court involvement?
- Has the use of voluntary, community-based services or interventions, an in-home intervention or an in-home dependency petition been ruled out or attempted unsuccessfully?
- Is the family likely to endanger the child by fleeing to avoid further intervention?

Implementation and Procedure Guide

Consult with your supervisor prior to contacting the Attorney General's Office regarding filing a dependency petition.

If you have questions concerning whether there are legal grounds for dependency on a specific case, consult your supervisor or an Assistant Attorney General.

Before calling the Attorney General's Office, have the answers to the following questions available:

- Is there an open case on the family?
- Does the petition contain allegations against all parents?
- Is there a divorce? If so, who has legal custody?
- Are all persons who provided information named?
- Will people who provided information be available to testify?
- Are there medical records, photographs, police reports or other relevant documents?
- Are there other children in the home not included in the petition? What is their status?
- Are there any prior CPS reports on this family?
- Are there other parties who should be included on the petition?
- Is the child subject to the Indian Child Welfare Act (ICWA)?

If so advised by the Attorney General's Office, prepare the dependency petition worksheet, CT00900, found in the Court Document Detail and submit it to the Attorney General's Office following district procedures.

If necessary, conduct an extensive and documented search for missing parents and extended family members or other significant persons as placement resources for the child. If you are unable to identify or locate a parent after conducting a diligent search, complete an Affidavit of Unknown Residence, CT00600, found in the Court Document Detail, and submit it to the Attorney General's Office along with the petition worksheet.

If a parent cannot be identified or located, arrange for service by publication in the newspaper at least five days prior to the dependency hearing. See Finding Missing Parents, Relatives and Other

Significant Persons (Chapter 6 Section 2).

Amend the petition if you learn new, substantive information about the parents after the petition has been filed.

Prepare a Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing, found in Court Document Detail, CT01200. Submit the report to the court not later than the day before the preliminary protective hearing. If the report is prepared for the Initial Dependency Hearing (also known as a 21-Day Hearing), submit it to the court, the Attorney General's office and the Foster Care Review Board at least three working days prior to the hearing. See Preparing Court Reports for CPS Cases (Chapter 20, Section 6) for further instructions on attachments and routing of the report.

Complete and route the Parental Assessment Financial Statement, FC-009, found in the Forms Registry, as described in Assessing Parent's Financial Responsibility for Children in Care (Chapter 20, Section 7). Include your recommendation for financial assessment with the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing.

Route a copy of any Court Order or Minute Entry addressing parental assessment to the Parental Assessment Specialist, Site Code 940A.

Route the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing as specified in Preparing Court Reports for CPS Cases (Chapter 20, Section 6).

DOCUMENTATION :

Document consultation with your supervisor using the Case Notes window designated as Supervisory Contact type.

Document consultation with the Attorney General's Office using the Case Notes window designated as AG Contact type.

File a copy of the Dependency Petition, along with any Court Orders or Minute Entries resulting from the dependency hearing, in the legal section of the hard copy record.

Revision History:
DES(07-2006)

Next

6-2

Legal Basis: ARS §8-802 enables the department to file dependency petitions.

The Adoption and Safe Families Act of 1997 (P. L. 105-89) enables the department to use the federal Parent Locator Service through the Division of Child Support Enforcement for child welfare services, including location of absent parents.

Rules: Rule 15 of the Rules of Procedures of the Juvenile Court specify legal requirements for service of process to parents, guardians and custodians.

Revision History:
DES(07-2006)

Chapter 6: Section 2

Finding Missing Parents, Relatives, and Other Significant Persons

Legal Basis

Policy: The department shall conduct an extensive and documented search for absent parents and guardians in order to facilitate service of process.

The department shall conduct an extensive and documented search for absent parents, guardians, custodians, extended family members and other significant persons as placement resources for children in out-of-home care.

Extensive search for absent parents shall occur prior to key decision points in the life of a case and **no less than once every six months**.

Search for extended family members and other significant persons prior key decision points of case and no less than once every six months as placement resources for children in out-of-home care.

To determine whether to use the Arizona Parent Locator Service through the Division of Child Support Enforcement, consider the following questions:

- Is the parent's whereabouts unknown to the department?
- Is there personally identifiable information about the absent parent known such as the parent's name, date of birth, and Social Security Number?
- If personally identifiable information about the absent parent is unknown, can this information be obtained from other sources, such as extended family members?

Implementation and Procedure Guide

Obtain personally identifying information and any information on the whereabouts of the absent parent, guardian, custodian, extended family member or significant other person from any source who may have knowledge of the absent person.

Make efforts to locate the absent parent, guardian, custodian, extended family member or other significant person, such as mailing a certified letter or making a visit to the last known address, or placing a telephone call to the last known telephone number.

If these efforts are unsuccessful, follow district operating procedures to make a search request. Provide all available identifying information. The minimum information necessary to make a search request is the name of the absent parent, guardian, custodian, extended family member or other significant person.

To enable a more comprehensive and successful search, obtain and provide as much of the following information as possible:

- full name;
- date of birth;
- Social Security Number;
- last known address;
- previous addresses;
- last known place of employment or occupation;
- professional licensee number;
- telephone number;
- physical description;
- military history (active, reserve, branch, where stationed);
- criminal history (incarceration, probation, parole);
- last place seen;
- current spouse or girlfriend/boyfriend;
- names of children and hospital of birth;
- assistance from public agencies (name of agency and state); or
- any other information which might assist in finding the person.

BEST PRACTICE TIP:
It is important to ask both the extended family (even if the child is not in care) and the youth coming into care if they have knowledge of the whereabouts of absent parents. It is also critical to ensure that the search includes both the maternal and paternal parents.

Complete searches for the absent parent, guardian, custodian, prior to key decision points during the case and **no less than once every six months**. When a child in out-of-home care is not placed with an extended family member, or is placed with an extended family member who is unable or unwilling to provide a permanent placement for the child, **initiate searches for**

extended family members or other significant persons prior to key decision points during the case and **no less than once every six months.**

Key decision points include:

- § prior to the filing of the dependency petition;
- § prior to the Preliminary Protective Hearing,
- § disposition Hearing, and Permanency Hearing;
- § prior to the Hearing on the Motion for Guardianship or Termination of Parental Rights;
- § prior to case plan staffings; and
- § when additional information that will assist in the search is discovered.
- § prior to pre-adoptive placement.

District Staff

1. Based on the information provided, complete a search of the Arizona Tracking and Locating Automation System (ATLAS) for addresses of parents. If the search is successful, route the results of the search to the assigned CPS Specialist.

2. If the address of the parent is not found, **submit a search request** to the Arizona Parent Locator Service, Division of Child Support Enforcement.

3. If the address of a guardian, custodian, extended family member or other significant person is unknown, submit the search request to the contracted agency for a professional search. This search includes a search of automated databases such as national credit bureaus, driver's license bureaus, birth and death records, criminal records, and other appropriate resources.

4. Indicate **a 24 hour or a 5 day** search. Designate **a 5 day** search unless there is an urgent need for the information.

5. The Arizona Parent Locator Service will search databases including ATLAS, Arizona Technical Eligibility Computer System (AZTECS), BG01, Motor Vehicle Division, and credit bureaus.

6. If the contract agency's search is unsuccessful, ensure that the contract agency completes an Affidavit of Diligent Search if the search is needed for service of process purposes. Forward a copy of the Affidavit to the Office of the Attorney General and assigned CPS Specialist.

7. If the parent, guardian, custodian, extended family member or other significant person is located, the contracted agency will follow-up to confirm the address and forward the address to the district staff.

8. Route the results of a successful search to the assigned CPS Specialist, and the Office of the Attorney General when the search is needed for service of process purposes.

DOCUMENTATION :

Document efforts to locate an absent parent, guardian, custodian, extended family member or other significant person including the request for search using the Case Notes window and by filing copies of forms requesting a search in the hard copy file.

Document the address of the parent and guardian on the FC-064-A, Attachment A, and process according to directions found in Preparing Court Reports for CPS Cases (Chapter 20, Section 6).

Also, document the address of the parent and guardian using the Address and Phone Numbers window.

File a copy of the Affidavit of Diligent Search in the hard copy record.

Revision History:
DES(07-2006)

Previous / Next

6-3

Legal Basis: ARS §8-502 authorizes the department to administer the placement of children.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6: Section 3

Providing Out-of-Home Care under a Dependency

Legal Basis

Policy: When the court has granted a dependency petition, the department shall provide out-of-home care for a child if no services or interventions can adequately ensure the child's health and safety in the family's home, either:

- while the parent(s) address(es) the safety factors that prevent them from caring for the child safely at home; or
- while another permanency plan is implemented.

The department shall make every effort to minimize the length of time that a child resides in out-of-home care:

- by working closely with parents, extended family, and community support networks to facilitate the child's safe return to the home; and
- by actively pursuing a concurrent permanent plan for the child .

DOCUMENTATION :

Document the decision to provide out-of-home care under a dependency by completing the following windows:

- Determination of Case Status
- Removal Status windows
- Legal Status window
- Custody Notices window
- Removal Review windows.

Revision History:
DES(07-2006)

Previous / Next

6-4

Legal Basis: The Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188) prohibits denial or delay in the foster or adoptive placement of children on the basis of race, color or national origin of the foster or adoptive parent or the child involved.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires that the child's health and safety be the paramount concern when making placement and permanency planning decisions and providing services.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) allows for the exchange of Protected Health Information (referred to as PHI) between covered entities for purposes of treatment, payment and health care operations.

ARS §8-513(C) sets forth the right of a child in out-of-home care to maintain contact with siblings, relatives and friends, unless the court determines that the contact is not in the child's best interests.

ARS §8-514 requires the department to place a child in the least restrictive placement available, consistent with the needs of the child. The order of placement preference is: with a parent; grandparent; in kinship care with another member of the child's extended family, including a person who has a significant relationship with the child; in licensed foster care; in licensed therapeutic foster case; in a group home; or in a residential treatment facility. The placement preference for an Indian child is in accordance with the Indian Child Welfare Act.

ARS §8-514.03 (a) establishes a kinship foster care program to promote the placement of a child with relatives.

ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

ARS §8-813(A)(1) directs the department to "establish an appropriate plan for placement of the child."

ARS §8-813 requires the department to develop policies and procedures to allow a child in out-of-

home care to maintain contact by telephone, mail or visits with the child's parents, family members, friends, other relatives and any former foster parent, unless the court determines that the contact is not in the child's best interest.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6: Section 4

Assessing the Placement Needs of Children Who Require Out-of-Home Care

Legal Basis

Policy: The department shall complete an individual assessment of the placement needs for every child who requires out-of-home care prior to placement in out of home care.

To assess the child's placement needs, gather information from:

- personal observations;
- clinical and medical reports from previous medical, mental or behavioral health care providers;
- the child's parents or caregivers;
- school reports;
- CPS electronic and hard copy case records;
- previous out-of-home care providers;
- the child;
- current receiving foster home and shelter care providers; and
- relatives.

Gather or initiate a request for any of the above information that is not available at the time of placement **within five working days** of identifying a potential source of information.

Include in the assessment, a thorough consideration of:

þ the child's relationships and attachments with: parents, grandparents or another member of the child's extended family including persons who have a significant relationship with the child, siblings, current foster parents, and former foster parents, if applicable..

BEST PRACTICE TIP:
Often a CPS Specialist is faced with complex decisions about where to place a child: with a kinship foster caregiver or with a licensed foster care provider who has no prior relationship with the child. Kinship has been defined as broader than “blood relatives” because a child may

have individuals in their life who are like family. Policies and practices support consideration of and placement with kinship foster caregivers provided that the kin meet all relevant state child protection standards.

A kinship placement should not result in a child losing every connection in the child's life. If by placing a child in kinship foster care, the child loses significant friends, adults and family members, other options should be carefully weighed. For example, if a child is excelling in school and has other positive involvements, removing these strengths from the child's life may not be in the child's best interest. These are very difficult decisions and there is no "one size fits all" answer.

- the characteristics of the child: age, gender, religion, primary language;
- the child's health and developmental needs: physical, emotional, educational, social and behavioral; and
- the mental and behavioral history of the child as potential safety concerns for other children that may have contact with the child.

BEST PRACTICE TIP:
Children who have experienced significant trauma in their home life have a need for an environment where they are provided emotional stability and consistency. At the same time, they need caregivers who are able to support the child's need for connection to their birth family, friends and existing important relationships. As the CPS Specialist is assessing the needs of the child, it is important to find a caregiver who is willing to ensure that the child can maintain connections to their family, friends, and others identified as important to the child.

Implementation and Procedure Guide

The race, color or national origin of the child may be considered in the placement decision *only* when the individualized assessment of the child's needs *requires* such consideration. The parents' placement preference regarding race, color or national origin shall not be considered. This reflects the legal requirements of the Multi-Ethnic Placement Act and Interethnic Placement Act (Exhibit 19).

BEST PRACTICE TIP:
While the placement of a child cannot be denied or delayed based on race, color or national origin of the foster parent or child, a child benefits from maintaining connection to their race, culture and ethnicity.

It is important for the CPS Specialist and the caregiver to ensure that the child maintains connection to their race, culture, and ethnicity in a variety of ways.

Consult with the district mental health specialist when the child has chronic behavioral health needs.

Refer all children in out-of-home placement to the local Regional Behavioral Health Authority (RBHA) for a behavioral health assessment **within 24 hours** of removal. See Title XIX-Behavioral Health and Substance Abuse Services (Chapter 9 Section 11) and Title XIX Covered Services (Exhibit 20).

Discuss the assessment of the child's needs with your supervisor and other service team members, as applicable.

DOCUMENTATION :

Document the assessment of placement needs by completing the following windows:

- Child Assessment and Special Rate Evaluation;
- Special Needs Detail;
- Medical/Dental Condition Detail;
- Medication Detail;
- Psych/Behavioral Condition Detail;
- Practitioner Detail;
- Examination Detail;
- Participant Education Condition;
- Participant Education Detail; and
- Hospitalization Detail.

The Medical Summary Report contains information entered on the above windows.

Follow district operating procedures and instructions for completion of the Service Authorization Request window and the Service Authorization Approval window.

Revision History:
DES(09-2006)

Previous / Next

6-5

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) is the federal law that governs child welfare services to children and families, including the concept of least restrictive placement.

The Indian Child Welfare Act (ICWA), 25 U.S.C.§1901 et seq., is the federal law that governs the placement of Native American children.

The Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188) prohibits denial or delay in the foster or adoptive placement of children on the basis of race, color or national origin of the foster or adoptive parent or the child involved.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires the department to consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided the relative caregiver meets all state child protection standards.

ARS §8-513(C) sets forth the right of a child in out-of-home care to maintain contact with siblings, relatives and friends, unless the court determines that the contact is not in the child's best interests.

ARS §8-514 requires the department to place a child in the least restrictive placement available, consistent with the needs of the child. The order of placement preference is: with a parent; grandparent; in kinship care with another member of the child's extended family, including a person who has a significant relationship with the child; in licensed foster care; in licensed therapeutic foster case; in a group home; or in a residential treatment facility. The placement preference for an Indian child is in accordance with the Indian Child Welfare Act.

ARS §8-514.03(a) establishes a kinship foster care program to promote the placement of a child with relatives.

ARS §8-514.03 (b) requires that a kinship foster care applicant and all household members eighteen years of age or older submit fingerprints to the department for the purpose of obtaining state and federal criminal records check pursuant to 41-1750 and PL 92-544.

ARS §8-813 requires the department to develop policies and procedures to allow a child in out-of-home care to maintain contact by telephone, mail or visits with the child's parents, family

members, friends, other relatives and any former foster parent, unless the court determines that the contact is not in the child's best interest.

ARS § 8-824(G)(7) requires the department to report to the court any efforts made to place siblings together, and if they are not placed together, the reason why.

ARS § 8-824(G)(8) requires the department to report to the court any efforts made to facilitate communications among siblings.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6: Section 5

Selecting an Out-of-Home Care Provider

Legal Basis

Policy: The department shall seek to provide every child who requires out-of-home care with a placement that addresses his or her unique needs. No single factor shall be the sole determining factor in the selection of a placement.

The department shall ensure that a child is placed in the least restrictive type of placement available, consistent with the placement needs of the child.

The department shall not deny or delay a foster or adoptive placement of a child on the basis of race, color or national origin of the foster or adoptive parent or the child involved.

The department shall seek adult relatives or adults with whom the child has a significant relationship to meet the placement needs of the child in out-of-home care.

The department shall make efforts to place siblings together unless there is documented evidence that placement together is detrimental to one of the children.

Within the constraints of available resources and when consistent with the needs of the child, the department shall seek to place a child who requires out-of-home care:

- in close proximity to the parents home; (P.L. 96-272)
- with members of the child's extended family and adult siblings; (P.L.104-193)
- with minor siblings who are in out-of-home care;
- in the least restrictive placement that will meet his/her needs; (P.L. 96-272)
- within the child's own school district; and
- with caregivers who can communicate in the child's language.

*For children who are **not Native American**, the order of placement preference, unless otherwise dictated by child need is:*

- parent;
- grandparent;
- a member of the child's extended family, including a person who has a significant relationship with the child;
- licensed family foster home;
- therapeutic foster care
- group home;

- therapeutic group home;
- residential treatment facility;

For Native American children, the order for placement preference shall be determined **in accordance with the requirements of the Indian Child Welfare Act**, as follows:

- a member of the child's extended family;
- a foster home licensed, approved or specified by the child's tribe;
- an Indian foster home licensed or approved by an authorized non-Indian licensing authority;
- an institution approved by the Indian tribe, or operated by an Indian organization which has a program suitable to meet the Indian child's needs. (25 U.S.C.§1901 et seq.)

This order of placement preference for Native American children **must be followed** except under the following circumstances:

- the child's parents have relinquished their parental rights and requested anonymity. In this case, preference shall be for placement with other Native American families;
- the child's tribe sets a different order of preference; or
- the tribe chooses not to intervene in the case and the state court finds that there is good cause to change the order of placement preference. (25 U.S.C.§1901 et seq.)

For more information on the placement of Native American children see Native American Child Placements and Placement Preferences (Chapter 18, Section 6).

To determine whether to place a child *with a kinship foster caregiver* consider these questions:

- Have efforts been made to identify a parent, grandparent, or member of the child's extended family including a person who has a significant relationship with the child? Efforts shall include:
    - contacting parents, relatives including adult siblings and kin;
    - asking the child;
    - asking the siblings;
    - holding a Team Decision Making meeting; and
    - using the family locator service.

BEST PRACTICE TIP:
Team Decision Making (TDM) meetings have been shown to be extremely effective in engaging the family in the process of decision making about child placement and all other aspects of case planning and service delivery.

- Is the potential caregiver willing and able to ensure the health and safety of the child?
- Can any available relative or person who has a significant relationship with the child meet the placement needs of the child and the child's siblings?
- Can any available relative or person who has a significant relationship with the child meet the placement needs of the children separately?
- Are the strengths and parenting style of the potential caregiver appropriate to meet the placement needs of the child?
- If the child has chronic behavioral health needs, would the child's behavior place other children in the home at risk?
- If the child has chronic behavioral health needs, is the potential kinship caregiver able to provide the necessary level of supervision to prevent harm to self or others by the child?
- Is the potential kinship caregiver willing and able to work with the department whether the caregiver agrees or disagrees with the decision to place the child in out-of-home care?
- How will placement of the child affect other children in the home?
- Is the placement consistent with the wishes of the birth parent and child, if applicable?

BEST PRACTICE TIP:
When placing children with grandparents or with other kinship caregivers, it is important that the CPS Specialist engage in conversations about child safety and ways the kinship caregiver can allow child-parent contact (if appropriate) and still ensure child safety.

To determine whether to place a child with a *licensed non-relative foster family* (who has no prior relationship with the child), consider the following questions:

- Are there no available parents, grandparents, other extended family members including persons who have a significant relationship with the child who can meet the placement needs of the child?
- Is the placement consistent with the wishes of the birth parent and child, if applicable? (The parent's preference regarding race, color or national origin shall not be considered.)
- Are the strengths and parenting style of the caregiver appropriate to meet the placement needs of the child?
- Is the caregiver willing to work with the birth family to support visitation and the reunification process?
- How will the child fit into the existing family with regard to age, gender, sibling relationships?

- If the child has chronic behavioral health needs, will the child's behavior place other children in the home at risk?
- If the child has chronic behavioral health needs, is the caregiver able to provide the necessary level of supervision to prevent harm to self or others by the child?
- Is the placement in compliance with the Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996?
- Is the placement in compliance with the placement preferences of the Indian Child Welfare Act, if applicable?

To determine whether to place the child in a *group home,* consider the following questions:

- Are there no available parents, grandparents, other relatives, significant persons or non-relative family licensed foster homes that can meet the child's needs?
- Does the child have a history of unsuccessful placements in family settings?
- Does the child present supervision or behavior management requirements that can not be met in a family environment? Could the child's needs be met in a family environment if the family had more intensive support?

BEST PRACTICE TIP:
A youth's need to develop independent living skills is never a reason for not placing the youth in a family setting; in other words, a youth's need to develop independent living skills is never a reason to place a youth in group care.

Family relationships are crucially important. Relationship planning or the developing of a permanent lasting relationship with at least one unconditionally, committed, claiming adult is a primary hope for older foster care youth.

Too often we give up on the possibility of older children being adopted or living in a family. According to Pat O'Brien, Executive Director of You Gotta believe, " there are many families out there who want to parent teen age foster children. In addition to all the families we find who are unknown to children we ultimately place them with, there are also many families who are already in a child's life who would be willing to parent the child if they were approached in an appropriate and sensitive way."

To determine whether to place a child in a *therapeutic group home or residential treatment center,* consider the following additional questions:

§ Does the child have a serious mental health diagnosis?
§ Does the child have a documented need for a therapeutic environment?
§ Does the child have special education requirements that can only be met in a highly structured setting?

§ Does the child demonstrate a need for structure and supervision beyond that which is possible in a group home setting?

Implementation and Procedures Guide

To select a placement for a Native American child: **See** Native American Child Placements and Placement Preferences **(Chapter 18, Section 6).**

þ Complete the Indian Child Information Report, FW-106 and the American Indian Detail window associated with the Person Detail window.
þ Forward the FW-106 to the DCYF Indian Child Welfare Specialist, Site Code 940A, within five working days.
þ Confirm the child's membership or eligibility for membership in a tribe by forwarding all pertinent information to the tribe with a letter requesting confirmation of membership status.
þ Inform the child's tribe of the pending placement. Legal notice to the tribe is required even when parents relinquish their parental rights. (25 U.S.C.§1901 et seq.)
þ Consult an Assistant Attorney General if there is any question about the child's status as Native American or about the requirements of the Indian Child Welfare Act.

To select a placement with a kinship foster caregiver, follow the implementation procedures found in Providing Kinship Care Services (Chapter 6, Section 6).

Prior to placement with a licensed non-relative foster family (who has no prior relationship with the child):

þ **Within two working days**, identify available foster homes according to district procedures by:

§ contacting appropriate district designees and completing district placement request forms;
§ working with the licensing agencies.

þ Review information on available foster homes to match the child's placement needs with family factors, using the licensing agency specialist and other resources such as home studies.
þ Determine whether any available foster home will accept all of the siblings needing placement.
þ Determine whether any available foster parent will permit and facilitate contact between siblings not placed together.
þ Determine whether any available foster home is located in the child's current school or school district.

þ After identifying prospective foster homes, CPS Specialists or designated district staff:

§ Consult with the district Mental Health Specialist regarding placement of the child if the child has chronic behavioral health needs.
§ Contact prospective foster families and discuss the child's needs, the case plan for the child, expectations of the foster parents, contact and visitation plan, and their willingness to consider the child and the child's siblings, if applicable.
§ Make pre-placement visits with the child to the prospective foster family homes, whenever possible.
§ Select the home that is best able to meet the placement needs of the child and the child's siblings, if applicable.
§ Select the home that is best able to meet the placement needs of the child and will permit and facilitate contact between siblings not placed together, if one foster home cannot care for all of the siblings.
§ Select the home that supports the maintenance of connections with the child's parents.
§ If necessary, convene a case conference to discuss placement selection.

þ Determine the reimbursement rate to be recommended by reviewing the documented placement needs of the child:

§ medical and any special care requirements;
§ transportation;
§ level of supervision;
§ educational; and
§ mental and behavioral health.

To select placement in a group care setting

If there are no options for family care and the decision is to place the child in a group care setting, follow the procedures below:

þ Develop a tentative placement plan and obtain supervisory approval. After receiving approval:

§ Contact approved providers.
§ Review the child's needs with providers.
§ Forward to the approved provider pertinent background information on the child

including previous mental and behavioral health records.

§ Arrange pre-placement interviews with the placement facilities.

§ Determine the most suitable placement for the child.

§ Notify the district Mental Health Specialist following the placement of the child or to seek alternative resources if none of the providers were chosen.

§ Ensure that group home staff will facilitate contact between siblings not placed together.

To select placement in a therapeutic group home:

þ Determine if the child is enrolled with a Regional Behavioral Health Authority (RBHA) through review of case documentation, discussion with the child's parent(s) or guardian(s) or contact with a CMDP Behavioral Health Coordinator.

If the child is *not* currently enrolled with a RBHA:

§ Follow procedures in Accessing Services: Title XIX Behavioral Health and Substance Abuse Services (Chapter 9, Section 12) to determine Title XIX Eligibility and refer eligible children for behavioral health services or therapeutic placement.

§ Participate in the RBHA Child and Family Team (CFT), provide information on the child's behavior and pertinent documentation, and request Title XIX funding of a therapeutic placement.

If the child *is* enrolled with a RBHA:

§ Work with the Child and Family Team or treatment coordinator to request a staffing for determination of therapeutic placement needs.

§ Participate in the RBHA Child and Family Team, provide information on the child's behavior and pertinent documentation, and request Title XIX funding of a therapeutic placement.

§ Develop a tentative placement plan and obtain supervisory approval.

If placement is approved or denied

If the RBHA approves therapeutic placement for the child:

§ Participate in the placement selection by consulting with the RBHA Child and Family Team regarding preferred providers and options available to the RBHA.

§ If you do not agree with the provider chosen by the RBHA, contact the district

Mental Health Specialist to determine if a dispute resolution process is necessary.

If the RBHA denies therapeutic placement for the child:

§ Contact the district Mental Health Specialist to discuss initiation of an appeal of the RBHA decision.
§ Follow the steps outlined below for selection of placement in a therapeutic group home for children who are not Title XIX eligible.

If the child is not Title XIX eligible:

§ Contact District Mental Health Specialist for approval.
§ Submit required documents to the district Mental Health Specialist for approval. Include current psychological/psychiatric reports, significant medical information, and provider reports.

After receiving approval from District Mental Health Specialist or designee:

§ Contact approved providers;
§ Review the child's needs with providers;
§ Forward pertinent background information on the child including previous mental and behavioral health records;
§ Arrange pre-placement interviews with the placement facilities;
§ Determine the most suitable placement for the child;
§ Notify the district Mental Health Specialist following the placement of the child or to seek alternative resources if none of the providers were chosen; and
§ Ensure that therapeutic group home staff will facilitate contact between siblings not placed together.

þ Contact the district Mental Health Specialist or designee to determine additional requirements for exceptional therapeutic group home placements, including:

- out-of-state placements;
- in-state placements in facilities without a DES contract; or
- placements in facilities identified as requiring special approval.

For placement in a residential treatment center, contact the District Mental Health Specialist, see Arranging for Residential Treatment Services for a Dependent Child (Chapter 8, Section 1).

If group care placement is court ordered:

- Contact Mental Health Specialist to co-ordinate placement services and funding.
- After making contact with the potential placement, prepare an Addendum Report to the Court, CT00200, advising the court of the status of the order, the provider's name, the funding source, and date the service will begin.
- Forward the report to the court according to district procedures.
- If the RBHA refuses to provide court-ordered services, contact the district Mental Health Specialist to initiate an appeal.

DOCUMENTATION :

For Kinship and Family Foster Care Placements

Ensure documentation of the reason for no pre-placement visits is entered into the Case Notes window designated as Key Issues type.

Ensure completion of the following windows according to district operating procedures: Service Authorization Request, Service Authorization Approval and Service Authorization Provider Match.

If the child is placed in kinship foster care, ensure that the significant person is entered on CHILDS Provider Management, according to district procedures. Complete the following windows: Provider Maintenance Detail, Provider Maintenance Facility Detail, Person Detail, Facility Contacts, Provider Maintenance Household, and Provider Maintenance Service Detail.

Document the reasons why siblings are not placed together using the Explain on the Out-of-Home Characteristics window.

Document the efforts made to identify possible placements, the home selected and reasons for selection of the placement using Case Notes window.

Document the home selected and the reasons for selection of the placement using the Case Notes window designated as Key Issues type.

For Placement in a Group Setting

Complete the Service Authorization Request window. Forward the required documents to the district Mental Health Specialist. Include current psychological/psychiatric reports, significant medical information, and provider reports.

Await the completion of the Service Authorization Approval window by the district Mental

Health Specialist and approval from the district Program Manager or designee.

Document the assessment for group care settings by recording the relevant information and consultations with professional staff using the Case Notes window designated as Case Conference type.

Complete the Service Authorization Provider Match window according to district procedures.

For therapeutic group home placements:
If the RBHA is not making the placement, select the provider and complete the Service Authorization Request window according to district procedures.

File the RBHA Individual Service Plan (ISP), which contains documentation of the request for placement in a therapeutic group home or residential treatment facility, in the hard copy case record. Document the request for RBHA placement, the RBHA's refusal, and appeal initiation, if applicable, using the Case Notes window designated as Case Conference type.

For *placement of Native American children*:
Document the placement of Indian children by completing the Indian Child Information Report, FW-106. File a copy of the FW-106 in the case record.

Complete the Service Authorization Request window.

Revision History:
DES(09-2006)

Previous / Next

6-6

Legal Basis: The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires the department to consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided the relative caregiver meets all state child protection standards.

ARS §8-514 requires the department to place a child in the least restrictive placement available, consistent with the needs of the child. The order of placement preference is: with a parent; grandparent; in kinship care with another member of the child's extended family, including a person who has a significant relationship with the child; in licensed foster care; in licensed therapeutic foster case; in a group home; or in a residential treatment facility. The placement preference for an Indian child is in accordance with the Indian Child Welfare Act.

ARS §8-514.02 gives the department the authority to place a child with a parent or relative and specifies that the parent or relative may not, without the written approval of the department, allow the child to be placed with any other person; allow the child to have contact with the alleged abusive or neglectful parent, guardian or custodian or other person designated by the department; or allow the child to leave the state.

ARS §8-514.03(A) establishes a kinship care program to promote the placement of a child with relatives.

ARS §8-514.03(B) provides the application requirements for a kinship care family that is not a licensed foster home.

ARS §8-514.03(C) directs the department to provide written notification to a kinship foster care applicant within 15 business days when the department determines that kinship foster care placement is not in the best interest of the child. The notice must include specific reasons for the denial, the applicant's right to appeal and the process for reviewing the decision.

ARS §8-514.03(E) directs the department to establish procedures for a CPS Specialist to inform a kinship care family of available financial and non-financial services and eligibility requirements, and to assist the family in completing the necessary application.

ARS §8-514.03(F) requires the department to obtain a signed statement from kinship foster care parents who decline applications for financial services, indicating that the family declined services. A copy of the signed statement must be given to the family.

ARS §8-514.03(G) requires the department to provide through existing means or referrals specified non-financial services for kinship care providers. Those services are: family assessment, case management, child day care, housing search and relocation, parenting skills training, supportive intervention and guidance counseling, transportation, emergency services, parent aid services, respite services, and additional services that the department determines are necessary to meet the needs of the child and family.

Rules: Rules for the licensing of family foster parents are found in Family Foster Parent Licensing Requirements, R6-5-5801 et. seq. of the Arizona Administrative Code.

Rules for the licensing of family group foster parents are found in Group Foster Home Licensing Standards, R5-6-5901 et. seq. of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 6: Section 6

Providing Kinship Foster Care Services

Legal Basis

Policy: For a child who is in the custody of the department and requires out-of-home care, the department shall establish kinship foster care services that promote the placement of a child with the childs relative.

The department shall identify and assess relatives and persons who have a significant relationship with the child for the placement of a child in out-of-home care.

A kinship foster caregiver means an adult relative or person who has a significant relationship with the child, who is caring for the child, who is under the care, custody and control of the department. A kinship foster caregiver shall be evaluated and approved by the department based upon an assessment of the family and home.

A kinship foster caregiver shall be at least 18 years of age, be fingerprinted and cleared by a state and national criminal history records check, be cleared by a Child Protective Services check of child abuse and neglect reports and history, and able to meet the childs placement needs including health and safety.

All persons age 18 and older residing in the kinship foster caregivers household shall be fingerprinted and cleared by a state and national criminal history records check and be cleared by a Child Protective Services check of child abuse and neglect reports and history.

The department shall initiate the assessment of the kinship foster caregiver as a potential placement for the child **within five work days** of the request.

The department shall initiate the assessment through the Interstate Compact for Placement of Children (ICPC) **within five days** of the request for a relative residing out-of-state.

The department shall provide written notification to a kinship foster caregiver **within 15 working days** when the department does not recommend the kinship foster care placement to the juvenile court. The notification shall include specific reason(s) for the denial of approval, the right to appeal the recommendation and the process to request review by the assigned juvenile court judge.

The department shall provide information to all kinship foster caregivers about the following financial benefits:

- foster care reimbursement only if they become licensed as family foster parents;
- monthly personal and clothing allowance on behalf of the child; and
- special payments that may be available to the child.

The department shall encourage and support kinship foster caregivers to become licensed foster parents.

The department shall provide information to relative kinship foster caregivers about Temporary Assistance to Needy Families (TANF) Cash Assistance (CA).

The department shall obtain a signed statement from a relative kinship foster caregiver who elects to not apply for financial services after being informed of the services. The department shall provide the relative kinship foster caregiver a copy of the signed statement.

A relative kinship foster caregiver may apply for financial services at any time regardless of whether or not a statement declining financial services has previously been signed by the relative kinship foster caregiver

The department shall provide non-financial services to **all** kinship foster caregivers. The department may provide through existing means or referral, the following non-financial services:

- child care;
- parent aide;
- respite care;
- case management;
- family assessment;
- transportation;
- housing search and relocation;
- parenting skills training;
- supportive intervention and guidance counseling;
- emergency services; and
- additional services that the department determines are necessary to meet the needs of the child and family.

The department shall share with the kinship foster caregiver all information about the child to ensure that the caregiver meets the needs of the child and to assist the caregiver in carrying out the case plan.

To determine whether to place a child with a ***kinship foster caregiver***, consider the questions in the Decision Making Guide in Selecting an Out-of-Home Provider (Chapter 6 Section 5) **and the following questions**:

- Are there prior reports of child abuse or neglect or risk of child abuse or neglect by the potential caregiver? If there are prior reports, what were the outcomes?
- Does any member of the potential caregiver household have a criminal history that indicates the child would be at risk of harm if placed in the home?
- Is there any information which would preclude the potential caregiver from providing a safe, nurturing environment for the child?
- Does the potential caregiver have the capacity to meet the childs developmental, emotional, social, health and safety needs? If not, would they with support?
- What are the relationships between the child, the childs parents and the potential caregiver family?
- Is the potential caregiver committed to caring for the child until permanency is achieved?
- If the child is an American Indian child and subject to the Indian Child Welfare Act (ICWA), what is the relationship between the kinship caregiver and the childs Indian tribe?

BEST PRACTICE TIP:
Family relationships are complex and as such kinship caregivers may need help and support dealing with the many emotions and issues involved in providing care to the children including:

Loss
§ Interruption of life-cycle

§ Future plans
§ Space, privacy
§ Priorities

Role/Boundary Definitions

§ From supportive to primary caregiver
§ From advisor to decision-maker
§ From friend to authority

Guilt

§ Fearful of contributing to family disruption
§ Becoming a primary caregiver and raising child
§ More committed to meeting the child's needs instead of parents needs

Embarrassment or Shame

§ Due to birth parent's inability to remain primary caregiver

Projections/Transference

§ Unresolved issues- with birth parent transferred to the child
§ Difficulty perceiving the child's personality as different from the birth parent

Loyalty

§ Usurping or replacing birth parent's role
§ Fear of hurting parents feelings and being rejected

Child Rearing Practices

§ Updating and recalling techniques and methods
§ Need to learn non-corporal techniques of punishment and discipline

Stress Management/Physical Limitations

§ Developing coping skills and support in managing children and additional responsibilities

Bonding and Attaching

§ Establishing a parent/child relationship instead of a relative/child relationship

Anger and Resentment

§ Birth parent's absence
§ Birth parent's attempts to regain custody or continue contact
§ Birth parent's sabotage or competition for child's loyalty to birth parent
§ Agencies and professionals
§ At/with "themselves" for becoming a surrogate parent

Morbidity and Mortality

§ Concerns of illness/death triggered by previous losses and separations
§ Who will take care of me if grandma gets sick or dies?

Fantasies

§ Many parents fantasize about reuniting with their children
§ These fantasies can sometimes be unrealistic
§ These fantasies may cause unrealistic expectation about reuniting with the parent

Overcompensation

§ Caregiver may try to make up for the parents failings or mistakes
§ This reinforces childs experience of life as extreme and not balanced
§ Challenge for caregiver is to provide balance and consistency

Competition/Sabotage

§ Parent can sabotage the placement by undermining the authority of caregiver
§ Parent may challenge, defy, or not comply with agreements regarding visiting, curfew
§ Parent may give child permission to defy caregivers and professionals

National Resource Center for Family Centered Practice and Permanency Planning

Implementation and Procedures Guide

A kinship foster caregiver means an adult relative or person who has a significant relationship with the child, who is caring for the child, who is under the care, custody and control of the department.

Identify relatives and persons who have a significant relationship with the child who have an interest in providing care for the child. See Relative Search Best Practice Guide (Exhibit 12).

Inform potential kinship foster caregivers of the following requirements:

- Kinship caregivers must be at least 18 years of age.
- Kinship caregivers and adult household members must be fingerprinted for and cleared by state and federal criminal history record check.
- Kinship caregivers and adult household member must be checked and cleared for prior and current child abuse and neglect history on the Central Registry and the CHILDS Case Management Information System.
- Kinship caregivers must provide at least two references.
- Kinship caregivers must agree to personal interviews and at least one home visit.
- Kinship caregivers and household members must participate in the family assessment process.

BEST PRACTICE TIP:
The intent of kinship care is to minimize the trauma of placement for a child by placing the child with someone the child knows and trusts and to maintain safe connections and family ties for the child. Issues such as the familys socio-economic status, size of the home and number of bathrooms are less significant than maintaining the family connections.

Inform all potential kinship foster caregivers of the financial services available to them including family foster care licensure and ACYF personal and clothing allowances.

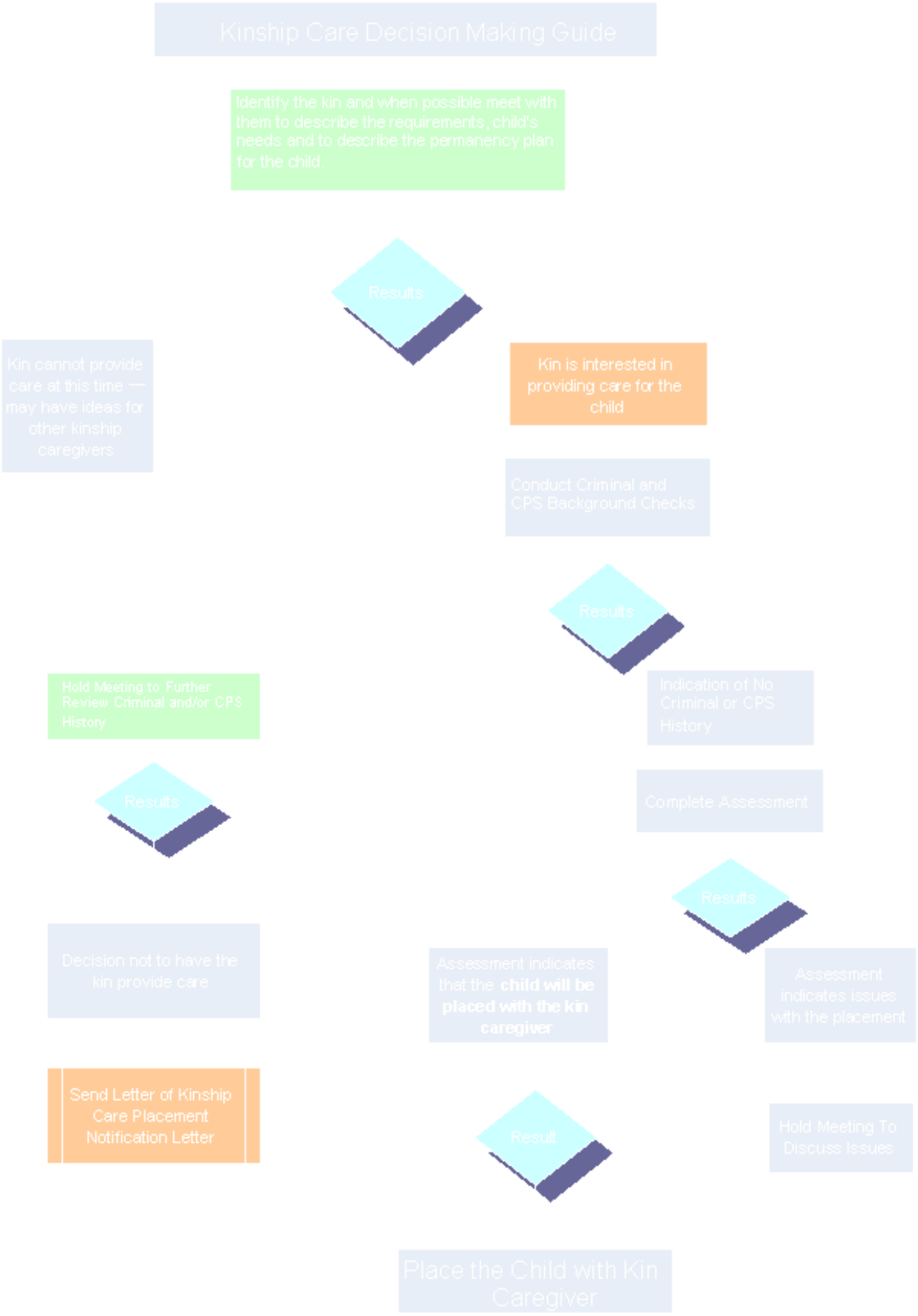
In addition, inform potential relative kinship foster caregivers of Temporary Assistance to Needy Families (TANF)/Cash Assistance (CA).

BEST PRACTICE TIP:
Financial and social work support through licensing enhances kinship placement stability. CPS Specialists should promote the licensing of kinship caregivers by encouraging, supporting and assisting kin through the licensing process.

Inform ***all*** kinship foster caregivers of the non-financial services available to meet the needs of the child:

- child care;
- parent aide;
- respite care;
- case management;
- family assessment;
- transportation;
- housing search and relocation;
- parenting skills training;
- supportive intervention and guidance counseling;
- emergency services; and
- additional services that the department determines are necessary to meet the needs of the child and family.

The chart on the following page depicts the Kinship Caregiver Placement Process.


Kinship Care Decision Making Guide
Identify the kin and when possible meet with them to describe the requirements, child's needs and to describe the permanency plan for the child.
Results
Kin cannot provide care at this time — may have ideas for other kinship caregivers
Kin is interested in providing care for the child
Conduct Criminal and CPS Background Checks
Results
Hold Meeting to Further Review Criminal and/or CPS History
Indication of No Criminal or CPS History
Results
Complete Assessment
Results
Decision not to have the kin provide care
Assessment indicates that the child will be placed with the kin caregiver
Assessment indicates issues with the placement
Send Letter of Kinship Care Placement Notification Letter
Result
Hold Meeting To Discuss Issues
Place the Child with Kin Caregiver

Kinship Foster Caregiver Assessment

Begin the family and home assessment on each potential kinship foster caregiver who resides in Arizona **within five work days** of confirming their interest in becoming a kinship caregiver for a child.

- Provide a copy of the Kinship Foster Care pamphlet, ACY-1081A, to the potential caregiver and review the pamphlet with the potential caregiver.
- Have the potential kinship caregiver and all adult members of the household complete the Checklist for Assessment of Kinship Foster Care and Significant Person Placement, FSC-1015A, found in the Forms Registry, to obtain information from each adult about criminal and child abuse and neglect history.
- Have the potential kinship caregiver complete the Information for Kinship Foster Care Placement Consideration, FSC-1016AFORNA, to obtain basic information on each prospective kinship foster care family. Give a copy of the form to the potential caregiver.
- Complete a state criminal records history check with the Department of Public Safety (DPS), prior to placement of the child, and fingerprinting for a state and federal criminal history check on all individuals residing in the home who are age 18 or older. For processing by the DES Office of Special Investigations (OSI), each person must complete and submit to the OSI Office a Fingerprint Clearance Card Application, DPS-802-06857
- Complete a search of the Central Registry and CHILDS Case Management Information System for current or prior involvement with Child Protective Services on all individuals residing in the home who are age 18 or older.
- Interview each potential kinship caregiver.

To request a home study on a potential out-of-state kinship foster caregiver follow the procedures in Referring a Child for Placement through the ICPC (Chapter 10 Section 2).

Make a preliminary determination that the potential kinship caregiver meets the requirements for consideration based on information obtained from a DPS state criminal history record, the CPS Central Registry, information in CHILDS Case Management Information System and information disclosed by family members.

BEST PRACTICE TIP:
Even if the kinship caregiver has a criminal history it is important to consider when this crime occurred and the nature of the crime. A DUI that occurred 20 years prior may not have any immediate relevance on the caregivers ability to care for the child today.

When the potential kinship foster caregiver family has a criminal or child abuse or neglect *preliminary clearance*, continue the family and home assessment by:

- making at least one visit to the home of each potential caregiver family;
- personally interviewing the potential caregiver;
- interviewing other members of the household of each potential caregiver family, whenever possible;
- conducting at least two reference checks by telephone or letter, using the Evaluation of Potential Caretaker(s), FW-103, for each potential caregiver. For a potential relative kinship foster caregiver, at least one reference should be a relative who is not the parent of the child being considered for placement. An adult child of the potential caregiver should be used as a reference whenever possible;
- completing an assessment of the family and home, **within 30 days**, if possible, on each potential caregiver family, using the Assessment for Kinship Foster Care or Significant Person Placement, CT01100, found in the Court Document Detail

(see the CT01101 for guidance on completing the CT01100);
- assessing the ability of the potential caregiver to meet the child's safety, health and placement needs and the needs of the childs siblings, if applicable; and
- if the child has chronic behavioral health needs, consult with the district Mental Health Specialist prior to selecting a placement.

When a potential kinship caregiver family member has a criminal or child abuse and neglect history indicating that the child's health and safety would be *at risk* of harm if placed in the home:

- Inform the family or individual in writing **within five work days** that CPS is not able to clear one or more members of the family due to criminal or child abuse or neglect history.
- If the family or individual wishes to correct or clarify criminal or child abuse or neglect history information, offer the individual an opportunity to meet with the Program Manager or management level designee to present additional information.
- If the family or individual makes a request to present additional information, schedule a meeting with the following persons **within five work days** of the request:
  - the potential kinship foster caregiver;
  - other family members as designated by the potential caregiver;
  - the Program Manager or management level designee;
  - the CPS Specialist; and
  - the CPS Specialists supervisor.

Ø **If after the meeting to receive additional information, the Program Manager or management level designee, supervisor, and CPS Specialist determine that the family *should not* be recommended for placement**, send the Kinship Care Placement Notification letter (Notice letter), located in public folders, to the potential caregiver **within 15 work days** of the decision. Include in the written notice:

- the specific reasons the potential caregiver was not recommended for placement;
- the process to request the assigned juvenile court judge to review the determination that placement with the potential caregiver is not in the best interest of the child.

Ø **If after the meeting to receive additional information, the Program Manager or management level designee, supervisor, and CPS Specialist determine that placement of the child with the potential kinship foster caregiver family *does not* present a risk of harm, continue and complete the family and home assessment as delineated above.**

BEST PRACTICE TIP:
Kinship caregivers require support to care for a child who has been abused or neglected. Few parents are capable of easily managing the behaviors that may exist when children have been traumatized without some kind of support. For kinship placements to be successful, services and support must be offered and made available.

When One or More Potential Kinship Caregivers Have a Positive Assessment:

Select the kinship foster caregiver who is best able to meet the placement needs of the child, following the Implementation and Procedures Guide in *Assessing the Placement Needs of Children Who Require Out-of-Home Care* ***(Chapter 6 Section 4)*** and considering placement preference in policy section of *Selecting an Out-of-Home Care provider* ***(Chapter 6 Section 5)*.**

BEST PRACTICE TIP:
Separating siblings should be a last resort. When siblings must be separated, the CPS Specialist should work with the caregivers to facilitate frequent contact between the siblings.

If one kinship foster caregiver cannot care for all the siblings, select the kinship caregiver who:

- can best meet the needs of the child;
- will permit and actively facilitate contact between siblings who are not placed together; and
- will permit and actively facilitate contact by telephone, mail or visits with the childs parents, family members, friend, other relatives and any former foster parents, unless the court determines the contact is not in the childs best interest.

Once the kinship foster caregiver is selected:

- Complete the Motion for Change of Physical Custody, CT01700, found in the Court Document Detail, and submit the CT01700 and the Assessment for Kinship Foster Care or Significant Person Placement, CT01100, to the juvenile court for approval of the placement.
- Complete Agreement for Child Placement, PS-055.
- Advise kinship foster caregiver about CMDP.
- Advise the kinship foster care giver about Behavioral Health Services available through the Regional Behavioral Health Authority (RBHA).
- Provide CPS child care services to kinship caregiver according to the procedures in Providing CPS Child Care Services (Chapter 6 Section 13) or assist the kinship foster caregiver in completing applications for child care and other available services, as needed
- To prepare and place a child in kinship foster care, follow the Implementation and Procedures Guide in Placing Children in Out-of-Home Care (Chapter 6 Section 7).
- Inform the kinship foster caregiver about special payments available to the child. See Facilitating Payments to Resource Families Providing Foster Care (Chapter 6 Section 21)

BEST PRACTICE TIP:
Financial and social work support through licensing enhances kinship placement stability. CPS Specialists should promote the licensing of kinship caregivers by encouraging, supporting and assisting kin through the licensing process.

When a relative kinship foster caregiver is selected and placement has occurred, the CPS Specialist should review and update as necessary the Kinship Foster Care Placement Consideration, FSC-1016AFORNA, with the relative caregiver:

- The CPS Specialist should inform the relative kinship foster caregiver that a monthly personal and clothing allowance will be issued on behalf of the child. After explaining this, have the relative caregiver check the applicable box on the FSC-1016AFORNA.

- The CPS Specialist should inform the relative kinship foster caregiver about the benefits of applying for foster home licensure. After explaining the benefits, have the relative caregiver check the applicable box on FSC-1016AFORNA. (While this begins the process for foster home licensure, it does not obligate the relative caregiver to complete the licensure process, nor does it guarantee that the relative caregiver will qualify for licensure.)
    - The CPS Specialist should fax the completed FSC-1016AFORNA to the Home Recruitment Response Specialist at 602-542-3330 and refer the relative kinship foster caregiver to the Home Recruitment Response Specialist at 1-877-543-7633 (AzKidsneedu) or www.azkidsneedu.gov (AzKidsneedu website) to initiate the process.
- The CPS Specialist should inform the relative foster kinship caregiver (those related through blood, adoption, marriage) about the benefits of applying for Temporary Assistance to Needy Families (TANF) Cash Assistance (CA). The relative caregiver should check the applicable box on the FSC-1016AFORNA and complete the FA-001, Application for Cash Assistance (CA)/Temporary Assistance for Needy Families (TANF) according to the following procedure:
    - Indicate that he/she is applying for Temporary Assistance to Needy Families/Cash Assistance (TANF/CA) for only the child(ren) placed in his/her care by the department.

- Complete all application items pertaining to the TANF/CA Program with information relevant to the child (ren) being placed.
- Sign the application.

The CPS Specialist should:

- Write KSFC on the top right corner of the FA-001 application. This indicates Kinship Foster Care.

- Fax the application and court order to the departments Family Assistance Administration Office (FAA) that services the zip code of the relative kinship foster caregivers residence.
- Send the hard copy application and the court order to the FAA office. www.azdes.gov/FAA/contact.asp

- Inform the relative kinship foster caregiver that an FAA worker will either contact them by phone or make a home visit, according to the caregivers preference, to:
  - Complete the application process.
  - Determine whether the child is eligible for TANF/CA.

- The CPS Specialist should inform the relative caregiver to notify FAA when the kinship foster care family is licensed and approved for foster care reimbursement so that FAA can terminate the TANF/CA.

- The CPS Specialist should confirm that the relative kinship foster caregiver has signed the Information for Kinship Foster Care Placement Consideration, FSC-1016AFORNA, declining financial benefits when the kinship foster care parent does not wish to apply for:
  - monthly personal and clothing allowances;
  - foster home licensure; or
  - TANF/CA

- Ensure that the relative kinship foster caregiver has a copy of the FSC-1016AFORNA and inform the caregiver that he or she may apply at a later date.

When a non-relative kinship foster caregiver is selected and the placement has occurred, inform the caregiver:

- that a monthly personal and clothing allowance will be issued on behalf of the child;
- of the foster home licensing process. If the person wishes to be licensed, refer the caregiver to 1-877-543-7633 (AzKidsneedu) or to www.azkidsneedu.gov (AzKidsneedu website) to initiate the licensing process.

Results of the Assessment Indicate That the Potential Kinship Foster Caregiver Should Not Provide Care:

When the completed assessment indicates concerns that a potential kinship foster caregiver cannot meet the health, safety and placement needs of the child:

- Inform the potential kinship caregiver in writing **within 5 work days** of the assessment concerns and offer the family an opportunity to meet with the Program Manager or management level designee to discuss and address the departments concerns with the family and provide additional information about the concerns.

- If the family or individual makes a request to present additional information to the Program Manager or management level designee, schedule the meeting **within five work days** of the request. The following persons should participate in the meeting:
  - the potential kinship foster caregiver;
  - other family members as designated by the potential kinship caregiver;
  - the Program Manager or management level designee;

  - the CPS Specialist; and
  - the CPS Specialists supervisor.

- If the Program Manager or management level designee, the supervisor and CPS Specialist determine that the family should be recommended for placement, request court approval for the placement.

- If after the meeting to receive additional information, the Program Manager or management level designee, the supervisor and CPS Specialist determine that the family *will not* be recommended for placement, send the Kinship Foster Care Placement Notification letter (Notice letter), located in public folders, to the kinship foster caregiver within 15 work days of the decision. Include in the written notice:
  - the specific reasons the family was not recommended for placement;
  - the process to request the assigned juvenile court judge to review the determination that placement with the kinship caregiver is not in the best interest of the child.

DOCUMENTATION :

Ensure all placement data is entered in CHILDS as soon as the child is placed, or within two working days, according to district procedures.

- Complete a service authorization for unlicensed relative kinship foster caregivers using URAD (Unlicensed Relative Application Pending) for relative kinship caregivers who wish to initiate the foster home licensing process.
- Complete a service authorization for unlicensed relative kinship foster caregivers using URED (Unlicensed Relative) for relative kinship caregivers who *do not* wish to initiate the foster home licensing process.
- Complete a service authorization for an unlicensed non-relative using URND (Unlicensed Non-relative Providers).

When placement with the kinship foster care parent is approved, ensure that the kinship foster care parent is entered into the CHILDS Provider Management, according to district procedures, through completion of the following windows: Provider Maintenance Detail, Provider Maintenance Facility Detail, Person Detail, Facility Contacts, Provider Maintenance Household, and Provider Maintenance Service Detail.

If siblings are not placed together, document the reason(s) in the Out-of-Home Characteristics window using the Explain window.

Document efforts made to identify kinship foster care placements, the kinship foster care family selected (if applicable) and reasons for the selection of the specific family using the Case Notes window designated as Key Issues type.

Document the sharing of information with the kinship foster care parent about financial and non-financial services in the Case Notes window designated as Out-of-Home Care Provider type.

File the Information for Kinship Foster Care Placement Consideration in the hard copy case record.

File a copy of the written notice to each kinship foster care family who is not recommended for placement of a child in the hard copy case record.

Document the meeting with the Program Manager or designated management level designee using the Case Notes designated as Management Contact type.

For More Information: See Developing the Out-of-Home Care Plan and Contact and Visitation Plan (Chapter 9 Section 6) for information on providing services and supervision to children in kinship foster care and their kinship foster care parents.

For More Information: See the CHILDS Guide for Field Users, "Provider Module", in Public Folders for information on entering kinship foster care parents in CHILDS Provider Management.

For More Information: See the Kinship Foster Care Folder in Public Folders, Policy, DCYF for information and sample letters and TANF child only cash assistance application process.

Revision History:
DES(09-2006)

Previous / Next

6-7

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) is the federal law that governs child welfare services to children and families, including providing health and education records to caregivers.

ARS §8-514 gives the department the authority to place children in foster care, and requires that specific written information about the child be provided to the caregiver at the time of placement.

ARS §8-514.05(A) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to the child's foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is current placed.

ARS §8-514.05(C) authorizes a foster parent, group home staff, relative, or other person or agency in whose care the child is placed to consent to evaluation and treatment for emergency conditions that are not life-threatening, and routine medical and dental treatment and procedures including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions.

ARS §8-514.05(D) prohibits a foster parent, group home staff, relative, or other person or agency in whose care the child is placed from consenting to general anesthesia, surgery, testing for the presence of the human immunodeficiency virus, blood transfusions, and abortions.

Rules: Section R6-5-5801 et seq. of the Arizona Administrative Code addresses placement of children in family foster homes.

Revision History:
DES(07-2006)

Chapter 6 Section 7

Placing Children in Out-of-Home Care

Legal Basis

Policy: The department shall prepare children for placement in order to maximize the opportunity for success of the placement and to minimize the trauma to the child.

The department shall share with out-of-home care providers all information about the child to meet the needs of the child and to assist in carrying out the case plan.

Implementation and Procedures Guide

BEST PRACTICE TIP:
When children must be removed from home to ensure their safety, they experience loss which can result in emotional harm and damage to relationships. It is imperative that the CPS Specialist take the time to explain to the child (using language the child can understand) what is happening and reassure the child of their parent's love.

Encourage children to take personal items such as toys, blankets, music, pictures, etc. Children need to be able to look at their room and see something of their own, something that connects them to their past. It is really important that the CPS Specialist communicate with the child in some way the day after the placement. When children are removed from their home, they are often removed from everything and everybody they know and they do not understand the rules.

Whenever possible, siblings should be placed together. If they cannot be placed together, develop an agreement between the resource families so that the siblings maintain contact as often as possible through visits, phone calls, e-mails.

To prepare a child for out-of-home placement:

- Talk to the child about what to expect in the out-of-home care setting.
- Encourage the child to maintain connections with his family or previous caregivers through retention of personal keepsakes, such as life books.
- Allow as much time as possible to facilitate the child and provider in getting acquainted and to answer questions or explain the case plan.
- Facilitate pre-placement visits, such as day visits, mutual activities, and an overnight visit with the prospective out-of-home caregiver, if practical.
- Personally take the child to their new caregiver and stay with the child to answer questions and help reassure them that they are safe.

BEST PRACTICE TIP:
Removing a child from their family can be traumatic for the child even if the parents have been abusive. A sense of loss, fear and confusion are emotions many children face. Awareness of the emotions the child is facing and providing a safe way for the child to talk about these emotions can minimize the trauma the child experiences.

Some tips for making a child feel as comfortable as possible include:

Before leaving the child with the caregiver, answer the questions the child may have, including:

§ What should they call their new caregivers?
§ Where will they sleep?
§ What are the rules about bedtime?
§ If they are hungry what can they eat? Can they go into the refrigerator?
§ Where are the bathroom and towels located?
§ Will they go to school the next day? If so, where?
§ Where can they put their things?
§ Can they call their parents?
§ Can they call the CPS Specialist?
§ Can they call their siblings?
§ When will the first visit occur? Research tells us that children who visit with their parents regularly are much less traumatized by being in care than those who go for long periods without seeing their family.

When placing a child in out-of-home care:

- Discuss the rate to be paid with the licensed non-relative or licensed kinship foster care provider.
- Inform the unlicensed non-relative or unlicensed kinship foster care provider that they will not receive foster care maintenance payments and encourage and assist the unlicensed provider to apply for foster parent licensing.
- Give the caregiver the child's Medical I. D. card.
- Give the care provider at the time of or **within five working days** of the placement, the child's Placement Packet and additional documents. The Placement Packet includes:

þ Child's Placement Packet Contents, FC12000. **Have the provider sign acknowledging receipt of the packet.**
þ Child Placement Summary/Agreement, FC01100 (FC-011), completed at

the time of placement. **Have the provider sign acknowledging that he or she has read, understood and agreed to the placement terms.**

- Notice to Provider (Medical) and (Educational), FC06900 (FC-069), completed at the time of placement; and the following blank forms for completion by the caregiver:
  - Basic Wardrobe Checklist, FC1000 (FC-010);
  - Child's Health and Medical Record, FC01400 (FC-014), (at least five copies);
  - Allowance Signoff Ledger, FC12800 (FC-128);Purchase Ledger, FC12600 (FC-126);Child's Contract Record, FC12700 (FC-127);
  - Child Information Guide, FC13000 (FC-130); Foster Parent Wrap-Up (Feedback on Services) FC12900 (FC-129); and
  - Significant Incident, (FC-122) (give provider five copies).
  - Child's Medical/Educational History and Status, (FC-192).

- Give the care provider the following reports and forms at the time of placement, if available, or **within five working days** of placement:

  - Medical Summary Report, from the Case Summary window (File and Reports); **Have the licensed family foster or kinship parent sign the Medical Summary Report acknowledging the recommended reimbursement level**.
  - a copy of the child's immunization record;
  - a copy of the child's birth certificate;
  - a copy of any minute entry setting a future dependency or delinquency hearing involving the child;
  - a copy of the most recent Foster Care Review Board report, if the initial review has been held;
  - Child Information Guide, FC13000 (FC-130), completed by prior provider, if applicable; and
  - Basic wardrobe checklist, FC10000 (FC-010), completed by prior provider, if applicable;

- Share with the provider at the time of placement, if available or within five work days of receipt, all information which will assist in providing care for the child, including:
  - a copy of the case plan;
  - special needs and health conditions;
  - behavioral and mental health concerns and any diagnosed conditions;
  - visitation plans;

§ planned appointments and other agency involvement;
§ previous placement information;
§ cultural practices and religious involvement;
§ sexual orientation;
§ food and activity preferences;
§ educational history and needs; and
§ history of abuse or neglect that may affect the child's behavior or needs.

BEST PRACTICE TIP:
Information helps the caregiver better understand the child, better care for the child and better advocate for the needs of the child. Information about the child (such as the child's food likes and dislikes, activity preferences and interests, fears and behavior issues, and friends with whom the child may want to stay in contact) will help the child to adapt. The more the caregiver knows about the child's background, needs, trauma history, education and medical history, the better equipped the caregiver will be to successfully care for the child.

- Inform the family care provider of policies and procedures regarding:

  § contacting the CPS Specialist during and after business hours;
  § contacting the RBHA CPS Specialist;
  § contact and visitation arrangements between the child, child's parents and siblings, family members, other relatives, friends, and any former foster parents
  § services available through the Comprehensive Medical and Dental Program (CMDP);
  § availability of daily personal and clothing allowances and special payments;
  § the ACYF Discipline Policy, (Exhibit 44); and
  § what the foster or kinship care family is expected to provide.

- Arrange for medical examination and treatment, when indicated, or as specified in Meeting the Medical Needs of Children in Out of Home Care (Chapter 6 Section 11).
- Instruct the provider to enroll the child in the local school **within five days**, if he or she is school-age, unless an alternative plan has been made.
- Ensure that the family foster or kinship care provider knows and understands that the provider is:

  § authorized to consent to evaluation and treatment for emergency conditions that are not life threatening, and routine medical and dental treatment and

procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions;

§ prohibited from consenting to general anesthesia, surgery, testing for the presence of the human immunodeficiency virus, blood transfusions, clinical trials and abortions or abortion related treatments; and

§ authorized to give emergency consent if the emergency room physician or medical provider advises that immediate treatment is necessary and further delay of treatment in order to notify the department is potentially harmful to the child.

- Ensure that the family foster or kinship caregiver has:

§ a copy of the ACYF Discipline Policy, (Exhibit 44);

§ a copy of Comprehensive Medial and Dental Program (CMDP) Member Handbook;

§ a car seat for all children under five years of age and knowledge of how to properly install it and that the provider is required to use it. (ARS §28-907) If no car seat is available, lend the provider a car seat, if available in the district; and

§ knowledge that a child under sixteen years of age must wear lap and shoulder belts.(ARS §28-909)

When a child has special education needs and the child's parent or guardian is not available to act as the parent as defined by the Individuals with Disabilities Education Act (IDEA), ensure that the Arizona Department of Education appoints a surrogate parent to act as the IDEA parent as specified in Meeting the Educational Needs of Children in Out of Home Care (Chapter 6 Section 10).

When placing a child in a *group care setting*:

§ Arrange a pre-placement interview for the child at the facility.

§ Ensure or assist in the enrollment of the child in the local school district or on-grounds school **within five days**.

§ Arrange for placement of the child in the group care facility.

§ Complete and maintain a copy of the group care agency's registration packet and ensure that the provider updates the Placement Packet.

Ensure that the provider is aware of policies and procedures regarding contact between the child, the child's parents and siblings, family members, other relatives, friends and former foster parents.

Ensure that the provider knows that the provider is authorized to consent to evaluation and treatment for emergency conditions that are not life-threatening, and routine medical and dental treatment and procedures including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions.

Ensure that the provider know that the provider is authorized to give emergency consent if the emergency room physician or medical provider advises that immediate treatment is necessary and further delay of treatment in order to notify the department is potentially harmful to the child.

Ensure that the provider understands that the provider is prohibited from consenting to general anesthesia, surgery, testing for the presence of the human immunodeficiency virus (HIV), blood transfusions, clinical trials for treatment of HIV/AIDS, and abortions or abortion related treatments.

When placing a child in a residential treatment center, follow procedures described in Arranging for Residential Treatment Services (Chapter 8 Section 1).

For children who will be placed out-of-state, follow Reviewing, Evaluating and Approving ICPC Placements, (Chapter 10, Section 3) procedures**.**

DOCUMENTATION :

Ensure all placement data is entered in CHILDS as soon as the child is placed or within two working days according to district procedures.

Complete the Child Assessment and Special Rate Evaluation window when placing a child in a family foster home.

Ensure that the Provider Service Authorization window is updated.

File a copy of the Medical Summary Report, Child's Placement Packet Contents and Child Placement Summary/Agreement forms with caregiver signatures and any other forms signed by the caregiver in the hard copy case record.

Document the sharing of all information in the Case Notes window designated as Out-of-Home Care Provider type.

For More Information: On completing the detail windows that are associated with the production of the Medical Summary Report, see the CHILDS Guide for Field Users, "Child Assessment and Special Rate Evaluation/Medical Summary Report," in Public Folders.

For More Information: On entering unlicensed out-of-home care providers in CHILDS Provider Management see the CHILDS Guide for Field Users, "Provider Module", in Public Folders.

For More Information: On creating, saving and updating the Placement Packet see, “non court docs”, in Public Folders, CHILDS Guides for Field Users, Case Management.

Revision History:
DES(07-2006)

Previous / Next

6-8

Legal Basis: ARS §8-824, ARS §8-825, ARS §8-843, ARS §8-845, and ARS § 8-846 require the department to provide services to children in out-of-home care and their families.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6 Section 8

Providing Supervision of Children in Out-of-Home Care

Legal Basis

Policy: The department shall provide case planning and case management for children in out-of-home care under a dependency, as specified in Developing the Family Centered Case Plan, (Chapter 9 Section 1).

The department shall provide ongoing supervision of children in out-of-home placement to ensure that they are safe and that their needs are met.

For children in out-of-home care with another permanent planned living arrangement of long term foster care or independent living, and placed in a licensed foster home, kinship foster care home with whom a Long Term Foster Care Agreement has been signed; CPS Specialists shall consult with the out-of-home care provider, the child, and other service team members as appropriate to determine the frequency of face-to-face contacts. At a minimum, CPS Specialists shall have **quarterly** face-to-face contact with the child and the provider together in the provider's home.

For all children in out-of-home care, the child's CPS Specialist shall have face-to-face contact with the child and the caregiver **at least once a month**, unless an exception substituting face-to-face contact by another professional for face-to-face contact by the CPS Specialist is approved. **At least one visit in every three month period** shall be conducted by the CPS Specialist, with the caregiver and the child together in the caregiver's home.

CPS Specialists shall consult with the out-of-home caregiver, the child, if verbal, and other service team members as appropriate to determine if the child and/or caregiver requires more frequent face-to-face contact and/or telephone contact between face-to-face contacts.

When a child is placed in an emergency shelter or receiving foster home, the CPS Specialist shall have face-to-face contact with the child and the caregiver **every two weeks** and telephone contact with the caregiver, and the child, if verbal, on **alternate weeks**.

The CPS Specialist's supervisor may approve face-to-face contact by another ACYF employee professional, such as another CPS Specialist or CPS Case Aide, to substitute for face-to-face contact by the CPS Specialist with the child or caregiver.

The CPS Specialist's supervisor may approve, as the result of a case plan staffing recommendation, face-to-face contact by another involved professional who is associated with the child and understands the issues involved in the case (but is not an ACYF employee) to substitute for face-to-face contacts by CPS Specialist with the child and the caregiver.

The two exceptions above do not apply to the CPS Specialist's **quarterly** face-to-face contact with the child and caregiver together in the caregiver's home.

CPS Specialist shall have **monthly** telephone contact with children, if verbal and caregivers when the **monthly** face-to-face contact is made by another ACYF staff or other involved professional. For children placed in emergency shelter or an emergency receiving foster home, CPS Specialist shall have **weekly** telephone contact with children and caregivers when the required face-to-face contact is made by another ACYF staff or other involved professional.

To determine *when the child and/or caregiver requires more than monthly face-to-face contact and/or telephone contact from the CPS Specialist between face-to-face contacts*, consider the following questions:

- Has the child or caregiver asked for more frequent CPS Specialist contact?

BEST PRACTICE TIP:
If problems have occurred in the relationship between the caregiver and child, more frequent visits with the child and the caregiver may be helpful. Spending time to address issues in the home, when the placement can still be salvaged, is MUCH less time consuming for the CPS Specialist and MUCH less traumatic to the child than having to find the child a new placement.

- Does the child have a history of placement disruptions?
- Are there indications of instability in the current placement? What are they and how do you know?
- Does the child have special needs that could exceed the skills or abilities of the caregiver?
- Are there stressors in the caregiver's home that may impact the child or the stability of the placement?
- Have there been changes in services, contact and visitation, or family circumstances which could be disruptive to the child or caregiver?
- Are services being provided to the child and/or caregiver to address the child's special needs, support the caregiver, or reduce stressors in the caregiver's home?

Exceptions to Face to Face Contact

To determine *when an exception substituting face-to-face contact by another professional for face-to-face contact by the CPS Specialist with a child or caregiver is appropriate,* consider the following questions:

§ Does another professional have a supportive relationship with the child and have weekly or monthly face-to-face contact with the child?
§ If the child is in an emergency shelter or receiving foster home, would contact from another professional meet the child's emotional needs and needs for case related information?
§ If the child is in an emergency shelter or receiving foster home, is this the child's initial placement into out-of-home care?
§ Is the child able to communicate his or her needs via telephone with the CPS Specialist? Does the child have the opportunity?
§ What is the stability and longevity of the placement? How do you know?
§ Is the child placed out-of-district without courtesy supervision?
§ Does the child or caregiver require significant support?
§ Are the caregiver and the child in agreement with another ACYF employee professional or other involved professional making the monthly face-to-face contact?
§ Does the service team agree with the exception to monthly face-to-face contact by the CPS Specialist?
§ Does the CPS Specialist have a plan to maintain face-to-face contact with the child and caregiver at least once every three months?
§ For a child with a permanency goal of long-term foster care or independent living, and placed in a licensed foster home, kinship foster care, or significant person home with whom a Long Term Foster Care Agreement has been signed; do the case manager, supervisor, out-of-home care provider, child, and service team agree that quarterly face-to-face contact is sufficient to meet the child's and provider's needs? (If so, quarterly face-to-face contact by the case manager is sufficient and no substitute for the CPS Specialist's monthly contact is required).

Implementation and Procedure Guide

BEST PRACTICE TIP:
There are many ways that a child can get lost in the child welfare system—one specific way is for the CPS Specialist not to see the child on a regular basis. The CPS Specialist is the link to "next steps" in the life of a child. If the CPS Specialist "disappears"--or so it may appear to the child--the child may feel abandoned. Even if the caregivers are kind and loving, the child needs to see his/her CPS Specialist to understand what is happening in their "case". Youth in care tell us that the closer they feel to their CPS Specialist, the more hope they have in their future. A CPS Specialist should never underestimate the power they have in the life of a child

in care.

CPS Specialist shall assess the following during contacts with children and care caregivers:

- the child's safety;
- the child's and the caregiver's adjustments to each other;
- the ability of the placement to meet the child's needs;
- the safety of the physical home environment;
- the developmental progress of the child;
- the child's educational, physical health, and emotional and behavioral health status and needs;
- the appropriateness and adequacy of services and supports provided the child; and
- the appropriateness and adequacy of services and supports provided the caregiver to maintain the caregiver's ability to care for the child.

Provide supervision for a child placed in a *family foster home or kinship home* by:

- personally placing the child;
- making follow-up telephone contact with the caregiver and the child, if verbal, **within 24 hours** of placement, if the placement was made by someone other than the CPS Specialist; or
- making follow-up telephone contact with the caregiver and the child, if verbal, **within 5 days** of placement, if the placement was made by the CPS Specialist,
- making a visit in the caregiver's home with the child and the caregiver **within ten days** of placement, if the placement was made by someone other than the CPS Specialist;
- having face-to-face contact with the child and caregiver at least **once per month**. (If a child is placed out-of-district without courtesy supervision, visits may occur **every two months** with supervisory approval.);
- consulting with the caregiver, the child, if verbal, and other service team members as appropriate, to determine if the child and/or caregiver requires more frequent face-to-face contact and/or telephone contact from the CPS Specialist between face-to-face contacts;
- visiting at least **once in every three month period** with the caregiver and the child, together in the caregiver's home;
- reviewing the information recorded by the caregiver in child's Placement Packet;
- obtaining prior supervisory approval when:
  - requesting another ACYF employee professional make face-to-face contacts with the child and the caregiver;
  - requesting another involved professional person who is not an ACYF employee to make face-to-face contact with the child and the caregiver. After obtaining

supervisory approval, discuss the exception at the case plan staffing.

- Ensure that the team members are aware of the reasons necessitating the exception, the role and qualifications of the proposed other professional, a description of the relationship between the proposed other professional and the child and caregiver.
- Ensure that the team members sign the case plan documenting the team's agreement with the recommended exception.
- Ensure that the planned arrangement for another involved professional person to make the **monthly** face-to-face contacts with the child and the caregiver is reviewed during subsequent case plan staffings.

§ ensuring the date and time of face-to-face contacts made by another ACYF staff or other approved professional person are documented in CHILDS;
§ making monthly telephone contact with the child and caregiver when the face-to-face contact is made by another ACYF staff or other involved professional; and
§ if the child has another planned permanency living arrangement of long-term foster care or independent living, and is placed in a licensed foster home, kinship foster care, or significant person home with whom a Long Term Foster Care Agreement has been signed; consult with the out-of-home care provider, the child, and other service team members as appropriate, to determine the frequency of face-to-face and telephone contacts.

Provide supervision for a child placed in *group care* by:

§ following the contact schedule and any alternative face-to-face contact arrangement procedures for family foster care above;
§ convening a district multi-disciplinary or administrative team for children placed in therapeutic group homes and residential treatment centers to review treatment goals, appropriateness of placement, the need for continuation of the placement, and discharge planning a minimum of once every six months, when a review has not been completed by the RBHA or the placement;
§ complying with the district multi-disciplinary or administrative team recommendations, unless a change is approved by the District Program Manager;
§ participating by phone or in person in staffings arranged by the caregiver; and
§ reviewing the information recorded by the caregiver in the child's Placement Packet.

Provide supervision for a child placed in *receiving or shelter care* by:

§ making telephone contact with the caregiver and child if verbal, **the next work day** after placement;
§ making face-to-face contact with the caregiver and child **within 72 hours**, if the

placement was made by someone other than the assigned CPS Specialist;

§ making face-to-face contact **every two weeks** and making telephone contact with the caregiver, and the child, if verbal, on each alternate week throughout placement in receiving or shelter care;

§ when appropriate, requesting prior supervisory approval for another ACYF staff or other involved professional to make required face-to-face contact with the child;

§ making **weekly** telephone contact with the caregiver, and the child if verbal, when the face-to-face contact is made by another ACYF staff or other involved professional; and

§ reviewing the information recorded by the caregiver in the child's Placement Packet.

DOCUMENTATION :

Document all face-to-face contacts with the child and caregiver, using the Case Notes window designated as the appropriate type. Select the In Person contact type radio button and highlight the names of all parties present in the “Contact With” list on the Case Notes window. Select the "In Placement Contact" check box if the child and out-of-home care caregiver were seen together or separately in the caregiver's home.

Document observations and other information related to the child’s safety, the child’s and caregiver’s adjustments to each other, the ability of the placement to meet the child’s needs, the developmental progress of the child, and the appropriateness and adequacy of services and supports provided the child and the out-of-home caregiver in the Case Notes window, designated as the appropriate type.

Document service team recommendations for another involved professional to make the monthly face-to-face contacts and the reason for the exception using the Explain box on the Case Plan Tasks window, Out-of-Home Care Plan type. If approval for an ACYF employee professional to make face-to-face contact with the child and out-of-home care caregiver is obtained between case plan staffings, document any ongoing exceptions in the Out-of-Home Care Plan developed at the next case plan staffing.

Document the date and time of all face-to-face contacts with the child or caregiver made by another involved approved professional in the Case Notes window designated as the appropriate type. Select the In Person contact type radio button on the Case Notes window.

Summarize the results and recommendations of the district multi-disciplinary or administrative team review in the Case Notes window designated as Case Conference type.

Document the review of the child's Placement Packet in the Case Notes window designated as the appropriate type. Update CHILDS to reflect information provided by the out-of-home caregiver on the child’s needs and status using the detail windows associated with the CHILDS medical

summary report; Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Examination Detail, Practitioner Detail, Participant Education Condition, Participant Education Detail and Hospitalization Detail windows.

File completed Child Placement Packet forms in the hard copy record.

Supervisor:

Document supervisor approval of any exception to monthly contact with a child or out-of-home caregiver using the Case Notes window designated as Supervisory Contact type.

For More Information: On providing services and supervision to children in out-of-home care and their out-of-home care caregivers, See Supervision and Contacts With Children in Out of Home Care (Exhibit 23).

For More Information: On documenting face-to-face contacts in CHILDS, see the CHILDS Guide for Field Users, "Case Notes - Documenting Face to Face Contact," in Public Folders.

For More Information: On updating the detail windows associated with the CHILDS Medical Summary Report, see the CHILDS Guide for Field Users, "Medical Summary Report," in Public Folders.

Revision History:
DES(07-2006)

Previous / Next

6-9

Legal Basis: ARS §28-907 requires the use of a child passenger restraint system for a child who is under five years of age.

ARS §28-909 requires the use of a lap and shoulder belt for a child under sixteen years of age.

Rules: Section R6-5-5832 of the Arizona Administrative Code addresses the transportation of children by foster parents.

Revision History:
DES(07-2006)

Chapter 6: Section 9

Meeting the Transportation Needs of Children in Out-of-Home Care

Legal Basis

Policy: The department will transport children safely.

The department will share responsibility for routine transportation of children in out-of-home care with providers as specified in the child's case plan or Child's Placement Summary Agreement.

The department will take adequate steps to assure the safety of children who require non-routine travel.

Implementation and Procedures Guide

When a child needs routine transportation:

§ Use a child passenger restraint system for any child under five years of age, or the vehicle restraint system, which includes both the lap and shoulder belt if the vehicle is equipped with shoulder belts, for any child over four and under 16 years of age.

§ Clarify expectations related to transportation with foster care providers, using the Child Placement Summary/Agreement, FC-01100, (FC-011), found in the Forms Registry as part of the Placement Packet.

§ Arrange for the foster care providers to provide transportation for routine health care and activities.

§ Contact CMDP to arrange non-emergency transportation for medical services when foster care providers can not transport the child.

§ Contact the Regional Behavioral Health Authority for transportation if it is medically necessary for non-emergency mental health or substance abuse treatment services.

When a child requires non-routine travel:

§ Determine if the child will travel alone, with the CPS Specialist, or with a non-agency escort, based upon the age, development and special needs of the child.

§ Confer with the receiving agency and/or caregiver.

§ Obtain approval of the Program Manager or designee according to district procedures.

§ Obtain a court order, if the child will:

- travel out of state for more than **30 days**, or
- travel out of the country.

When the child is traveling alone:

§ Make arrangements with the state-contracted travel agency or commercial transportation company.

§ Prepare a Payment Voucher, using the Find Invoice window, according to district procedures.

§ Provide the transportation company with an affidavit specifying:

- the child's identification;
- the names and phone numbers of the CPS Specialist and his or her supervisor;
- the legal status of the child and court order;
- the travel arrangements and destination;
- the name of the person to meet the child;
- the responsibility for the child's medical care; and
- the emergency contact name and phone number.

When the child is traveling with the CPS Specialist:

§ Prepare a transportation plan, specifying transportation arrangements, a placement plan and a description of the CPS Specialist's role and responsibility.

§ Prepare a justification to accompany the child out-of-state, when applicable.

§ Following district procedures, submit the transportation plan to the ACYF Program Administrator for approval at least ten working days prior to departure.

When the child is traveling with a non-agency escort:

§ Use as an escort an adult who has a positive relationship with the child and has references to verify his or her reliability.

§ Prepare a travel plan for supervisor approval, including the affidavit information specified above and the name of the escort.

§ Prepare for the escort relevant information regarding the child's special needs (general health, medical needs, prescription drugs, and special diet), and maintain this information in a separate, sealed envelope.

§ Send the travel plan to the destination prior to departure.

§ Arrange for payment of transportation costs of child and escort as well as per diem expenses, according to district procedures.

DOCUMENTATION :

Document the District Program Manager approval of non-routine travel using the Case Notes window designated as Management Contact type.

For More Information: On children being placed out of state, see Reviewing, Evaluating and Approving ICPC Placements(Chapter 10 Section 3).

Revision History:
DES(07-2006)

Previous / Next

6-10

Legal Basis: Federal law 20 U.S.C.§1414 governs procedures for special education services.

ARS §15-761 et seq. is the educational law which requires that parents have the opportunity to participate in special educational decisions, affecting their children.

ARS §15-763.01 requires the participation of a parent or that the court consider appointment of a surrogate parent for a child needing placement in special education and defines the use of surrogate parents for educational decisions.

Rules: Rules requiring licensed foster parents to send children to public school unless an alternative educational arrangement is approved in the child's case plan are found in R6-5-5829.E of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 6: Section 10

Meeting the Educational Needs of Children in Out of Home Care

Legal Basis

Policy: In collaboration with out-of-home care providers and schools, the department shall ensure children are provided services to help children achieve their educational potential.

Every child in out-of-home care shall have an individualized Out of Home Care Plan that specifies:

- the child's educational status;
- services provided to the child or out-of-home caregiver to address the child's educational needs; and
- indication of whether the child is attending the home school district.

The department shall ensure that referrals are made to home school districts to adequately assess and address the special education and other educational needs of dependent children.

The department shall, in collaboration with out-of-home care providers, schools, public health and community agencies, and the child's parents provide sexuality developmental education to children in out-of-home care.

The department shall encourage parental involvement in special education decisions.

The department shall arrange for the appointment of a surrogate parent when a child is in need of special education services and:

§ a birth or adoptive parent or legal guardian cannot be located and the child does not reside with a relative;
§ a public agency cannot determine the whereabouts of a parent;
§ the parent is unwilling to be involved in educational decision making;
§ parental rights have been terminated; and
§ the child has a case plan of termination of parental rights, and it would be dangerous to the child to involve the parent, or the parent is unwilling or unable to participate appropriately.

The department shall work cooperatively with home school districts to ensure that children requiring residential treatment receive appropriate educational services, particularly in regard to determining and addressing special education needs.

A child shall not be placed in a residential treatment center without an approved education voucher, unless the child attends public school under a Certificate of Educational Convenience.

Children who have not been evaluated for special education or who do not have a current Individual Educational Plan (IEP) shall be placed in facilities with both special and non-special education programs.

To determine whether a child needs a surrogate parent, consider the following questions:

- Does the child have special education needs?
- Is the parent or guardian available to make special education decisions?
- Is the child placed with a relative?

When arranging for the appointment of a surrogate parent, select an individual who has the ability to:

- Review all of the child's relevant records and reports.
- Participate in developing the child's Individual Educational Plan (IEP) and other education-related meetings.
- Represent the child in any mediation or appeal proceedings.
- Review diagnostic evaluations.
- Monitor the child's progress.
- Adhere to confidentiality requirements.

The surrogate parent can not be an employee of a state agency, or an employee of a subcontractor for a state agency (ARS §15-763.01)

Remember that:

- A foster parent may serve as a surrogate parent following completion of surrogate parent training and appointment by the court.
- A foster parent may serve as a surrogate parent for a child living with the foster parent or living in some other out-of-home placement.

A list of qualified surrogate parents may be obtained through the Arizona Department of Education (ADE). Although foster parents are encouraged to become surrogate parents,

anyone who completes training and is on the list with the ADE is eligible.

- § Determine whom to recommend as a surrogate parent, based on the selection criteria previously stated and verification of completion of training.
- § Petition the court for appointment of a surrogate parent.

Request that the court terminate or suspend the surrogate parent when:

- § special education services are no longer necessary;
- § the parent becomes available;
- § the child turns 18 (unless he or she is declared mentally incompetent);
- § the child is no longer a wared of the court; or
- § the surrogate parent is not adequately representing the interests of the child.

Implementation and Procedures Guide

Upon initial placement of a child into out-of-home care, obtain the child's prior educational records, including records from any early intervention preschool program attended by the child.

Print a copy of the child's Medical Summary Report and provide it to the out-of-home care provider with the child's Placement Packet at the time of the child's initial placement into out-of-home care and whenever the child changes placements. Provide a copy of the updated Medical Summary Report to the out-of-home care provider at least once every six months.

Prior to and during the case plan staffing, provide family and service team members comprehensive information on the educational status of the child and the service and support needs of the out-of-home provider in relation to the child's education. Elicit the comments and recommendations of the family and service team members, and reach consensus, whenever possible, on the outcomes, tasks and services required to meet the child's educational needs.

Cooperate with the out-of-home care provider to ensure adequate communication with the child's school and referrals to the home school district to adequately assess and meet the child's special education and other educational needs, and attendance at meetings or conferences related to the child's education. Encourage the out-of-home care provider to take the lead role in monitoring and advocating for services to meet the child's educational needs. Determine if the out-of-home care provider requires assistance in this role from the CPS Specialist, a surrogate parent, or another service team member; and provide or arrange this assistance as needed.

Ensure parents whose rights have not been terminated are informed of and involved in their child's educational services to the greatest extent possible.

BEST PRACTICE TIPS:
Ensure that parents whose rights have not been terminated are informed of and involved in their child's educational services to the greatest extent possible. Parents who are notified about their child's educational activities, meetings, conferences and events can maintain involvement and interest in their child's life. The child's foster parents and/or CPS Specialist shall be encouraged/expected to keep parents up to date on their child's educational issues and progress.

Monitor the child's educational status by requesting updates from the out-of-home care provider, and the child, if verbal, during monthly contacts and at the time of case plan staffings. Request the out-of-home care provider supply a copy of the child's report card and any other significant records. As needed, adjust the educational services and supports between case plan staffings.

Notify the child's home school district if a child is expected to be absent from school more than ten days due to change in residence, emergency shelter, hospitalization or run away status.

When a child is to be placed in a residential treatment center (RTC) or Therapeutic Group Home (TGH) with an on-ground school:

§ Contact the District Mental Health Specialist to request completion of the State Placing Agency Voucher prior to placing a child into an RTC or TGH with an on-ground school.
§ **Within 60 days** of the initial State Placing Agency Voucher, the home school district will complete an evaluation or for students who have previously been determined eligible for special education services, a review of educational placement.
§ Ensure that the State Placing Agency Voucher application is signed by a representative of the home school district and a representative of ACYF who is authorized to sign educational vouchers. Contact the District Mental Health Specialist for this listing.
§ Based on the results of the evaluation or review, the home school district will determine whether the placement is for special education reasons, or for reasons of care, safety, or treatment.
§ The home school district will submit a Home School District Voucher Funding packet to the Arizona Department of Education.

To initiate an educational placement in an RTC or TGH with an on-ground school:

§ Determine if the child is receiving or has received special education services.
§ Arrange for the appointment of a surrogate parent, if necessary.
§ Obtain written consent from the parent or surrogate parent for release of information to and from the home school district.
§ Contact the child's home school district to discuss the child's special education

status, educational needs, and plans to place the child in a residential treatment facility.

§ If the child has no history of special education within the last 12 months, advise the parent or surrogate parent to make a written request to the home school district for an evaluation to determine the possibility of special education need and eligibility.

§ If the child has a history of special education within the past 12 months, contact the home school district requesting an Individual Educational Plan (IEP) meeting to determine the child's special education needs within an RTC or TGH setting.

§ Provide applicable records to the home school district to assist in determining educational needs within the RTC or TGH setting.

When a child requires continued or ongoing educational placement in an RTC or TGH setting:

§ Participate in semester, annual and other educational staffings.

§ Contact the District Mental Health Specialist to initiate a new voucher application if a child is transferred between RTCs or TGHs and **more than 10 days** elapse between placements.

§ Work with the home school district prior to discharge to plan for integration into public school.

§ Terminate RTC placements, made for educational purposes, only after an Individual Educational Plan (IEP) team is convened and a review determines that termination of residential placement is appropriate.

File copies of the child's educational records in the hard copy case record.

DOCUMENTATION :

Using the Case Plan Tasks window, Out of Home Care Plan type, document the outcomes, tasks, services, and supports identified prior to and during the case plan staffing to meet the child's educational needs. Provide explanations associated with any of the outcomes, tasks, services, or supports to serve as the child's education plans.

Using the Out of Home Characteristics window, specify whether the child is attending the home school district, and if not, provide an explanation.

Document the child's school name and grade level and any educational condition or diagnosis using the Participant Education Detail and Participant Education Condition Detail windows.

Document review and provision of the child's Medical Summary Report to the out-of-home care provider by filing a copy, signed by the care provider, in the hard copy record.

Document the discussion of the child's educational status and needs with the out-of-home care

provider using the Case Notes window.

Document the plan for collaborating to ensure the child is provided services to help the child achieve his or her educational potential using the Case Plan Tasks window, Out of Home Care Plan Type.

Document the approval of home schooling using the Case Plan Tasks window, Out of Home Care Plan Type.

Document the parent's or surrogate parent's written consent for the release of information on the Release of/Request for Information, FC-178. File the form in the hard copy record.

Document the parent's or surrogate parent's request for an evaluation of special education eligibility on the Parent Request for Comprehensive Educational Evaluation, FC-182. File a copy of the form in the hard copy record.

Keep copies of all Individual Education Plans and other educational reports in the hard copy record.

Document notification that a child is expected to be absent from school using the Case Notes window designated as Collateral Contact type.

For More Information: On provision of child sexual development education services to children in out-of-home care, see Providing Child Sexual Development Education (Chapter 6 Section 15).

For More Information: If you have questions concerning specific district procedures or unusual circumstances, consult with the District Mental Health Specialists and other district or Central Office behavioral health/special education staff.

Revision History:
DES(07-2006)

Previous / Next

6-11

Legal Basis: The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191):

- allows for the exchange of Protected Health Information (referred to as PHI) between covered entities for purposes of treatment, payment and health care operations;
- limits the use and disclosure of Protected Health Information;
- establishes an individual's right to control access to and use of their Protected Health Information; and,
- balances health information protection and individual rights against public health and safety needs.

ARS §8-813 directs the department to provide medical care and dental care for dependent children.

ARS §8-514.05(A) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to the child's foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed.

ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

ARS §8-514.05(C) authorizes a foster parent, group home staff, relative, or other person or agency in whose care the child is placed to consent to evaluation and treatment for emergency conditions that are not life-threatening, and routine medical and dental treatment and procedures including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions.

ARS §8-514.05(D) prohibits a foster parent, group home staff, relative, or other person or agency in whose care the child is placed from consenting to general anesthesia, surgery, testing for the presence of the human immunodeficiency virus, blood transfusions, and abortions.

ARS §44-133 provides for a person acting in loco parentis to consent to emergency hospital care, medical attention or surgery.

Rules: Rules concerning medical services provided through AHCCCS are found in Section R9-22-101 of the Arizona Administrative Code.

Sections R6-5-6000 et. seq. of the Arizona Administrative Code address medical services provided through CMDP.

Rules concerning licensed foster parents' responsibilities for ensuring that the child's medical and dental care needs are met are found in Section R6-5-5830 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 6 Section 11:

Meeting the Medical Service Needs of Children in Out of Home Care

Legal Basis

Policy: The department shall assure that both dependent children and children in voluntary out-of-home care receive medical and dental services to allow them to achieve and maintain physical and mental health.

Meeting the health care needs of both dependent children and children in voluntary out-of-home care is a responsibility shared among parents, CPS Specialists, out-of-home care providers and medical providers under the Comprehensive Medical and Dental Care Program (CMDP).

The department shall obtain written consent of the parent or a certified copy of a court order authorizing treatment for non-routine surgery, general anesthesia, blood transfusion, abortion or abortion related treatment, an unusual medical procedures, or if required by the service provider.

Implementation and Procedures Guide
A child is eligible for CMDP services if he or she is:

- a foster child placed through court order or Voluntary Foster Placement
- Agreement in a licensed foster home or licensed child welfare agency;
- a child in the home of a court approved relative or significant person. (The parent may reside in the home of the relative, but the child may not be placed with that parent);
- a child in an adoptive home prior to the finalization of the adoption;
- a child in an independent living program, as defined by ARS §8-521; and
- a child who is a runaway, when the department retains custody. (ARS §8-512)

To obtain information about any insurance coverage on the child:

- Request information about the parent's insurance coverage for the child from the parents. Enter this information on the Health Coverage Detail window. Complete the Parental Assessment Financial Statement, FC-009 found in the Forms Registry.
- Request court assistance if parents are uncooperative in providing the required information for children who have dependent insurance coverage.

BEST PRACTICE TIP:
The responsibility of child welfare services is to ensure child safety, child permanency and child well-being. One of the things that constitutes child well-being is continuity of medical care. Children come into care with many presenting issues that need consistent medical

attention. Health care delivery to children in out-of-home care requires adequate record keeping, communication among providers, adequate health care supervision including comprehensive physical and mental health screening, referral and follow up.

Gather available information and clinical and medical reports on the child from previous medical and behavioral health care providers.

At the time of or within five days of placement, ensure the foster care provider receives a completed Notice to Provider (Medical), FC06900, found in the Forms Registry as part of the Placement Packet, and a Child's Medical/Educational History and Status Form, FC-192 or a current Medical Summary Report. Confirm that the foster care provider has a copy of the CMDP Member Handbook, HMP-394.

Arrange for the child to have a complete medical examination that meets Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements prior to the initial placement, if possible (utilizing the parent's resources) or **within 30 days** after initial placement in out-of-home care. (An examination for injuries conducted at a shelter care facility does not substitute for a complete medical examination.)

- § Prior to the child's initial medical examination that meets EPSDT requirements , if not previously completed, complete the Child's Medical/Education History and Status form, FC-192, with the assistance of the parent, relative or other caregiver who is familiar with the child's prior health history.
- § Give a copy of the Child's Medical/Educational History and Status form, FC-192, and all other available medical records on the child to the person who accompanies the child to the child's medical appointment.

Ensure that recommended follow-up care and referrals from the medical provider are provided.

Ensure that the child receives a medical examination annually. [ARS §8-813(D)]

BEST PRACTICE TIP:
The National Academy for State Health Policy has identified the following values that are necessary for the provision of medical care for children in foster care:

1. All children have the right to have a record of their own developmental, social, health and educational historical information.

2. Health and education data is essential for the development of optimal case plans for children.

3. Child Welfare staff at every point in the service continuum have a responsibility to make sure that the information is collected, maintained and utilized:

4. Creation and maintenance of developmental, social, health and educational information for

children in out of home care must be a collaborative effort.

For children, ages 3 and older at the time of out-of-home care placement, coordinate with the out-of-home care provider to arrange a dental assessment within 30 days of placement, or obtain the results of a dental assessment that occurred **within 30 days** prior to the child's placement. Coordinate with the out-of-home care provider to ensure the child receives a dental examination semi-annually thereafter.

Facilitate referrals for mental health and substance abuse needs, according to district operating procedures. Facilitate referral to Children's Rehabilitative Services, if applicable.

Obtain written consent of parents or a certified copy of a court order authorizing treatment:

- § if required by the service provider; or
- in any case requiring non-routine surgery, general anesthesia, blood transfusion, or unusual medical procedures including abortion and abortion related surgery.

For authorization/approval process for a child to participate in a clinical trial or for testing for the presence of the Human Immunodeficiency Virus (HIV) see Providing Services for Children who are or Maybe HIV/AIDS Positive (Chapter 6, Section 12).

Ensure that out-of-home providers know that they are authorized to consent to:

§ evaluation and treatment for emergency conditions that are not life-threatening; and,

§ routine medical and dental treatment and procedures including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions.

Ensure that out-of-home providers understand that they are prohibited from consenting to general anesthesia, any non-routine surgery, testing for the presence of the human immunodeficiency virus, a clinical trial for HIV/AIDS treatment, blood transfusions, and abortions or abortion related treatments.

Ensure that out-of-home providers understand that the providers may give emergency consent if the emergency room physician or medical provider advises that immediate treatment is necessary and further delay of treatment in order to notify the department is potentially harmful to the child**.**

Ensure that out-of-home providers understand and carry out their responsibilities regarding medical services for children in their care. These include:

§ arranging for routine medical care, such as an initial and annual comprehensive medical examinations, additional EPSDT examinations, immunization, standard medical tests and routine dental care according to the age of the child;

§ maintaining a current record of their foster child's medical care on the Child's

Health and Medical Record, FC01400 (FC-014), in the child's Placement Packet; and

- § contacting the CPS Specialist regarding:
  - o any injury and any illness that exceeds three days and recurs regularly;
  - o any service for which the medical service provider requires written consent from the legal guardian or legal custodian, or prior authorization;
  - o any recommended service or treatment, if there is a question about coverage under CMDP;
  - o any service that requires prior authorization, according to *Fostering a Medical Home: CMDP Handbook for Foster Care Providers*, HMP-114;
  - o any service which would ordinarily require prior authorization but was provided in an emergency;
  - o all visits to health care providers for other than routine services; and
  - o inability to transport child to medical appointments or to arrange other alternative transportation.

When a child is no longer eligible for CMDP coverage send the child's medical identification card to CMDP at Site Code 942C.

DOCUMENTATION :

Document the child's health information on the following appropriate medical windows: Medical/ Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Special Needs Detail and Hospitalization Detail.

File all reports and evaluations received from medical providers, including EPSDT examination reports and recommendations and completed Child's Health and Medical Record, FC01400 (FC-014), in the hard copy record.

For More Information: On CMDP Services, including EPSDT requirements, see *Fostering a Medical Home: CMDP Handbook for Foster Care Providers*, HMP-114 and the CMDP Member Handbook, HMP-394.

For More Information: On consents for non-routine surgery and medical procedures, see Preparing Court Reports for CPS Cases (Chapter 20, Section 6).

For More Information: On family planning and pregnancy care services see Providing Family Planning Services (Chapter 6 Section 16) and Providing Pregnancy Care Services (Chapter 6 Section 17).

For More Information: On services including clinical trials for children in out-of-home care

who are or may be HIV/AIDS positive see Providing Services to Children Who Are or May Be HIV/AIDS Positive (Chapter 6, Section 12).

Revision History:
DES(07-2006)

Previous / Next

6-12

Legal Basis:45 CFR § 46.404 allows children to participate in research not involving greater than minimal risk with proper consent by parents, guardians, the child, or the court.

45 CFR § 46.405 allows children to participate in research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subjects, with proper consent by parents, guardians, the child, or the court and adherence to approved research protocols.

45 CFR §46.409 allows children who are wards of the court to participate in clinical trials or other research if the State believes that it is in the best interest of the child and children will ultimately benefit.

ARS §8-514 requires that the foster parents receive a child's medical history.

ARS § 8-512 directs the department to provide medical care and dental care for dependent children placed in out-of-home care.

ARS § 8-813 directs the department to provide an out-of-home placement capable of meeting a child's special treatment needs

ARS §8-514.05(A) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to the child's foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed.

ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

ARS §8-514.05(C) prohibits a foster parent, group home staff, relative, or other person or agency in whose care the child is placed from consenting to testing for the presence of the human immunodeficiency virus, general anesthesia, surgery, blood transfusions, and abortions.

ARS §13-3620 discusses DCYF employees' access to medical records of children.

Rules: R6-5-5837

Revision History:

DES(07-2006)

Chapter 6 Section 12:

Providing Services to Children Who Are HIV Positive or Who Have Been Diagnosed with AIDS

Legal Basis

Policy: The department shall ensure that all HIV/AIDS positive children under its care shall receive appropriate medical care and treatment and that their rights shall not be abridged.

Services shall not be denied to any child on the basis of HIV/AIDS status.

The department shall not remove a child from his or her home solely because he or she is high risk for HIV/AIDS infection, HIV/AIDS positive, or has caregivers who are HIV/AIDS positive.

Children who are HIV/AIDS positive and are in need of out-of-home care shall receive services in the least restrictive setting that meets the assessed needs of the child.

Caregivers shall be fully informed of a child's HIV/AIDS status and high risk behaviors. The department shall provide access to information and support to caregivers to facilitate their ability to safely provide care for HIV/AIDS positive children.

Testing a child for HIV/AIDS status must be recommended by a physician and performed to identify the child's medical needs. Testing of infants and children shall take place only when one of the following exists:

- upon recommendation of a physician, when the child displays symptoms or the child or parent presents high risk factors;
- a child is born to a mother who is known to be HIV/AIDS positive during pregnancy; or
- a child has been involved in sexual activity where an exchange of bodily fluids has likely occurred.

If available, the department shall seek the parent's consent for testing if the child is 12 or under.

The department shall share information regarding the HIV/AIDS status of children in out-of-home care and other related medical information only on a need-to-know basis.

The department shall confirm that prior to a child participating in a clinical trial all consents are

obtained and an independent advocate is appointed for the child by the health institute conducting the research.

To determine the most appropriate out-of-home placement for a child who is HIV/AIDS positive, consider:

- the best interests of the child;
- the provider's ability to provide specialized care;
- the provider's ability to respect the child's right to confidentiality;
- the impact of the child's placement on other children in the home; and
- the least restrictive, most family-like environment that will meet the needs of the child.

In particular, when considering placement in a group care facility, consider these factors:

- the level of risk of transmission of HIV/AIDS to other residents through sexual contact or exchange of bodily fluids;
- the ability of the HIV/AIDS positive child to manage his or her aggressive and/or sexual behaviors;
- the maturity and ability of other residents to protect themselves and to manage their own behaviors;
- the ability of the setting to protect the HIV/AIDS positive child from opportunistic infections; and
- the facility's capacity to provide or to arrange for intensive medical services as medical needs increase.

Implementation and Procedures Guide

Provide all case planning and case management services for HIV/AIDS positive children as described in Developing the Family Centered Case Plan (Chapter 9, Section 1), with the following additions:

- Convene a case plan staffing to discuss the case:
  - § before the child is placed into care, or **within seven working days** of an emergency placement, or
  - § within **the first 30 calendar days** of opening an in-home services case.
- Visit the placement at least **twice during the first month** after the initial placement of the child.

To arrange for HIV/AIDS testing of a child:

- Personally communicate to the child's physician any factors that would place the child at risk for HIV/AIDS exposure, including intravenous drug use, sexual abuse, and voluntary risk behavior of either the mother or the child.
- Obtain the physician's order for testing.
- Obtain approval from your supervisor.
- Contact the child's parent(s) or legal guardian about the request for HIV/AIDS testing and ask them to sign a consent for testing if the child is age 12 or younger. If a parent refuses to sign the consent, consult with your supervisor and/or district HIV/ AIDS representative and the Assistant Attorney General to obtain court authorization.
- Refer the matter to the juvenile court if there is disagreement among the parties.

When testing a child age 13 and older, follow these additional steps:

- Obtain counseling for the child from the local health department or another Professional.
- Allow a child age 13 or older to consent to his or her own HIV/AIDS testing if the youth meets the criteria for testing.
- Allow a child age 13 or older to consent to testing if he or she requests testing but does not meet the criteria. Encourage the youth to receive counseling on the procedure.
- Request court approval for a child age 13 or older, who meets the testing criteria, when parental or guardian consent cannot be obtained and when the child refuses to give consent for testing and for whom it is determined testing is appropriate.

When obtaining medical treatment for a child:

- Support HIV/AIDS treatments ordered by a physician for dependent children.
- Obtain court approval for participation.

When a request for a child to participate in a clinical trial for HIV/AIDS treatment is received:

- Immediately notify the supervisor, APM, DCYF/CPS Policy Specialist and the Assistant Attorney General (AAG). (Persons making the request may include the CPS Specialist, a child’s parent, foster parent, group home staff, GAL, CASA, child, child’s attorney or physician).
- Obtain court approval for participation in clinical trials or protocols when it is the physician's opinion that the proposed protocol is beyond what is accepted as standard in the medical community.
- Obtain prior authorization from the APM or designee and written consent from the

parent or guardian, GAL, and child, if the child can give informed consent.

- Obtain the following information and forward to the AAG:

  - § the child's medical records;
  - § information about the proposed treatment;
  - § the name, address and phone number of the sponsoring health institution conducting the research; and
  - § the child's treating physician and medical personnel responsible for or supervising the proposed clinical trial.

- Contact the health institute conducting the research for the assignment of an independent advocate for the child.

When an HIV/AIDS positive child is placed in a relative, significant person or family foster home:

- Complete the Memorandum of Understanding and Disclosure of Facts as Known, FW-502, found in the Forms Registry.
- Allow a family with other children to determine whether they will consider an HIV/AIDS positive child for placement or for continued placement.
- Coordinate supportive services for the family and child.
- Develop agreements with the foster family regarding payment rates and other issues arising from the special care needs of the HIV/AIDS positive child, if necessary.
- Ensure that care providers receive training on working with a child in their care who has HIV/AIDS.
- Closely monitor the child's care and the caregiver's ability to be responsive to the child's medical and psychosocial needs.

When a child who is HIV/AIDS positive is to be placed in a group care facility:

- Complete the Memorandum of Understanding and Disclosure of Facts as Known, FW-502, found in the Forms Registry.
- Consult the child's physician prior to placing a child in a group care facility.

When a child who is HIV/AIDS positive needs child care services:

- Assist in a referral to the Child Care Administration (CCA) for eligible caregivers with HIV/AIDS positive children; See Providing CPS Child Care for Children Placed in Out-of-Home Care, (Chapter 6, Section 13).
- Advise caregivers of available homes and center placement options.

- Advise the child care provider of the child's HIV/AIDS status only if this status impacts the child's daily care needs, the safety and well being of the child or the safety of other children and/or adults in the facility. Any disclosure of medical information is limited to a clear need to know basis.
- Consider a setting which minimizes exposure of the child's blood fluids to others if a child exhibits high risk behaviors such as lack of control of body secretions or biting, or who has any type of draining lesion.
- Place a foster child who is HIV/AIDS positive and does not exhibit symptoms or high risk behaviors in any child care setting.

For HIV/AIDS positive children whose permanency plan is adoption, follow procedures specified in Presenting the Child's Information to the Prospective Adoptive Parents (Chapters 13 Section 7), with the following exceptions:

- For the purposes of recruitment, identify the child as "medically at risk."
- Consider the following when assessing the family's ability to meet the needs of the child:

  § the family's ability to deal with loss**;**

  § the family's expectations regarding terminally ill children;

  § the flexibility of the family's schedule to accommodate medical and/or counseling appointments;

  § the family's ability to accept the limitations on their lifestyle that a terminally ill child would present.

- Fully inform prospective adoptive parents who have been determined to be appropriate for placement of an HIV/AIDS positive child of the child's medical condition and needs. Provide information contained in the physician's report detailing medical condition, prognosis and care.
- Provide specialized training to families expressing a willingness to consider HIV/AIDS positive children for adoption.
- Give adoptive parents a written list of HIV/AIDS related resources and support services.

DOCUMENTATION :

Document that a caregiver has been informed of a child's positive HIV/AIDS status in the Case Notes window designated Out of Home Care Provider and by filing the Memorandum of Understanding and Disclosure of Facts As Known, FW-502, in the child's hard copy record.

Document parental consent or court approval for HIV/AIDS testing and treatment and participation in a clinical trial using the Case Notes window designated as Parent/Caretaker Contact.

Document any consultation with physicians regarding the child's condition as well as the physician's approval for testing using the Case Notes window designated as Collateral Contact type and, if applicable, in the Examination Detail window and the Practitioner Detail window. Use the Explain to document HIV/AIDS test results.

Document diagnosis of HIV/AIDS on the Medical/Dental Condition Detail window.

Document supervisory approval of testing and notification of request for child’s participation in a clinical trial using the Case Notes window designated Supervisory Contact type.

Document AAG notification of requests for a child’s participation in a clinical trial using the Case Notes window designated AG Contact type

Document APM approval and DCYF/CPS Policy Specialist notification of requests for a child’s participation in a clinical trial using the Case Notes window designated as Management Contact type.

Document staffings using the Case Notes window designated as Staffing type.

Revision History:
DES(07-2006)

Previous / Next

6-13

Legal Basis: Not applicable

Rules: R6-5-49

Revision History:
DES(07-2006)

Chapter 6 Section 13:

Providing CPS Child Care Services for Children in Out of Home Care

Legal Basis

Policy: The department may provide CPS child care services as a support service for out-of-home family foster care providers up to a maximum of 23 days per month per child through the Child Care Administration (CAA).

Birth and/or adopted children of family foster care providers are not eligible for CPS child care.

CPS child care may be provided to children in out-of-home care for the following purposes:

- to enable an out-of-home care provider to work;
- to enable an out-of-home care provider to participate in educational activities;
- to enable an out-of-home care provider to attend medical, dental or behavioral health appointments, case plan staffings, administrative case reviews, court and FCRB hearings or participate in activities associated with visitation with another foster child;
- to enable the out-of-home care provider to handle an emergency situation such as death, medical emergency, or family or personal crisis, or
- to enable the child to participate in socialization and/or specific skills development in cognitive, social or psycho-motor areas.

To determine whether to offer CPS child care services to out-of-home family foster care providers, consider these questions:

- Are the providers employed or participating in educational services?
- Are the providers attending medical appointments, case plan staffings, court and FCRB hearings, administrative case reviews, or participating in activities associated with visitation with another foster child?
- Does the foster child have documented needs that require socialization and/or specific skills development in cognitive, social or psycho-motor areas?
- Do the providers require emergency services to cope with situations such as a death, medical emergency, family crisis or personal crisis?

Implementation and Procedure Guide

Have the out-of-home family foster care provider consult with Child Care Resource and Referral (CCR&R), 1-800-308-9000 to identify a child care provider and verify that an identified provider has a current DES registration agreement and has a vacancy for the child.

Have the family foster care provider determine whether the child care provider is able to meet the identified social, medical or behavioral needs of the child.

Obtain supervisory approval to request CPS child care services using the CPS Child Care Referral, CC-224, and submit the request to the local office of the DES Child Care Administration for authorization. Request CPS child care for a period **not to exceed six months**. In an emergency, contact the local Child Care Administration (CCA) office, indicate immediate need, and send the completed form within two working days of the contact.

Do not contact the child care providers to authorize payment for child care; the CCA will contact the child care providers to authorize payment.

Review the need for continued CPS child care services **at least every six months** during the case plan staffing.

Obtain supervisor approval prior to requesting a **second six month period** of child care services.

When requesting a third referral for child care services **within a 24 month period**, in addition to the above two steps, obtain approval of the Program Manager or designee. Send an E-Mail of explanation to the Program Manager or designee. Include this E-mail approval with the CPS Child Care Referral, CC-224.

A new CPS Child Care Referral, CC-224 must be submitted to:

- initiate a change in provider;
- indicate any change in hours to be authorized; and
- request that child care services be reauthorized.

Notify and update the licensing agency when a foster parent is using CPS child care services.

DOCUMENTATION :

Document the request for child care services, changes in the provider, and the end date of those services on the CPS Child Care Referral , CC-224. File a copy in the child's hard copy record.

Document the need for and use of child care services in the child's case record using the Case Notes window designated as Collateral Contact type.

Specify use of child care services in the child's case plan using the Case Plan Tasks window.

Document request for program manager or designee approval of a third referral within a 24 month period using the Case Notes window designated as Management Contact type.

Program Manager or designee:

Document approval of a third referral **within a 24 month period** using the Case Note Comment window.

Revision History:
DES(07-2006)

Previous / Next

6-14

Legal Basis: ARS §8-515.05(A) requires the department to inform a licensed foster parent, excluding a shelter care provider or receiving foster parent, of the reasons for removing a child from a licensed foster parent and placing the child in another foster care placement, unless the removal is for the following:

- protect the child from harm or risk of harm;
- place the child in a permanent placement;
- reunite the child with siblings;
- place the child in a kinship foster home;
- place the child in the least restrictive setting or in a therapeutic setting; or
- place the child in accordance with the Indian Child Welfare Act (ICWA).

ARS §8-515.05(B) requires the department to convene a case conference to review the reasons for the removal of a child if the licensed foster parent disagrees with the removal. The licensed foster parent and two members of the Foster Care Review Board (FCRB) who participate in a Removal Review Team shall participate in the case conference. A child shall not be removed unless a majority of the members of the review team agree that removal is necessary.

ARS § 8-515.05(C) requires the department to hold the case conference within 72 hours, excluding weekends and holidays, of being informed of the licensed foster parent's disagreement with the removal. The department must inform the licensed foster parent and the FCRB of the time, date and location of the case conference.

ARS §8-515.05(D) requires one of the following to occur if, as a result of the case conference, the department intends to move the child and the foster parent continues to disagree:

- If the child is in the court ordered physical custody of the licensed foster parent, the Foster Care Review Board members must make a recommendation to the court regarding the removal of the child prior to the change of physical custody; (The child shall remain in the placement pending court order for change of placement.) or
- If the child is not in the physical custody of the licensed foster parent, the department must advise the foster parent of the conflict resolution process and expedite the process. The child shall remain in the placement pending the outcome of the conflict resolution process.

Rules: Not applicable

Revision History:

DES(07-2006)

Chapter 6 Section 14

Supporting Placement Stability and Arranging for Changes in Placement

Legal Basis

Policy: The department will promote stability for children in out-of-home care by minimizing placement moves and, when moves are necessary, by providing services to make placement changes successful for the child.

Every child in out-of-home care shall have an individualized Out-of-Home Care Plan. Refer to Developing the Out of Home Care Plan, (Chapter 9, Section 6).

Children in out-of-home care shall be provided current information about matters affecting the child, and provide children and out-of-home care providers an opportunity to share their thoughts and feelings regarding those matters.

The CPS Specialist shall provide caregivers with up to date information about all matters affecting the child and ensure that caregivers are given adequate notice to attend hearings, staffings and case conferences.

For children in out-of home placement, a change in placement shall be made only after the CPS Specialist and supervisor have a case conference with the out-of-home provider and the child (if appropriate) unless an emergency situation exists. Whenever possible, the case conference shall be held **at least 14 days** prior to the date of the child's move and in person.

When the licensed foster parent, excluding a shelter care provider or receiving foster home provider, *disagrees* with the plan to move the child, the CPS Specialist shall inform the foster parent that they have 24 hours to request a Foster Home Transition Conference to review the reasons for the change of placement. Inform the foster parent that the foster parent is *not* entitled to a Foster Home Transition Conference when the change of placement is for one of the following reasons:

- protect the child from harm or risk of harm;
- place the child in a permanent placement;
- reunite the child with siblings;
- place the child in a least restrictive setting or in a therapeutic setting; or
- place the child in accordance with Indian Child Welfare Act (ICWA).

The change of placement shall be made only after completion of the Foster Home Transition process unless removal is necessary to protect the child from harm or risk of harm.

The CPS Specialist, the CPS Specialist's supervisor, the licensed foster parent, and two members

of the FCRB who participate in a Removal Review Team, at minimum, shall participate in the Foster Home Transition Conference.

The department shall hold the Foster Home Transition Conference **within 72 hours**, excluding weekends and holidays, of being informed of the licensed foster parent's disagreement with the change of placement.

The child shall remain in the foster home if the majority of the Foster Home Transition Conference participants disagree with the plan to move the child.

If the child is not in the court ordered physical custody of the licensed foster parent and if, as a result of the Foster Home Transition Conference, the majority of the participants agree with the plan to move the child and the foster parent continues to disagree with the plan, the department shall advise the foster parent of the conflict resolution process. The child shall remain in the foster home pending a final decision from the conflict resolution process.

Any time a child is in the court ordered physical custody of the licensed foster parent, the department shall initiate a change in physical custody when moving a child. The child shall remain in the foster home pending a court order for change of physical custody.

The department shall expedite the conflict resolution process to make the final decision when a licensed foster parent continues to disagree with the plan to remove a foster child from a licensed foster home and to place the child in another licensed foster care placement following the Foster Home Transition Conference.

Parents and all interested parties shall be notified if a change in placement is considered.

For a Native American child, the child's tribe shall be notified and the order of placement preference shall be followed, in accordance with the requirements of the Indian Child Welfare Act, whatever a change in placement is considered. (25 U.S.C.§1901 et seq.)

With support services, can this placement?

- ensure the child's safety
- offer permanency
- care for the child and siblings if appropriate

Is the current placement?

- a kinship foster care provider
- is it the least restrictive placement the child needs
- is it in accordance with the Indian Child Welfare Act (ICWA)

To determine whether a child should be moved from an out-of-home placement to another placement, consider the following questions:

§ Did the out-of-home provider request the placement change? If so, explore with the caregiver why this placement change is being requested; what is the caregiver experiencing that has led them to conclude that he or she should no longer care for the child?
§ Is the caregiver willing and able to continue caring for the child with additional support services?
§ Is the out-of-home caregiver aware of and completing the tasks in the Out-of-Home Care Plan assigned to the caregiver? If not, why not? Does the caregiver agree with the plan? Are they unable to carry out their responsibilities?
§ If the out-of-home caregiver disagrees with the case plan goal, is the caregiver able and willing to support the goal?

When determining whether emergency intervention requiring removal is necessary to protect the child from imminent harm or risk of harm, refer to Providing Emergency Intervention (Chapter 3, Section 2)

Is the purpose of the removal to place the child in a permanent placement?

- In this instance the new caregiver is committed to caring for the child permanently. The new placement will probably result in dismissal of the dependency.

Is the purpose of the removal to reunite the child with siblings?

- The new foster care provider can meet the needs of the siblings.
- The placement of the siblings together is not harmful to the health and safety of any of the siblings.

Is the purpose of the removal to place the child in a kinship foster home?

§ The prospective kinship caregiver meets the department's criteria for approval as a kinship foster parent.
§ The assessment of the kinship foster parent indicates that the kinship foster parent can meet the health, safety and all other placement needs of the child.
§ The court has approved the child's placement with the kinship foster parent.

Is the purpose of the removal to place the child in a less restrictive setting?

- The child is able to function in a regular foster home which is the most family-like setting

and the planned move is from a professional, therapeutic/special foster home to a regular foster home.

Is the purpose of the removal to place the child in a therapeutic setting?

- The child requires a higher level of care than is being provided by current foster parents and the child's assessed needs require placement in a therapeutic or professional foster home, or in a group home, or therapeutic group care placement, or in a residential treatment center.

Is the purpose of the removal to place the child in accordance with the Indian Child Welfare Act (ICWA)? The order of placement preferences is:

- with a member of the child's extended family (including members of the child's tribe);
- in a foster home licensed, approved or specified by the child's tribe;
- in an Indian foster home licensed or approved by an authorized non-Indian licensing authority;
- in an institution approved by the Indian tribe, or operated by an Indian organization which has a program suitable to meet the Indian child's needs.

If the removal is not for any of the above circumstances, what services can be provided to the child or out-of-home care provider to prevent the move and stabilize the placement?

Implementation and Procedures Guide

To support placement stability, during face-to-face and telephone contacts, provide children in out-of-home care and out-of-home care providers current information about matters affecting the child, and provide children and out-of-home care providers an opportunity to share their thoughts and feelings regarding those matters.

BEST PRACTICE TIP
Children need to have age appropriate conversations about what is happening in their lives. Children in care tell us that one of the most difficult things about being in care—other than being away from their family—is not knowing what is happening in their lives. They feel as if they have no control over anything, and that what they do or say does not really matter. The more children are involved in planning for their own lives, the less they feel helpless and out of control. “Nothing About Me Without Me”!

Ensure that all requirements of the court are met.

For a Native American child, whenever a change in placement is considered, the child's tribe shall be notified and the order of placement preference shall be followed in accordance with the requirements of the Indian Child Welfare Act. (25 U.S.C.§1901 et seq.)

Ensure that the case is reviewed **every six months**, either by the Foster Care Review Board or

through the Department's Administrative Review procedures. (P.L. 96-272). Participate in the review and provide information and recommendations, as requested.

Unless an emergency situation exists, whenever possible, hold a case conference at **least 14 days prior** to a planned move, attended by the CPS Specialist, supervisor and out-of-home care provider and child (when appropriate) to:

- Inform the out-of-home care provider of the intent to move the child, if the provider did not request the placement change; (If possible tell the care provider prior to the case conference, so that they have a chance to prepare).
- Discuss the reason a placement change is being considered.
- For unplanned placement changes, discuss options to prevent the necessity of a placement change, including:
    - provision of CPS child care services;
    - provision of respite care; and
    - provision of other support services or specialized training for the out-of-home care provider.

BEST PRACTICE TIP
The voice of the foster parent should be considered critical to decision making about the child. The foster parent should be involved in decisions about the child's placement unless there are safety concerns. When a foster parent is informed and part of the process, they are able to help the child make a healthy and successful transition to a new home. They are able to respond to questions and actively interact with the new caregiver about the needs of the child. It is important to provide the family time for them to adjust to the child moving, to grieve and to process with the child the emotions associated with the child leaving. When children and foster parents have bonded, they need an opportunity to stay connected after the child leaves the foster home when it is in the child's best interest.

The conference should be held in person, whenever possible, but can also be by telephone. This case conference is not necessary if a case plan staffing was conducted that included the out-of-home provider and the planned placement change was agreed to and documented in the case plan.

BEST PRACTICE TIP:
Often placements fail due to the lack of support foster families receive. The CPS Specialist and foster family need to be partners and communicate with one another frequently about the progress of the child in care and the interactions that the resource family is having with the child's birth family. When the CPS Specialist and foster family work as partners, the child and their family is best served. Additionally, CPS Specialist will gain a support system in planning for and managing visitation, school and medical visits. When the CPS Specialist values the voice of the foster parent, the CPS Specialist is enhancing the permanency planning process for the child and diminishing the chance of disruption.

All children who change placements require a transition plan. If the current out-of-home care provider disagrees with the recommendation to move the child as a result of the case conference, do not start transition planning until final resolution on the child's placement has occurred,

otherwise proceed with transition planning.

Transition Planning

In developing a transition plan include:

- § notification to the parent and all interested parties that a change in placement is planned;
- § communication between the current and proposed caregivers before, during and after the placement change;
- § visitation (pre-placement) between the child and proposed caregivers;
- § continuing connections between the child and the current caregivers after the placement change, if appropriate;
- § providing support services to the child, current caregivers, and/or proposed caregivers during the transition period;
- § establishing transition period timeframes;
- § preparing the child and foster parent using available support services and strategies to reduce the trauma to the child and the provider; and
- § ensuring the transfer of all belongings to protect the child from additional losses.

Include both the existing and the new caregivers in developing the transition plan when possible.

As part of the planning process, obtain the following items from the current provider:

- § the complete child's Placement Packet;
- § the child's CMDP card; and
- § the child's clothing and other personal items.

Request that the existing foster parent complete the Foster Parent Wrap-Up, FC12900 (FC-129) from the child's Placement Packet.

Review the Child Placement Summary/Agreement, FC01100 (FC-011), Agreement section, to determine whether the existing provider no longer wishes to receive copies of the CPS Specialist's written reports to the court, and to maintain contact with the child.

Consult with schools regarding education and special education services and needs prior to moving the child.

Prepare reports to the juvenile court, as required.

Update special education vouchers for a child placed in a group care/residential facility.

Any time a child is in the court ordered physical custody of the licensed foster parent, the department shall initiate a motion for change in physical custody before moving a child. The child shall remain in the foster home pending a court order for change of physical custody.

If the licensed foster parent, excluding a shelter care provider or receiving foster home provider, **disagrees** with the plan to move the child, inform the foster parent of the **24 hour time frame** to request a Foster Home Transition Case Conference to review the reasons for the change of placement. Inform the foster parent that the foster parent is not entitled to a Foster Home Transition Case Conference when the change of placement is for one of the following reasons:

- protect the child from harm or risk of harm;
- place the child in a permanent placement;
- reunite the child with siblings;.
- place the child in a least restrictive setting or in a therapeutic setting; or
- place the child in accordance with Indian Child Welfare Act (ICWA)

Ensure the foster parent has the name and telephone number of the supervisor.

The department shall inform the licensed foster parent and the FCRB of the time, date and location of the Foster Home Transition Conference.

If the licensed foster parent disagrees with the removal, inform the new foster care provider that the placement of the child is on hold until the Foster Home Transition Conference occurs.

CPS Supervisor

Be available or make arrangements for another professional staff person to be available for contact by the licensed foster parent in the supervisor's absence.

If the foster parent disagrees with the plan to remove the child, **immediately** inform the FCRB Removal Review Team Program Specialist of the foster parent's disagreement. Provide the foster parent's name, the child's name (case name), and the physical custody status of the child to the FCRB Program Specialist.

Schedule the Foster Home Transition case conference to occur **within 72 hours**, excluding weekends and holidays, of the foster parent's notification of disagreement. Set a date, time, and place agreeable to the CPS Specialist, the foster parent and the two FCRB Removal Review Team volunteers.

If the FCRB Removal Review Team volunteers request to participate in the case conference by telephone, obtain the name and phone number of the volunteers from the FCRB Program Specialist.

Inform the foster parent of the date, time and place of the Foster Home Transition Case Conference.

Other qualified professionals/persons may be invited to participate during all or part of the Foster Home Transition Case Conference.

A foster child age 12 or older may participate, if appropriate.

Foster Home Transition Conference

Convene the Foster Home Transition Conference even if the FCRB cannot provide two members to participate, proceed with the conference. With the participants, identify the reason for the planned move to another foster care placement and review the circumstances that resulted in the decision to remove the child.

At the conclusion of the Foster Home Transition Conference, determine whether the majority of the participants agree that the change in placement is necessary

Following the Foster Home Transition Conference:

- The child shall remain in the foster home if the majority of the Conference participants disagree with the plan to move the child.
- If the child is in the court ordered physical custody of the licensed foster parent, initiate a change in physical custody if as a result of a conference, the majority of the conference participants agree with the plan to move the child. The child shall remain in the foster home pending a court order for change of physical custody.
- If the child is not in the court ordered physical custody of the licensed foster parent and if, as a result of the conference, the majority of the participants agree with the plan to move the child and ***the foster parent continues to disagree with the plan, advise the foster parent of the Conflict Resolution Conference process.*** The child shall remain in the foster home pending a final decision from the Expedited Conflict Resolution Process.

Expedited Conflict Resolution Conference

The Expedited Conflict Resolution Conference is to occur within three working days after the Foster Home Transition Conference. At a minimum the licensed foster parent, CPS Specialist, the supervisor, and the District Program Manager or other management level designee shall participate in the Expedited Conflict Resolution Conference. The Expedited Conflict Resolution Conference may be held in person or by telephone at a time and place mutually agreed upon.

Other individuals may attend if they agree to maintain confidentiality and sign a Confidentiality Agreement (FW-254).

With the participants, identify the reason for the planned removal and the outcome of the Foster

Home Transition Conference including the recommendations of the Foster Home Transition Conference participants.

If the Foster Home Transition Conference included the participants required by the Conflict Resolution Conference, a Conflict Resolution Conference is not necessary.

If at the conclusion of the Conflict Resolution Conference, the plan to remove the child continues and the foster parent continues to disagree, immediately provide and assist the foster parent with the completion of the Client Complaint/Grievance, ACY-1095A and expedite the Formal Grievance process.

The CPS Supervisor should notify the Foster Care Review Board Program Specialist of the final outcome of the conflict resolution process, if applicable.

CPS Specialist

If the final decision is to move the child:

- Unless there are extenuating circumstances, meet the child and the foster parent **within three working days** to develop a placement transition plan as previously outlined in ***Transition Planning*** in this section.
- Transfer the updated child's Placement Packet and the CMDP to the new provider.
- Transfer the child's clothing and the child's other personal items to the new provider.

BEST PRACTICE TIP
When a child is moving from one caregiver to another and it is not an emergency situation, the CPS Specialist should arrange for the child to meet the new caregiver prior to the child moving into their home. This will ease the fears of the child and allow the child to have some control.

When a child has a strong relationship with an existing caregiver and he/she is leaving that caregiver, the child will experience loss. Part of this loss can be alleviated by encouraging the former caregiver and the child to schedule phone calls, share e-mails or visit with one another in the near future when in the child's best interest.

DOCUMENTATION :

When a child is moved from one placement to another, complete the following **within two days**:

- If the child is moved from a paid placement to another paid placement, update the Service Stop Date and enter the Termination Reason on the Provider Service

Authorization window for the current provider, according to district procedures.

- Update the Service Authorization Provider Match window for the new provider.
- If the child is removed from an unlicensed kinship foster care home or significant person and there are no other children placed in the home, end date the Provider Service of URE in Provider Management.
- Update all placement related windows including the Placement/ Location Detail window if the child is placed in an unpaid placement such as hospitalization, runaway, or detention.

Update the legal status, and removal status on the Removal Status window and Legal Status window, if applicable.

Update information in the following windows: Special Needs Detail, Medical/Dental Condition, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Participant Education Condition, Participant Education Detail, Hospitalization Detail, and Child Assessment and Special Rate Evaluation and print a new Medical Summary Report.

Update the child's Placement Packet in CHILDS and print a new Placement Packet.

If the child is moved to the home of a parent:

- Enter the Removal End Date and the Removal End Reason of Reunification on the Removal Status window.
- Update the Placement/Location Detail window.
- Obtain income and resource information from the parent and enter it on the Income Detail window.
- Inform the parent that he or she will either receive notification from AHCCCS to enroll the eligible child into an AHCCCS Health Plan or that he or she will receive notification of discontinued eligibility from the DCYF Eligibility Unit.
- Provide significant information and copies of the child's medical and education records to the parent.

Document the services provided to support the child in out-of-home care and the out-of-home care provider's ability to meet the child's needs using the Out-of-Home Care Plan component of the written Case Plan.

Document discussions with the supervisor regarding the decision to move the child to another foster care placement including:

- the reason for intended removal of the child from the foster home;
- information on the date, time and method used to inform the foster parent of the plan to move the child (include the time frame by which the foster parent must inform the supervisor of the foster parent’s disagreement with the plan);

- the foster parent's agreement or disagreement with the plan to move the child; and
- the outcome of the conversation with the foster parent.

File documentation of Foster Care Review Board reports, Department Initiated Administrative Reviews, or court reviews in the hard copy record. Document participation in these reviews using the Case Notes window, Court Hearing type. Update the review date information using the Hearing Documentation window.

Document the case conference to review the change in placement and the transition plan using the Case Notes window, designated as Case Conference Type.

Document the placement transition plan developed during a case plan staffing in the Out-of-Home Care component of the case plan.

Document the reasons for any placement changes using Case Notes window and in the Addendum Report to the Juvenile Court attached to the Motion for Change of Physical Custody, and/or the next Progress Report to the Court for Permanency Hearing following the placement change.

File a copy of the Client Complaint Grievance, ACY-1095A, if applicable, in the case record.

File forms from the previous provider in the hard copy record.

Update CHILDS to reflect the change in placement and any changes in the placement needs of the child.

File forms from the previous provider in the hard copy record.

The CPS Supervisor*:*

Document the outcome of the Foster Home Transition Case Conference using the Case Notes window, designated as Case Conference type.

Document the outcome of the conflict resolution process, if applicable, using the Case Notes window, designated as Key Issues type.

Using the Case Notes window, document the following:

- contact, if any made with the foster parent regarding the foster parent
- agreement or disagreement with the plan to move the child;
- notification of the FCRB Removal Review Program Specialist;

- date, time and place of the Foster Home Transition case conference;
- outcome of the Foster Home Transition case conference;
- date, time and place of the Expedited Conflict Resolution Conference (if applicable); and
- outcome of the conflict resolution process.

For More Information: On providing services to children in out-of-home care and their out-of-home care providers, see Developing the Out-of-Home Care Plan, Health Care Plan, Contact and Visitation Plan (Chapter 9 Section 5).

For More Information: On providing supervision to children in out-of-home care and their out-of-home care providers, see Providing Supervision of Children in Out-of-Home Care (Chapter 6 Section 8).

For More Information: See the CHILDS Guide for Field Users, "Provider Module", in Public Folders for information on closing unlicensed care providers.

For More Information: On filing a motion for change in physical custody, see Preparing Court Reports for CPS Cases (Chapter 20, Section 6).

Revision History:
DES(07-2006)

Previous / Next

6-15

Legal Basis: A.R.S. §15-716 requires each school district to provide instruction on acquired immune deficiency syndrome and the human immunodeficiency virus that includes the promotion of abstinence.

Rules: Sections R6-5-5801 et. seq. of the Arizona Administrative Code addresses the requirements, training and expectation of an applicant for foster family licensing.

Sections R6-5-7401 et. seq. of the Arizona Administrative Code addresses the requirements of residential group care facility and outdoor experience programs.

Revision History:
DES(07-2006)

Chapter 6: Section 15

Providing Child Sexual Development Education

Legal Basis

Policy: CPS Specialists and out-of-home caregivers share with the schools the responsibility of educating and preparing children in out-of-home care to function as self sufficient, competent adults.

CPS Specialists and caregivers, in collaboration with the child's own parents, schools, public health and community agencies, provide education and training concerning sexual development and sexuality to children in out-of-home care.

Sexual development and sexuality learning programs for children must be appropriate to the age and development level of the children. The programs should include:

- Personal and family values regarding sexuality;
- Religious and cultural issues regarding sexuality;
- Self-respect and its relationship to sexual behaviors and character development;
- Physiological information;
- Personal hygiene related to sexuality;
- Long-term and permanent relationships with partners, spouses and friends;
- Family planning information including abstinence;
- Sexually transmitted diseases (STDs), including HIV/AIDS; and
- Recognizing, preventing and avoiding sexual abuse and the impact of sexual abuse and other sexual victimization on sexual development.

CPS Specialists will facilitate the provision of appropriate medical, counseling, psychological or psychiatric services, including human sexuality and family planning information emphasizing abstinence, to children who are wards of the court, committed to the care, custody and control of the department.

Tasks related to human sexuality and sexual development education, and family planning, emphasizing abstinence, will be included in the case plans of children receiving independent living skills preparation services.

Implementation and Procedures Guide

Ensure children are provided comprehensive sexual development and sexuality education, emphasizing abstinence, through the child's school, by a community agency, or by the child's out-of-home care-provider.

Assist the caregiver in finding child development information appropriate for the children in their care. Some agencies with resources to provide children with appropriate medical, educational, and mental health services related to sexuality can be located by contacting CMDP, Department of Health Services (DHS) - Women and Children's Health, DHS Behavioral Health Services, RBHA's, schools, community organizations, and the Arizona Prevention Resource Center, at 1-800-432-2772.

Assist the caregiver in recognizing the difference between normal sexual developmental issues and sexual developmental issues of children who have been sexually abused.

Ensure the caregiver of teens receiving independent living skills preparation services are aware of the tasks included in the foster child's case plan that concern human sexuality, sexual development, and family planning emphasizing abstinence.

Revision History:
DES(07-2006)

Previous / Next

6-16

Legal Basis: Title XIX of the federal Social Security Act specifies that family planning and pregnancy related services are mandatory categories of covered medical services.

A.R.S. §8-512 directs the department to provide comprehensive medical and dental care for dependent children.

A.R.S. §36-2904(N) requires that the Comprehensive Medical and Dental Plan (CMDP) provide written notification to children of reproductive age, either directly or through the parent or legal guardian, of the specific covered family planning services available to them and a plan to deliver those services upon the member's request.

A.R.S. §36-2907(A)(9) addresses family planning service delivery by an AHCCCS medical provider.

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 6 Section 16

Providing Family Planning Services

Legal Basis

Policy: The department shall assure that appropriate medical, counseling, psychological and/or psychiatric services, including human sexuality and family planning information emphasizing abstinence, are provided to children who are wards of the court, committed to the care, custody and control of the department.

Tasks related to human sexuality, sexual development, and family planning, emphasizing abstinence, will be included in the case plans of children receiving independent living skills preparation services.

The department supports the promotion of abstinence.

To determine whether involvement of the child's parents in family planning decisions is appropriate, consider these questions:

- Are the whereabouts of the parents known?
- Are the parents involved in the case?
- Does the child oppose the involvement of the parents?
- What is the nature of the parent-child relationship?
- Are the parents supportive of the child?
- Would involvement of the parents endanger the child's safety or welfare?
- What is their legal relationship to the child? Has there been a Termination of Parental Rights (TPR) on either parent?

Implementation and Procedures Guide

Encourage the caregiver to participate in discussions on family planning, including abstinence, with foster children age 12 and over. In their role of primary caregivers of foster children, caregivers should be involved in the provision of family planning information emphasizing abstinence to their foster children. Caregivers are encouraged to seek community, public

education, and health information programs available to all parents.

Caregivers are expected to participate with the CPS Specialist in the review and discussion of CMDP's written family planning information to foster children, ages 12 and older.

If a caregiver is opposed to the provision of family planning information to a child age 12 or older, the caregiver should inform their licensing specialist/agency and the CPS Specialist before they agree to the placement of a child age 12 or over in their home.

Ensure information and services are provided by using the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22) as a guide.

Provide, arrange or confirm that the child receives information on abstinence from the Department of Health Services, school based education programs, or other community resources.

Provide CMDP's written family planning information to all children in out-of-home care, ages 12 and older, within ten days of initial placement and annually thereafter. Review the services presented in CMDP's Family Planning Services Notice (CMD-078) with the child and the out-of-home care provider during face-to-face contacts.

***For a child age 12 or older requesting family planning services*:**

- § Discuss with the child who the child wants to know about the request and who the child wants to participate in the child's decision making on family planning services;
- § Arrange an appointment with, or refer the child to, a CMDP-registered health care provider;
- § If needed, consult with the CMDP Maternal/Child nurse to obtain a list of CMDP-registered health care providers.

Assure that services are provided:

- § In a manner free from coercion or mental pressure and in a manner which assures continuity of care and confidentiality;
- § With reasonable promptness by a qualified health professional;
- § By providers that inform the child about a variety of family planning methods to enable the child to make an informed decision.

DOCUMENTATION :

When a parent's rights have not been terminated and his or her whereabouts is known, document

a decision not to involve the parent in family planning decisions, and the reason for the decision using the Case Notes window, designated as Key Issues type.

Document the review of CMDP family planning services information using the Case Notes window, designated as Child Contact type.

Document the referral and arrangement for family planning services using the Case Notes window.

Revision History:
DES(07-2006)

Previous / Next

6-17

Legal Basis: Title XIX of the federal Social Security Act specifies that family planning and pregnancy related services are mandatory categories of covered medical services.

A.R.S. §8-512 directs the department to provide comprehensive medical and dental care for dependent children.

A.R.S. §13-1405 prohibits sexual conduct between a minor and an adult. If the minor is under 15 years old, the sexual conduct is a class 2 felony. If the minor is at least 15 years old, the sexual conduct is a class 6 felony.

Rules: Section R6-5-6005 of the Arizona Administrative Code addresses the medical services covered by CMDP including pregnancy care.

Revision History:
DES(07-2006)

Chapter 6 Section 17

Providing Pregnancy Care Services

Legal Basis

Policy: Meeting the health needs of children is a responsibility shared among parents, CPS Specialists, out-of-home care providers and medical providers under the Comprehensive Medical and Dental Care Program (CMDP).

Assessments or counseling provided to a pregnant child will be non-directive, neutral and will include the options of parenting the infant, planning for adoption or legal guardianship, temporary alternative care of the infant, or termination of the pregnancy.

The department shall include the parents of the pregnant child in the provision of services and consideration of options in relation to the confirmed pregnancy when agreed upon by the child and determined to be in the child's best interests.

The alleged father of the infant should be involved in decision-making and counseling, when appropriate.

1. Services to a Child Who Believes She Is Pregnant

To determine whether involvement of the child's parents in pregnancy care decisions is appropriate, consider these questions:

- Are the whereabouts of the parents known?
- Are the parents involved in the case?
- Does the child oppose the involvement of the parents?
- What is the nature of the parent-child relationship?
- Are the parents supportive of the child?
- Would involvement of the parents endanger the child's safety or welfare?
- What is their legal relationship to the child? Has there been a Termination of Parental Rights (TPR) on either parent?

Implementation and Procedures Guide

Ensure information and services are provided by using the Providing Pregnancy Care Services section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22).

Prior to arranging a medical examination to confirm the pregnancy, discuss with the child:

- Does the out-of-home care provider know that the child believes she is pregnant?
  - If not, assist the child to inform the out-of-home care provider of her possible pregnancy.
  - If yes, does the child feel comfortable with the out-of-home care provider's involvement in arrangements for services?

- Involvement of the child's parents in pregnancy care decisions.
- Does the child have a support person, such as a CASA, Special Friend, or a religious or spiritual advisor with whom she would like to speak?
- Who should be informed about the potential pregnancy?
- Who would she like to accompany her to the medical appointment?
- Which medical provider will be used?
- Who will make the appointment with the medical provider?
- What transportation arrangements are needed to get to the appointment?

Refer or arrange for a medical examination to confirm the pregnancy using a CMDP-registered health care provider or a provider registered with the child's AHCCCS health plan. Arrange the medical examination to occur no more than five work days from notification of the possible pregnancy.

If the child is not pregnant, refer or arrange for her to receive family planning information and consultation using:

- Information on abstinence from the Department of Health Services, school based education programs, or other community resources; and
- A CMDP-registered health care provider; or
- A provider registered with her AHCCCS health plan.

Discuss with the child:

- Does she agree with the out-of-home care provider's involvement in the arrangements for the medical appointment?

§ Does she want someone to go to the family planning appointment with her and if so, who?
§ What transportation arrangements are needed to get to the appointment?

If the relationship with the alleged father is against the law or if the pregnancy is or may be due to rape or incest, confirm with the out-of-home care provider that law enforcement has been notified. It is acceptable, and may be preferable, for the out-of-home care provider to notify law enforcement if the out-of-home care provider has first hand knowledge of the child's relationship with the alleged father. If a report has been filed, obtain the report number. If law enforcement declines to take a report, document the date and time law enforcement was notified. If a report has not been filed, notify law enforcement or ensure the out-of-home care provider does so within 24 hours of being notified of the possible pregnancy.

2. Services to a Child Whose Pregnancy Is Confirmed

To determine whether involvement of the alleged father in planning for the unborn infant is appropriate, consider these questions:

§ What is the nature of the relationship between the alleged father and the pregnant child?
§ Did the relationship violate state law due to differences in ages or other factors?
§ Is the pregnant child willing and able to identify and contact the alleged father?
§ Would involvement of the alleged father endanger the pregnant child's safety or welfare?

Implementation and Procedures Guide

Ensure information and services are provided by using the Services to a Child Whose Pregnancy Is Confirmed section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22).

The Caregiver Must:
If the examination confirms that the foster child is pregnant, and the caregiver is aware of the results of the examination, it is the responsibility of the caregiver, notify the CPS Specialist within one work day, unless the CPS Specialist is already aware of the results.

Caregivers must decide whether their foster child's pregnancy and the decisions she will make regarding her pregnancy will impact their willingness and ability to continue caring for her. Regardless of her decision, the out-of-home care provider must not verbally abuse, threaten or make humiliating comments, unreasonably deny privileges, contact and visitation, or isolate the child. These are Discipline Policy infractions.

The CPS Specialist Must:
Within one work day of the pregnancy confirmation, notify the CMDP Maternal/Child nurse.

Hold a case consultation with the supervisor within five work days to discuss who should participate in planning services needed by the child.

Following the case consultation between the CPS Specialist and the supervisor, discuss with the child who are the individuals she believes must be made aware of her pregnancy. Also discuss other potential service team members (such as a CASA, Special Friend, or religious or spiritual advisor) whom the child wants to be made aware of her pregnancy and who should be asked to participate in a case conference.

BEST PRACTICE:
A child, who is pregnant and in out of home care, must have a strong support system on which to rely. If the child's family is not actively involved, the child should be encouraged to have at least one person to whom she can speak freely about the pregnancy and her feelings about the decision that she has to make. The child should never be made to feel guilty about the pregnancy or pressured into doing what others around her "think she should do". It is her decision and she needs to have a caring, objective person in her life helping her to decide what is right for her.

Hold a case conference **within 10 days** of the pregnancy confirmation to determine the roles and responsibilities of the participating service team members as to what, by whom and how medical, counseling and any other needed services will be provided to the child to assist her in making decisions. The case conference will include the CPS Specialist and supervisor, the child's guardian ad litem (GAL), attorney and the caregiver. Include other service team members and parties, such as the child's parents, as appropriate and after considering the wishes of the child. In most instances, unless it is clearly not appropriate, include the child in the case conference.

At least two work days prior to the case conference, contact the assigned Assistant Attorney General to notify of the confirmed pregnancy and other significant information.

No more than five work days after the case conference, arrange non-directive, neutral assessment or counseling for the child through the RBHA or with an ACYF contracted counselor,

if she is not already seeing a counselor. The purpose of the counseling is to provide information on the options, which include parenting the infant, planning for adoption or legal guardianship, temporary care of the infant by family or non-relatives, or termination of the pregnancy.

Assist the child in scheduling counseling and arranging transportation to this appointment.

Determine whether the out-of-home care provider or another support person will participate in the counseling when agreed upon by the child.

Inform the child that medical assistance and other benefits and services may be available for her and her child through the Department of Economic Security and other organizations. These may include TANF, child support, child care, and WIC.

Obtain all known identifying information on any alleged father and assist the child to confirm the identity of the biological father. Inform the child of the father's financial liability for the infant.

Keep out-of-home care providers fully informed of the services being offered to the child.

Involve the child's parents and the alleged father of the infant in the counseling sessions when agreed upon by the child and determined to be in the child's best interest.

3. Services Provided When the Child Will Carry the Pregnancy to Term

Implementation and Procedures Guide

The Caregiver Should:
Review with the CPS Specialist and medical providers the child's medical and health condition, any other prenatal medical, nutritional and emotional needs, and any health or safety issues, such as substance abuse concerns. Each party shares the responsibility of assuring that the child receives early and consistent medical care.

Take the child or arrange transportation for her to medical and other appointments.

Encourage and assist the child to participate in parenting instruction if she plans to parent her infant.

The CPS Specialist Must:
Ensure information and services are provided by using the Services Provided When the Child Will Carry the Pregnancy to Term section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22) as a guide.

Within five work days, update the CMDP Maternal/Child nurse regarding the child's decision.

Within ten work days of learning the child's decision, hold a case conference to further assist the child in understanding the options available; to identify needs such as medical, social, emotional, and educational; and to identify current and future living arrangements. Develop a preliminary plan to address the child's needs. At minimum, the case conference will include the CPS Specialist, the supervisor, the out-of-home care provider, and the child's GAL and attorney. Include other team members and parties, such as the child's parents and significant support persons, such as a Special Friend, or a religious or spiritual advisor, as appropriate and after considering the wishes of the child. When appropriate, include the child in the case conference. The alleged father of the infant may be a participant in this conference when appropriate.

At least two work days prior to the case conference, contact the assigned Assistant Attorney General to notify of the child's decision to carry the pregnancy to term and other significant information.

Ensure the provision of early and consistent medical care through communication with the child's physician and/or out-of-home care provider on medical appointment scheduling and results of all appointments.

Ensure that potential health risks to the unborn child or the pregnant child, such as substance abuse and known health concerns including high risk behaviors and HIV positive or diagnosed AIDS, are fully shared with the child's physician.

Ensure that the out-of-home care provider is fully informed and aware of the medical, health, nutrition, and other prenatal medical and emotional needs of the child and is willing and able to meet her needs.

Assure that transportation to medical and other appointments is arranged.

Encourage participation in parenting instruction for a child who plans to parent her infant, and make arrangements as indicated.

Encourage the pregnant child and the out-of-home care provider to plan for the child's continuing educational needs.

Assist the child to obtain information on medical and other benefits that may be available to her and her child through the Department of Economic Security, Family Assistance Administration. Assist the child to apply for any benefits for which she may be eligible.

Arrange for assessment or counseling related to the pregnancy, as needed.

Discuss with the child the identity of the father of the unborn infant, determine his role in planning for the unborn infant, and his financial responsibility for the child. In all cases where possible, obtain an affidavit of paternity from the father. If the alleged father denies paternity, discuss with the child and the alleged father that a paternity test is needed.

Discuss with the child the role of her parents in planning for the unborn infant.

Fully inform the child of services available from the department and the community to support her ability to parent her child, including temporary care options such as care of the infant by family, in foster care, or through other arrangements.

With the current out-of-home care provider and district designated staff, review placement options available for the placement of the minor parent and her infant together.

4. Services Provided When the Child Decides on a Plan of Adoption For Her Infant

Implementation and Procedures Guide

The Caregiver Should:
Fully support the child in the decision that she has made for herself and her unborn child. The caregiver should transport or arrange transportation for the foster child to adoption planning services, and if she is comfortable with their involvement, participate in the services with her.

The CPS Specialist Must:
Ensure information and services are provided by using the Services Provided When the Child Decides on a Plan of Adoption section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22) as a guide.

Assist the child to arrange adoption planning services provided by department adoption staff or a private adoption agency.

Consult with an adoption unit supervisor, or a supervisor with adoption experience, to obtain the names of private adoption agencies in the child's local area and information on adoption services provided by department staff.

Assist the child to obtain any additional information needed for the child to make an informed choice between the available resources.

Assist the child to obtain information on medical and other benefits that may be available to her and her child through the Department of Economic Security, Family Assistance Administration. Assist the child to apply for any benefits for which she may be eligible.

Involve the child's parents and the alleged father of the infant in the planning when appropriate and in the pregnant child's best interest.

Facilitate involvement of the child's GAL and attorney throughout this process.

5. Services Provided When the Child Decides on a Plan of Legal Guardianship for Her Infant

Legal Basis: A.R.S. §14-5209 provides for the appointment of a guardian for a child through Probate Court.

Implementation and Procedures Guide

The Caregiver Should:
Ensure that the child feels supported in the decision that she has made. These are very emotionally charged times for an adolescent girl and it is critical that the caregiver supports her in achieve her goal. It is also important that the child know that the foster care is available to her and that she can continue to process her decision until the point that it is final.

The CPS Specialist Must:
Ensure information and services are provided by using the Services Provided When the Child Decides on a Plan of Legal Guardianship section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22)

Assist the child to consider the ability of the proposed guardian(s) to provide custodial care.

Inform the child and the proposed guardian(s) of the process for obtaining a legal guardianship for non-dependent children. If needed, consult with an Assistant Attorney General to learn this process.

Consult with a supervisor to determine what steps should be taken to protect the infant, if after the child's birth the mother pursues legal guardianship with a proposed guardian who may be unable to meet the health and safety needs of the infant.

Involve the child's parents and the alleged father of the infant in the planning when agreed upon

by the child and determined to be in the child's best interest.

Facilitate involvement of the child's GAL and attorney throughout this process.

DOCUMENTATION :

Document the pregnancy of the child in the Medical/Dental Condition Detail window using either the condition of "pregnant" or "pregnant teen".

Document all medical examinations of the child in the Examination Detail window.

Document medical information in the Examination Detail, Practitioner Detail, Medical/Dental Condition Detail windows. If needed, document any hospitalization in the Hospitalization Detail window.

Document the pregnancy of the child, the contact with the CMDP nurse, the report to law enforcement, if applicable, and the provision of assessment or counseling using the Pregnancy Care/Family Planning window.

Document if the pregnancy resulted from consensual intercourse, rape, or incest using the Pregnancy Care/Family Planning window.

Document information on all alleged fathers and the confirmed father of the infant, using the Pregnancy Care/Family Planning window. Add the confirmed father as a case participant with a case role type of Father P. Update the Family Relationship window to show the confirmed father's relationship to other participants.

Document the outcome of case conferences using the Case Notes window.

As applicable, document the child's decision to carry the pregnancy to term, the plan for the newborn, the outcome of the pregnancy, the date of the outcome, and the provision of assessment or counseling using the Pregnancy Care/Family Planning window.

As applicable, document the outcome of the pregnancy and the date of the outcome using the Pregnancy Care/Family Planning Window.

If a child refuses medical or assessment services or counseling, document the types of services offered and the child's response to the offers using the Case Notes window designated as the appropriate type.

Revision History:
DES(07-2006)

Previous / Next

6-18

Legal Basis: Title XIX of the federal Social Security Act specifies that family planning and pregnancy related services are mandatory categories of covered medical services. It provides for federal financial participation for certain medically necessary abortions, including pregnancies that result from rape or incest, under the Hyde Amendment. [42 U.S.C. § 1396d (1)-(5) and P. L. 105-78, Section 510 (1997)]

A.R.S. §13-3603.01 prohibits partial-birth abortions unless necessary to save the life of the mother.

A.R.S. §35-196.02 prohibits the use of state funds for the performance of any abortion unless the abortion is necessary to save the life of the woman having the abortion. (Note: Federal Law preempts this state statute if the child is Title XIX eligible and the pregnancy is the result of rape or incest.)

A.R.S. §36-2301 requires a physician to see that all available means and medical skills are used to promote, preserve and maintain the life of a human fetus or embryo that is delivered alive during an abortion procedure.

A.R.S. §36-2301.01 specifies procedures that physicians must follow when an abortion is performed and the fetus is viable, including abortions performed to preserve the life or health of the woman.

A.R.S. §36-2152 requires the written consent of a pregnant unemancipated minor's parents, guardian or conservator unless a judge of the superior court authorizes the physician to perform the abortion.

Rules: R9-22-205(B)(5) of the Arizona Administrative Code excludes AHCCCS coverage for abortions and abortion counseling services, unless authorized under federal or state law.

Sections R6-5-6006 and R6-5-6007 of the Arizona Administrative Code address medical coverage exclusions and prior authorization requirements.

Section R6-5-6012 of the Arizona Administrative Code addresses the consent for treatment by the court for children who are court wards or parental consent for children in voluntary placement.

Revision History:

DES(07-2006)

Chapter 6 Section 18

Providing Services When the Youth in Care Chooses an Abortion

Legal Basis

Policy: Funding for an abortion is allowable under federal and state law when it is medically necessary to save the life of the pregnant child and under federal law when it is necessary due to rape or incest.

Licensed and unlicensed out-of-home care providers may not consent to an abortion for a foster child.

To determine whether an abortion is in the child's best interest, all service team members and involved parties should consider these questions:

- Has a medical doctor advised that the child is physically able to carry the baby to term?
- Has a medical doctor advised that the child is physically able to have an abortion without major medical risk?
- Does the child have any medical conditions that could affect the success of a pregnancy or birth?
- What is the developmental functioning of the child?
- How emotionally stable is the child?
- Is the child able to understand information regarding pregnancy, birth, parenting, and abortion?
- What are the recommendations of the child's parents, therapist, and significant support persons?
- Does the child want to have an abortion?

To determine whether involvement of the child's parents is required, consider these questions:

- Are the whereabouts of the parents known?
- Are the parents involved in the case?
- Would involvement of the parents endanger the child's safety or welfare?

§ Was the child's pregnancy the results of sexual conduct with the parent, step-parent, adoptive parent, sibling or grandparent?
§ What is their legal relationship to the child? Has there been a Termination of Parental Rights (TPR) on either parent?
§ Does the child want the parents to be notified and involved?

BEST PRACTICE TIP:
When the child makes an active decision to have an abortion, it is critical that the caregivers, CPS Specialist and others involved in the process support the decision of the child. **Regardless of the perspectives of any of the team member**, this is the child's decision. If there is any member of the team who cannot support the decision of the child, he/she needs to withdraw their voice and involvement in the process.

Implementation and Procedures Guide

The Caregiver Should:
If their foster child's physician determines that an abortion is necessary to save her life or is medically necessary due to rape or incest, out-of-home care providers should:

§ Notify the CPS Specialist **immediately or by the next work day**, and follow the instructions of the physician.
§ Take or arrange transportation for their foster child to post-termination counseling, if arranged by the CPS Specialist; participate in the counseling sessions if their foster child agrees.

If the child wants an abortion that is not medically necessary to save her life or necessary due to rape or incest, out-of-home care providers must:

§ **Immediately or by the next work day** notify the CPS Specialist of her decision unless the CPS Specialist is already aware of her decision.
§ Be informed by the CPS Specialist that it is against the law to use public funds to pay for the abortion and for licensed out-of-home care provider to consent to an abortion for a foster child.

The CPS Specialist Should:
Ensure information and services are provided by using the Providing Abortion Services section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22) as a guide.

When a pregnant child's physician determines that an abortion is medically necessary to save her life:

§ As needed, assist the child's physician to arrange the medical procedure and obtain prior authorization from CMDP.
§ Upon learning of the medical necessity, immediately inform the child's parents of this medical condition and the arrangements for the medical appointment, unless, in consultation with the supervisor at minimum, it is determined that informing the parent is detrimental to the safety and welfare or best interest of the child, or the child requests her parents not be informed. If a parent is willing and able to consent to the procedure, facilitate the consenting parent's signature of the medical facility's forms.
§ If the child has requested her parents not be informed or involved or no available parent is willing and able to consent to the medical procedure, obtain a court order before the procedure is performed, unless an emergency exists. Complete the motion for medical/ surgical treatment no more than one work day from learning of the need for the medical procedure.
§ Arrange for post-termination counseling for the child, family members and other significant persons.

When a child states a desire to terminate her pregnancy and an abortion is not necessary to save her life, call the DCYF eligibility unit **within two work days** to verify the child's Title XIX eligibility status, confirming that the eligibility specialist or supervisor has the most recent and accurate eligibility related information.

Follow procedures for high profile cases as described in Family Centered Case Planning (Chapter 9).

If the pregnancy is due to rape or incest or necessary to prevent harm to bodily function of the pregnant child, and the child is Title XIX eligible:

§ Arrange a case conference to be held **no later than five days** from the date of notification of the child's decision. Obtain recommendations from the involved service team members regarding supportive services for the child, and determine the roles and responsibilities of the participating service team members as to the medical procedure, assessment or counseling and any other needed services.
§ At minimum, the case conference will include the CPS Specialist, the supervisor, the out-of-home care provider, and the child's GAL and attorney. Include other team members and parties, such as the child's parents and significant support persons, such as a Special Friend, or a religious or spiritual advisor, as appropriate and after considering the wishes of the child. When appropriate, include the pregnant child and the alleged father of the infant.
§ Prior to the case conference, obtain recommendations from an independent child welfare professional, such as a psychologist on contract with the department, to provide

consultation regarding the child's choice to terminate the pregnancy, the child's best interest relative to the pregnancy, and supportive services. Present the recommendations of the independent child welfare professional if he/she does not present in the case conference.

§ **No less than two days prior** to the case conference, notify the assigned Assistant Attorney General that the child is requesting an abortion and share other significant information.

§ If the child has consented to the involvement of her parents and it has been determined that their involvement is not detrimental to her safety and welfare, inform the parent, at the case conference or **no more than two work days** following the case conference, of the child's decision and the arrangements for the medical appointment, unless they have previously been informed. If a parent is willing and able to consent to the procedure, facilitate the consenting parents' signature of the medical facility's forms.

§ If the child has requested her parents not be informed or involved or no parent is available or willing to consent to the medical procedure, obtain a court order before the procedure is performed, unless an emergency exists. File the motion for medical/surgical treatment **no more than one work day** from learning of the planned medical procedure.

§ To assist with prior authorization, provide documentation to CMDP that the incident of rape or incest was reported to a law enforcement agency. Documentation should include the name of the law enforcement agency, report number, if available, and date the report was filed.

§ Arrange for post-termination counseling for the child, family members and other significant persons.

When no state or federal funds are available for abortion services because:

§ the abortion is not necessary to save the life of, or prevent bodily harm to, the pregnant child, nor due to rape or incest; or

§ the pregnancy is due to rape or incest or necessary to prevent harm to bodily function of the child, but the child is not Title XIX eligible; complete these tasks in addition to those listed above:

° Inform and explain to the child, the out-of-home care provider, other participating service team members, and the child's parents if they have been involved in the decision making process, that there are no federal or state funds available to pay for an abortion.

° Hold a case conference **no later than 10 work days** from the date of notification of the child's decision, inviting parties as described in the previous section. The Assistant Attorney General should attend the conference to address funding and potential legal issues.

° **At the case conference or no more than two work days** following, inform

the involved service team members of the department's position relative to the medical procedure, based on the child's best interest, relevant law, and the recommendations received. Determine the roles and responsibilities of the participating service team members in timely arrangement of the medical procedure, obtaining parental consent or a court order for medical or surgical treatment, and supporting the child.

- If a court order is required for the medical procedure because the child has requested her parents not be informed or involved or no available parent is willing and able to consent, provide to the court any service team member's and the independent child welfare professional's recommendations.
- If the child's GAL or another party files a motion for an order allowing the child to have an abortion, support or oppose the motion according to the child's best interest, unless the fetus is viable in the judgment of the attending physician.
- Oppose all motions for an order allowing a child to have an abortion of a fetus that is viable in the judgment of the attending physician.
- Consult an Assistant Attorney General if the department is ordered to pay for the abortion.
- Arrange for post-termination counseling for the child, family members and other significant persons.

If notified after the procedure that a child has obtained an abortion, ensure that appropriate medical services are provided to the child, and arrange post-termination counseling for the child, family members and other significant persons. If the child refuses medical services or counseling, continue to offer appropriate services.

DOCUMENTATION :

Document the pregnancy of the child and other medical information in the Medical/Dental Condition Detail window using either the condition of "pregnant" or "pregnant teen”, Examination Detail and Practitioner Detail windows.

Document all medical examinations of the child in the Examination Detail window.

Document the contact with the CMDP nurse and the provision of assessment or counseling using the Pregnancy Care/Family Planning window.

Document the outcome of case conferences using the Case Notes window.

Document the child’s decision to terminate the pregnancy, outcome of the pregnancy and the date of the outcome using the Pregnancy Care/Family Planning Window.

If a child refuses medical or assessment services or counseling, document the types of services offered and the child's response to the offers using the Case Notes window designated as the appropriate type.

Revision History:
DES(07-2006)

Previous / Next

6-19

Legal Basis: A.R.S. §8-106.01 addresses the Putative Father's Registry that is administered by the Arizona Department of Health Services, claims of paternity, and adoption related procedures for alleged and confirmed fathers.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6 Section 19

Services Provided When a Child Is the Alleged or Confirmed Father of an Unborn Infant

Legal Basis

Policy: The department shall advise and assist any male child who is a ward of the court committed to the care, custody and control of the department, and who believes he may be an expectant father, on appropriate parental rights and responsibilities.

Implementation and Procedures Guide

Ensure information and services are provided by using the "Services Provided When the Child Is the Alleged or Confirmed Father of an Unborn Infant" section of the Checklists for CPS Specialists: Providing Family Planning Services (Exhibit 22).

When a foster child is the alleged father of an unborn infant, advise and assist him to:

- Determine what his role and responsibility will be in planning for and meeting the needs of the unborn infant.
- Establish his parental rights.
- File notice of a claim of paternity with the Putative Father's Registry, when applicable, by contacting the Department of Health Services, Vital Records, 1818 W Adams Street, Phoenix, 85005.

Request assistance from the alleged father's caregiver in completing the above tasks.

DOCUMENTATION :

File a copy of the notice of claim of paternity in the child's case record.

Revision History:
DES(07-2006)

Previous / Next

6-20

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6 Section 20

Locating Children On Runaway Status

Legal Basis

Policy: The department shall make reasonable efforts to locate a child who is a ward of the court, placed in the care, custody and control of the department and who has run away from an out-of-home placement.

Upon receiving information that a child has left an out-of-home placement, and is determined to be on run away status, **immediately notify the child's parents, attorney, guardian ad litem and the caregiver of the child's disappearance.**

The CPS Specialist must contact the caregiver **by the next working day** to assure that a report to the local law enforcement agency has been filed.

The CPS Specialist should attempt to make a home visit to any identified parents, relatives or other significant person the child may have contacted.

Implementation and Procedure Guide

The following shall be completed by the CPS Specialist (or other staff as approved by the supervisor):

- § Contact the out-of-home provider by the next working day to assure that a report to local law enforcement has been filed. Obtain the DR number of the law enforcement report.
- § Immediately notify the child's parents, attorney, and/or guardian ad litem and the caregiver of the child's disappearance.
- § Make or attempt to make a home visit to any identified parent, relative or other significant person the child may have contacted.
- § Contact the duty Assistant Attorney General **within 24 hours** of the child's disappearance and initiate a motion for an order to pick up the child. (A pick up order is still required in situations where a warrant has already been or may be issued.)
- § Contact the child's school and obtain any pertinent information regarding the child's disappearance.
- § Contact any prior placements the child may have contacted and determine if they have any current information about the child.

With approval of the supervisor, contact the DCYF Central Office Program and Policy Specialist, OSI Coordinator, to initiate a request through the Department's Office of Special Investigations (OSI) for assistance in locating a runaway child when one or more of the following circumstances exist:

- The child is suicidal.
- The child has been diagnosed with a serious mental illness and is on medication which, if not available or administered properly, could place the child at risk of serious physical harm.
- The child suffers from a serious physical illness and is on medication, which if not available or administered properly, could place the child at risk of serious physical harm.
- The child is pregnant.
- Other specific child safety concerns exist (i.e., child of a young age, child is a risk to the community, child is with a known perpetrator, child is significantly developmentally delayed, etc.).

Fax the completed Request for OSI Assistance, FSC1017, found in the Forms Registry to the OSI Coordinator (fax: 602-542-3330). Forward any questions to the OSI Coordinator at 602-542-1356.

Upon the child's return to out-of-home care:

- Make a face-to-face contact with the child **within 24 hours** and determine the need for additional services.
- Obtain a medical exam for any child where there is indication of high risk behaviors, i. e. sexual activity, drug use, etc., while on runaway status.
- Notify the appropriate local law enforcement agency and the OSI Coordinator that the child has returned.
- Assess the appropriateness of the child returning to the same out-of-home placement. Terminate the placement if a decision is made that the child will not return to the same out-of-home care provider.
- Contact the duty Assistant Attorney General and initiate a motion to vacate the pick-up order once the child has returned to out-of-home care.
- If the child remains on runaway status for **seven days**, terminate all service and payment authorizations. Do not terminate CMDP.

*If the child remains on runaway status and is not able to be located for a period of **90 days** or longer, the CPS Specialist (or other staff as approved by the supervisor) must complete the following:*

- Re-contact the child's previous out-of-home care providers to obtain any pertinent information in locating the child.
- Re-contact the child's previous school (if enrolled prior to running away) and obtain any pertinent information in locating the child.
- Re-contact the child's parents, relatives or other significant persons to obtain any pertinent information in locating the child.

DOCUMENTATION :

Document all information including the law enforcement number, notification of all parties and specific attempts to locate the child in the CHILDS case record.

End service authorizations by updating the Provider Service Authorization window with Stop Date and Termination Reason after seven days for a child on runaway status, unless an earlier decision was made that the child will not return to the same provider. If this decision was made, terminate service authorization as of the date of the decision.

Update the Placement/Location Detail window with the child's current (runaway) status and end date this status when the child returns.

File a copy of the Request for OSI Assistance form in the hard copy case record**.**

Revision History:
DES(07-2006)

Previous / Next

6-21

Legal Basis: ARS §8-514.03 (E) directs the department to establish procedures for a CPS Specialist to inform a kinship foster care family of available financial services including family resource family licensing, ACYF benefits available to unlicensed caregivers, and TANF child-only cash assistance

ARS §46-134 (2)(C) enables the department to provide the cost of care for a child in a licensed care setting.

Rules: Rules concerning licensed Resource Families responsibilities for the use of funds provided for foster children are found in R6-5-5829.G of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 6: Section 21

Facilitating Payment to Resource Families Providing Foster Care

Legal Basis

Policy: The department shall provide maintenance payments to licensed resource families for the care of children in out-of-home placement.

All children in licensed out-of-home placements receive a monthly clothing allowance and monthly personal allowance. With supervisory approval, monthly allowance payments may be authorized for children in unlicensed kinship and unlicensed non-relative placements.

At times, special payments may be made to meet the special needs of children in care.

CPS Specialists are responsible for updating CHILDS with accurate and timely information to facilitate the prompt payment of foster care providers.

Implementation and Procedures Guide

To initiate payment to resource families, ensure the Service Authorization Request and Approval windows are completed, following district procedures, **within two working days** of placement.

Use the following information to assure accurate entry into CHILDS:

- The basic payment for a licensed resource family is FAM FHM-DAY.
- For children approved for special rates, the applicable rate is added to the basic rate.
- The basic payment automatically generates the monthly clothing allowance and monthly personal allowance.
- Agency-based placement rates include daily clothing and personal allowances.
- Kinship Foster Care Parents and unlicensed non-relatives are automatically authorized for daily clothing, daily personal and special payment allowances when the child is matched to the kinship foster care parent.
- Agency-based placements such as shelters, group homes, and residential treatment

centers, receive a contracted rate and may receive some of the special payment allowances upon approval by the supervisor.

§ Payment cannot be made beyond the service authorization end date. To extend a service authorization use the Service Authorization Request and Approval windows.

To determine the child's eligibility for a Special II or Special III foster care rate:

§ Complete the Child Assessment and Special Rate Evaluation window using the following windows, as applicable, to document the child's needs: Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Hospitalization Detail, and Participant Education Condition, and Participant Education Detail.

§ Obtain licensed resource family's signature on the Medical Summary Report. Obtain required approvals using Service Authorization Request and Approval windows according to District Operating Procedures. Document resource family sign-off by filing the signed Medical Summary Report in hard copy record and by using the Case Notes window designated Out-of-Home Care Provider type.

§ Complete the Service Authorization Request and Service Authorization Approval windows according to District Operating Procedures.

Request special payments allowances as indicated by the child's and provider's needs. Special payment categories are as follows:

§ Emergency/Special Clothing: Payment up to a maximum of $300 per state fiscal year. Youth in the Independent Living Subsidy Program are *not* eligible for this allowance.

§ Emergency Special Clothing-Extra: With Supervisor and **Assistant Program Manager** approval, payment can be up to a maximum of $200 per state fiscal year for children whose clothes are lost or destroyed due to circumstances beyond the child's control (for example: fire, theft, or flood). Youth in the Independent Living Subsidy Program youth are *not* eligible for this allowance.

§ Special Needs Allowance: With Supervisor approval, payment up to a maximum of $45 per state fiscal year to assist resource families. This money is not to be given to the foster child. It may be provided in a lump sum or in smaller payments to foster care providers for holiday, birthday, special occasion or other expenses. Independent Living Subsidy program are *not* eligible for this allowance.

§ Books and Education: Payment up to a maximum of $165 per school year for all

dependent children. Use of this allowance for special pre-school programs must be based upon the developmental and educational needs of the child. This payment may also be used for college level, technical and vocational classes for students who have not yet graduated from high school or obtained a G.E.D.

§ Graduation Expenses: Payment up to a maximum of $220 for high school graduation only.

§ Supplemental School Tuition and Fees: With Supervisor approval, payments up to a maximum of $165 per summer session or interim session at year round schools.

§ Day Camp: With Supervisor and Assistant Program Manager approval, payment can be approved up to a maximum of $350 per year. For use during summer sessions or interim sessions at year round schools. This allowance is available only to children in licensed and unlicensed (Kinship and non-relative) foster homes.

§ Overnight Camp and Child Vacations with Resource families: With Supervisor and Assistant Program Manager approval, payment can be approved up to a maximum of $550 per year for a combination of Overnight Camp and Day Camp or for family vacations for children in licensed and non-licensed (kinship and non-relative) foster homes. For use during summer sessions or interim sessions at year round schools. This allowance is available only to children in licensed and non-licensed (kinship and non-relative) foster homes.

§ Diapers - Special: With Supervisor approval , payment can be up to $125 per month for children with special needs, such as an ongoing medical condition, a child who is 3 or older who requires incontinent briefs, or a child who is 3 or older who has regressed in control of his/her bodily functions due to abuse or removal from home.

Note: Medically necessary formula is covered by CMDP

Keep in mind the following special payment requirements:

ü Day Camp, Overnight Camp and Child Vacations with Resource Families payments

§ Attendance at camp must benefit the child's development and socialization and be consistent with the case plan before authorizing payment.

§ Only camps and summer programs with valid Health Department certification are eligible for special allowance authorization.

§ Treatment costs are not allowable; payments should be comparable to traditional non-profit organizations.

§ To obtain approval authorization for camp, complete the Service Authorization Request window. Use the Explain to include a description of the proposed program,

the needs of the child, the benefits he or she will gain from attendance, the cost of the program, and the status of the birth parent's consent for attendance. The supervisor and Assistant Program Manager, if required, will complete the Service Authorization Approval window.

§ To obtain payment for child vacations with licensed and unlicensed Resource Families

- **Supervisor and Assistant Program Manager** or designee approval is required.
- The vacation plan must be consistent with the case plan.
- Payment may be made prior to or after the vacation.

§ To obtain approval, complete the Service Authorization Request window. Use the Explain Box to include the dates and itinerary of the vacation.

ü Special diapers payments

§ Obtain documentation from the child's doctor that identifies the medical situation that causes the need for frequent diapering and the frequency of diaper changes.

§ Determine the reimbursement necessary to cover the cost of diapers. (If the resource family is already receiving a regular diaper allowance for a child under 3, subtract it from the cost of the special diapers to determine the special diaper allowance needed.)

§ Complete the Service Authorization Request window. Use the Explain to include the justification, the cost, the recommended amount, and the time period for reimbursement. Submit the doctor's statement to the Assistant Program Manager according to district procedures.

§ Receive approval from the Supervisor for a specified time period and obtain approval if continuation is necessary.

ü Monthly Personal and Clothing Allowance payments

§ Discuss the monthly personal allowance with care providers. Ensure that providers understand:

- the amount of the allowance,
- that personal allowance belongs to the child and cannot be withheld or used as a payment for chores,
- that small payments for reimbursement of damages or loss may be established in consultation with the CPS Specialist, the provider and the child.

To correct any errors in payment to providers:

Notify the Payment Processing Unit (PPU) by E-Mail alerting them of the payment error. Provide the following information:

For Overpayments:

- § provider's name and ID
- § child's name and ID
- § service for which overpayment was made
- § service month
- § number of units or specific dates of erroneous payment
- § CPS Specialist name and phone number
- § whether provider has submitted check/money order to CPS Specialist or mailed to PPU (if CPS Specialist has received check/money order, this shall be forwarded immediately to PPU with explanatory memo containing all the above data)
- § check/money order must be made payable only to the Department of Economic Security.

Do not accept cash as reimbursement for overpayment from providers.

If necessary, appear as the department representative at a hearing with the Office of Appeals if a provider disagrees that a payment error has been made or with the amount of the error.

For Underpayments:

- § if error caused by provider, advise provider to resubmit statement/billing document;
- § if error caused by CPS Specialist, correct appropriate CHILDS windows, consult with PPU;
- § determine if the copy of billing document needs to be re-submitted. If so, advise provider.

End service authorization to by updating the Provider Service Authorization window with Stop Date and Termination Reason:

§ **within two days** after removal of a child from an out-of-home placement;

§ effective the day of the child's **18th birthday**, unless the youth meets the criteria outlined for voluntary foster care for a young adult;

§ **after seven days** for youth on runaway status, unless it has been decided sooner that the youth will not return to the same facility. If this determination has been made, service authorization is terminated as of the date of the decision;

§ **after seven days or fourteen days, with District Program Manager approval**, for youth placed in detention, unless it has been decided sooner that the youth will not return to the same facility or it is likely the youth will remain in detention beyond seven days. If the youth will not return to the same facility, service authorization is terminated as of the date of the decision;

§ **after seven days or fourteen days, with District Program Manager approval**, if the youth is hospitalized or is out of the placement for an extended period of time, including visits to the parent's home unless it is decided that the youth will not return to the same facility. If the youth will not return to the same facility, service authorization is terminated as of the date of the decision; and

§ **after seven days or fourteen days, with District Program Manager approval**, if the child is out of the placement for an extended period of time, including visits to the parent's home.

DOCUMENTATION :

Document all information necessary to generate payment on CHILDS, as described above.

Document the circumstances of the overpayment and underpayments using the Case Notes window designated as Collateral Contact type.

Update CHILDS using the Placement/Location Detail window to reflect any unpaid placements, such as runaway, hospitalization, or detention.

Document the need for special diapers by maintaining a copy of the physician's statement or prescription in the child's hard copy record and using the Practitioner Detail and Examination Detail windows.

Document any reimbursement or restricted access plan for the child's monthly personal allowance using the Case Notes window designated as Out-of-Home Care Provider type. The out-of-home care provider maintains documentation that the child received his or her personal allowance in the Allowance Signoff Ledger, FC12800 (FC-128), included in the Child's Placement Packet.

Document the circumstances necessitating the use of the Emergency Special Clothing-Extra allowance using the Case Notes window, designated as the appropriate type, and using the Explain on the Service Authorization Request window.

Supervisor:

Document approval using the service authorization window for:

- Emergency Special Clothing- Extra;
- Special Needs payments;
- Supplemental School Tuition and Fees;
- Day Camp payments;
- Overnight Camp payments; and
- Child vacations with licensed or unlicensed resource families.

Assistant Program Manager:

Document approval using the service authorization window for:

- Emergency Special Clothing- Extra;
- Day Camp payments;
- Overnight camp; and
- Child vacation with licensed or unlicensed resource families.

Program Manager:

Document approval using case notes or e-mail to authorize the provision of written approval to the licensed foster parent for the following “bed hold” payments to licensed foster homes:

- for youth placed in detention payment for an additional seven days;
- for hospitalized youth payment for an additional seven days; and
- if the child is out of the placement for an extended period of time, including visits to the parent's home, payment for an additional seven days.

For additional information see the Family Foster Home Care Rates and Fees Schedule (Exhibit 13).

Revision History:
DES(07-2006)

Previous / Next

6-22

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 6: Section 22

Working with Resource Families Around Issues of Discipline

Legal Basis

Policy: The department shall provide discipline guidelines for out-of-home care providers to ensure the health and safety of children, to encourage consistency, to facilitate communication and training, to support a problem-solving perspective regarding difficult care issues, and to provide a supportive atmosphere that allows care providers to identify problems and ask for assistance.

Use of unacceptable modes of discipline upon children in the department's care shall not be tolerated under any circumstances.

Implementation and Procedures Guide

Discuss discipline with all out-of-home care providers openly to facilitate a problem-solving approach, particularly when they are caring for children with difficult behavior patterns.

Reinforce that the department considers the following to be acceptable discipline methods:

- natural and logical consequences;
- encouragement and praise;
- positive communication, active listening;
- "I" messages;
- incentives/rewards/motivation;
- contracting;
- redirection;
- role modeling;
- time-out; and
- removal of privileges.

Underscore that the following are unacceptable discipline methods;

- verbal abuse;
- food, water and sleep deprivation;
- cruel, severe or corporal punishment;
- deprivation of contacts from family members;
- locking up a child;
- locking a child out of a home or care facility; and
- deprivation of personal allowance.

Consult a supervisor immediately if you have reason to believe that a care provider may be using unacceptable methods of discipline.

For More Information: For licensed providers, see ACYF Discipline Policy (Exhibit 44).

Revision History:
DES(07-2006)

Previous / Next

6-23

Legal Basis: ARS §8-514.03 (G) requires the department to provide to kinship resource families through existing means or referrals specified non-financial services including respite care.

Rules: Section R6-5-5801 et seq., address the licensing of a resource family to provide respite care.

Revision History:
DES(07-2006)

Chapter 6 Section 23

Providing Respite Care Services to Resource Families

Legal Basis

Policy: Within the constraints of available resources, the department shall provide temporary, short-term respite care for licensed resource families and for unlicensed out-of-home care providers:

- to provide relief to the caregiver, or to assist the family in coping with the daily demands of providing care to children with significant needs;
- to provide care during a family crisis, such as illness or death;
- to provide care when the caregivers are away from home and the foster child cannot accompany the caregivers due to school, parental visits, case plan requirements; or
- to enable the caregivers to participate in department approved/sponsored training when child care services are unavailable or unworkable.

Implementation and Procedures Guide

Follow district procedures for obtaining respite care placements and services from contracted foster home licensing agencies.

For licensed resource families:

- Refer the licensed resource family to their licensing agency to request respite care;
- Continue the approved foster care rate while the child is with the respite provider;
- Be aware that a licensed resource family receiving foster care reimbursement is eligible for **a minimum of 144 hours or six days** of respite care with a licensed foster parent, per fiscal year, provided through the licensed resource family's DCYF contracted foster home agency.

For kinship caregivers and unlicensed providers:

- According to district procedures, arrange for and approve respite care placement with a licensed foster parent through a referral to a contracted foster home licensing agency;
- Approve up to 1**44 hours or 6 days** of respite foster care.

BEST PRACTICE TIP:

The limits on resources cause the use of respite care to be a challenge for CPS Specialists. Yet there are times when respite care can make the difference between a placement disrupting or staying intact. CPS Specialists will best use respite care when they are in consistent contact with the caregivers, are aware of how foster family is handling day to day stressors of caring for the child(ren) placed in their home and understand when stress is impacting the stability of the placement.

Do not count against the maximum allowable hours respite care provided:

- § when extraordinary documented needs of a foster child prevents the caregivers from temporarily caring for the other foster children in the home;
- § when the caregivers are away and the child cannot accompany them due to school or case plan requirements; or
- § when the caregivers are participating in training **exceeding 24 consecutive hours.**

If necessary, obtain approval from the Program Manager or designee for up to **five days** additional respite care in emergency situations.

DOCUMENTATION :

For respite care used by kinship foster caregivers and unlicensed providers, document all information necessary to generate payment to the respite foster care parent, according to district procedures.

Document the purpose and approval of respite care not counted against the allowable hours of a licensed resource family using the Case Notes window designated as Out-of-Home Care Provider type.

Revision History:
DES(07-2006)

Previous

7-1

Legal Basis: ARS §8-513(C) sets forth the right of children in out-of-home care to maintain contact with siblings, relatives and friends, unless the court determines that the contact is not in the child's best interests.

ARS §8-813 requires the department to develop policies and procedures to allow a child in out-of-home care to maintain contact by telephone, mail or visits with the child's parents, family members, friends, other relatives and any former foster parent, unless the court determines that the contact is not in the child's best interest.

ARS § 8-824(G)(8) requires the department to report to the court any efforts made to facilitate communications among siblings.

ARS § 8-824(G)(9) requires the department to report to the court, a proposal for visitation for children in out-of-home care and their families.

Rules: Rules concerning licensed foster parents maintenance of a working relationship with a foster child's family are found in R6-5-5829.C of the Arizona Administrative Code.

Rules that permit a licensed foster parent to deny contact with a foster child's family or significant person when it is consistent with the case plan are found in R6-5-5833.C of the Arizona Administrative Code.

Rules concerning visitation, outings, mail and telephone communications procedures for children placed in licensed Child Welfare Agencies are found in R6-5-7448 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 7: Section 1

Ensuring Visitation Between Children in Out of Home Care and Their Family

Legal Basis

Policy: The department shall facilitate contact between a child in out-of-home care and the child's parents, siblings, family members, their relatives and individuals with significant relationships to the child to preserve and enhance relationships with and attachments to the family of origin. Contact may be by telephone, mail and/or in-person visitation.
The department may restrict contact between a child in out-of-home care and the child's parents, siblings, family members, other relatives, friends, and any former foster parents only when contact is detrimental to the child's health and safety.

The department shall facilitate contact by telephone, mail and visitation between a child in out-of-home care and the child's friends and any former foster parent unless such contact is documented as detrimental to the child's health and safety.

All case plans for children in out-of-home care shall include a contact and visitation plan which is developed with involvement of family members and the child, if age appropriate, or documentation of why contact and visitation is detrimental to the child's health and safety.

Frequency, duration, location and structure of contact and visits shall be determined based primarily upon the child's need for safety and for family contact with safety being the paramount concern. Visitation and other contact by telephone and mail shall not be used as a reward or as a punishment for the child or any family member.

Visitation shall take place in the most natural, family-like setting possible and with as little supervision as possible while still ensuring the safety of the child.

In determining a contact and visitation plan, consider these factors:

Child-specific factors:

- þ importance of contact with family and extended family members;
- þ best interests of the child;
- þ placement locations of siblings;

- chronological and developmental age;
- requests for and reaction to visits;

BEST PRACTICE TIP:
A child's reaction to a visit can be complicated to assess. Often when children return from visits they are very confused about their feelings. Sometimes they experience guilt at leaving their parents, sometimes they experience guilt for liking their new caregivers, sometimes they are angry that they cannot be with their family, sometimes they are lonely and confused. When a child acts out these feelings, it may look like anger or despondency or frustration. A natural reaction may be to believe that the visits are not "good for the child" based on the child's emotional reaction. CPS Specialists and caregivers understand that they have to look beyond the words and the behaviors of the child to better understand what the child is actually feeling.

- therapeutic needs; and
- school and activity schedules.

Family (parents, family members, and other relatives) factors:

- family's behavior and abilities that are specifically detrimental to the child;
- family's request for and reaction to visits;

BEST PRACTICE TIP:
A parent's reaction to a visit is also complicated to assess. Sometimes the lack of affect or the apparent lack of "appropriateness" of the parent with the child during the visit is judged quite harshly by the child welfare system. In reality, parents may not know how to react or they may be fearful of how their interactions with the child are perceived by others which can cause them to be passive during the visit. It is important to view the visit between a child and his/her parents as a learning opportunity for both. It is not a time for the CPS Specialist to sit in judgment of the birth family; it is a time to help the parents learn new skills and to have opportunities to play with and enjoy their children. CPS Specialists should utilize visits to create or re-create strong parent-child bonds.

- family's work, school or activity schedule;
- family relationships and interactions; and
- parent's compliance with case plan tasks that directly relate to the health and safety of the child.

Caregiver factors:

- level of involvement in visiting;
- willingness to assist with visitation;
- work, school or activity schedule;

- impact of visitation on other children in the placement.

Significant persons (friends and former foster parent) factors:

- length and quality of relationship with the child;
- person's contribution to the child's positive growth and development;
- person's wishes for contact with the child;
- person's motivation for contact with the child;
- person's behavior during contacts with the child;
- person's awareness of the needs of the child; and
- consequences for the child if contact is not maintained.

Based on these factors, determine the type, frequency, duration, and location of contact and visits. Determine if visits or other contact should be highly structured, moderately structured, or relaxed**.** For more information, see Visitation Supervision Continuum (Exhibit 26).

Implementation and Procedures Guide

Involve family members, the child, if age appropriate, and caregivers in developing the contact and visitation plan. In particular, assist the child and the parents to identify extended family and significant persons as potential placement options or non-placement support persons.

BEST PRACTICE TIP:
Visitation between the child and their family should occur as quickly as possible after the placement. It is very important to understand that it is the child's right to have a visit with his/her parents. Waiting for weeks for the child to interact with their parents can traumatize the child and create tremendous anxiety and anger in the parents. In those rare instances where a child's interaction with their parents is determined to place the child in danger, the child should be able to visit extended family or another individual with whom they have a significant relationship. The CPS Specialist must find ways to help the child feel as if he/she has not lost the people that matter in their lives. Research also teaches us about where visitation should occur.

See Parental Visiting and Family Reunification: How Inclusive Practice Makes a Difference (Exhibit 24).

Sonja Leathers Ph.D. concludes in the above study:
"Consistent with the results of other studies, the results of this study support the theory that maternal visiting is a stronger predictor of reunification than maternal problems, such as substance abuse, or children's characteristics, including length of time in care. The results of this study also suggest that where visits take place is related to how frequently they occur. Visiting in the birthparent's home or the foster home were both associated with more frequent maternal visiting than visiting at an agency, a fast food restaurant or another setting. In addition, maternal involvement in case reviews and other activities in the child's life was found to be associated with more frequent visiting. These results suggest that among young adolescents who have been placed in foster care longer than a year, inclusive practice is

associated with more frequent visiting, which substantially increases a child's chances for reunification."

Give parents a copy of Visitation Guidelines for Parents, FC-188, and discuss it with them.

Strive for weekly contact and visitation with parents and between siblings not placed together. Adapt the frequency as necessary to meet the child's needs.

BEST PRACTICE TIP:
The foundation of a successful visitation program is the people who establish and monitor visits; these individuals must be properly informed about the benefits of visitation and trained about visitation procedures.
The first step in facilitating visitation should be to set up a regular, written visitation schedule. Written schedules encourage birth parents to adhere to the visitation plan and often lead to more visits. Since they are essential to visits, birth and foster parents should be directly involved in setting up visitation schedules. Involving birth and foster parents and respecting their preferences for visit times and locations demonstrates that they are important members of the team.
Increasing evidence also suggests that when the first visit is held immediately following placement (within 48 hours), birth parents may be more likely to show up for visits and more inclined to see their value.
Successful visitation also relies on accurate assessment of birth parents' strengths and needs. Most visitation plans assume that birth parents understand what their child goes through if they don't show up for a visit, and that parents have leisure and recreation skills independent of drugs, alcohol, sex, danger, and violence.
Other common assumptions are that birth parents know how to: play with their children, talk politely with their children, enjoy their children's company, separate from the visit their frustration, shame, and humiliation over losing custody, read to children or read and understand court reports, contracts, priorities, major and minor requirements
Yet these assumptions do not always hold true. By overestimating parents' abilities, CPS Specialists can unwittingly undermine family reunification.

Comply with any court orders regarding contact and visitation.

Ensure that all persons included in the contact and visitation plan are entered as case participants using the most appropriate case role.

Consider information provided by service providers and caregivers concerning the progress of parents towards addressing risk factors as well as the specific needs of the child.

If contact and visitation are determined to be dangerous or damaging to the child and the child cannot be protected through a supervised or structured visit, contact the Attorney General's Office

to request that a motion be filed to restrict or prohibit contact.

Increase the frequency and duration of contact and visits as case plan tasks are achieved. Provide maximum opportunity for parent-child contact responsibility during reunification phase visits.

BEST PRACTICE TIP

Visitation between a child and their family has been demonstrated by the child and family service reviews to be the most important corollary to reunification. Virtually everyone who studies or is involved in child welfare agrees that visits between children and their parents matter.

Visits matter because they help maintain relationships within the birth family, empower birth parents, help birth family members face reality, and allow birth family members to learn and practice new skills and behaviors. They matter because they give CPS Specialists a chance to assess and document birth family progress.

Visits matter because they help children express their feelings and relate better to foster parents, calm some of children's separation fears, and give foster children and foster parents continuing opportunities to see the parents realistically.

Perhaps most important of all, visits matter because continued contact with parents increases the probability that children will go home to their families. Therefore, CPS Specialists must support frequent and consistent visitation between children and their parents. See Visitation Supervision Continuum (Exhibit 26) and Making The Most Out of Visits Between Children and Their Families (Exhibit 25) for additional tips on improving the practice of visitation.

Review and modify the contact and visitation plan in the course of case plan staffings.

If a child objects to contact and visitation, consult your supervisor.

If conflicts arise around contact and visitation:

- § Consider the child's health and safety as the paramount concern in conflict resolution.
- § Assure the family members and siblings' rights to contact over the needs or preferences of out-of-home care providers.
- § Give weight to the contact and visitation plan that best supports the case plan, even if the plan is less convenient or requires additional agency resources.
- § If conflicts are unresolved, explore other avenues for seeking resolution, such as mediation or the court system.

DOCUMENTATION :

Document the contact and visitation plan in the Visitation window.

When a decision is made that contact and visitation is detrimental to the child's health and safety, document the reasons in the Visitation window using the Explain window.

Document the need for visitation and contact limitations in the Visitation window using the Explain window.

Document contact between the child and the child's siblings, family members, other relatives, friends, and any former foster parents using the Case Notes windows.

Document the supervision of visitation using the Summary of Supervised Visitation, FC-189. File the FC-189 in the hard copy record.

Revision History:
DES(07-2006)

8-1

Legal Basis: ARS §8-271 provides definitions to clarify and broaden commonly used terms that apply to children's mental health services regarding admission and treatment.

ARS §8-273 describes procedures and requirements for court ordered residential placement, provision of treatment services and discharge from treatment.

ARS §8-513(C) sets forth the right of a child in out-of-home care to maintain contact with siblings, relatives and friends, unless the court determines that the contact is not in the child's best interests.

ARS §8-813(B) requires the department to develop policies and procedures to allow a child in out-of-home care to maintain contact by telephone, mail or visits with the child's parents, family members, friends, other relatives and any former foster parent, unless the court determines that the contact is not in the child's best interest.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 8: Section 1

Arranging for Residential Treatment Services for a Dependent Child

Legal Basis

Policy:

The department shall seek residential treatment services for a child who is assessed as needing a structured treatment setting with 24 hours a day supervision and an intensive treatment program or detoxification services.

The department shall obtain court approval for residential treatment services for a dependent child.

When a dependent child requires residential treatment services, the department shall participate in planning and decision making involving the child's treatment and discharge.

If the child is dually adjudicated, the department shall notify the other agency provider of all notices, motions, hearings or other proceedings related to the provision of residential treatment services.

To determine whether to pursue residential treatment services for a dependent child, consider the following questions:

- Has an outpatient assessment, inpatient psychiatric assessment or inpatient psychiatric acute care services (hospitalization) recommended residential treatment services?
- Does the child have a mental health diagnosis?
- Does the team believe (and have data to support) that residential care is an effective intervention for this diagnosis?
- Does the child demonstrate a need for structure and supervision beyond that which is possible in a group home setting?
- Does the child have a documented need for a therapeutic environment? If so, is residential care the optimal level? Can a less restrictive level with additional supports meet

the needs of the child as effectively?

§ Does the child have special education requirements that can only be met in a highly structured setting? Is it possible that the child's existing school setting can meet the child's needs if additional support is provided for the child and/or educators?

BEST PRACTICE TIP:
Placing a child in a residential care facility is a decision that should be made only when it has been determined that this is the only treatment option that will be effective for the child. While a child should never have to fail in less restrictive settings as a pathway to obtain the services that they need, placing a child in residential care is serious and has significant implications on child permanency. It means that the child will be in care for an extended period of time, it means that connections to kin, culture and community may be further severed.

However, if it is clear that a child must be placed in a residential facility, it is important that the CPS Specialist stress to the provider, the importance of ensuring that the child maintains connection to family, extended family and other important people in his/her life. The facility must never use visitation with family as a punishment or reward for the child. Visitation with family is a child's right and needs to be safeguarded. The goal of residential treatment is NOT for a child to learn to live well in an institution, but for the institution to help the child live well in the community. The longer a child remains in residential care, the more challenging it may be for the child to effectively live in a non-structured setting.

Implementation and Procedures Guide

If the child is dually adjudicated, notify the other agency provider of all notices, motions, hearings or other proceedings related to the provision of residential treatment services.

Attend all hearings regarding the placement in and provision of residential treatment services.

If an outpatient assessment, inpatient psychiatric assessment or inpatient psychiatric acute care services recommends residential treatment services and the child is Title XIX eligible, obtain RBHA authorization for the service.

If the child is not Title XIX eligible or the RBHA has denied authorization, submit required documents to the district Mental Health Specialist for approval. Include current psychological/ psychiatric reports, significant medical information, and provider reports.

Consult with the RBHA or district Mental Health Specialist, as appropriate, to determine the appropriate residential treatment facility.

Contact the assigned Assistant Attorney General to discuss filing a motion for residential treatment services.

Contact all parties including the child's attorney, and determine each party's position on the motion for residential treatment services. A hearing on the motion is not required if all parties agree with the motion.

Complete and fax the Motion for Placement, CT03300, found in Court Document Detail, including the Addendum to the Juvenile Court. The motion must include the following:

- A Written Statement From The Medical Or Clinical Director/Designee Of The Residential Treatment Service Facility (Exhibit 48) or the director's designee that the facility's services are appropriate to meet the child's needs.
- Fax the Motion for Placement, Addendum Report and all of the following documents to the assigned Assistant Attorney General:
  - A written psychological, psychiatric or medical assessment recommending residential treatment services. The court on a finding of good cause, may waive the written assessment. If the court does not waive the written assessment, the assessment shall include at least the following:
    - The reason why residential treatment services are in the child's best interests.
    - The reason why residential treatment services are the least restrictive treatment available.
    - The reason why the child's behavioral, psychological, social or mental health needs require residential treatment services.
    - The estimated length of time that the child will require residential treatment services.

BEST PRACTICE TIP:

Good residential facilities are planning for discharge at the moment of placement. They are actively pursuing strategies and interventions that assist the child in living well as rapidly as possible in a lesser restrictive environment. CPS Specialists need to ensure that consistent and frequent conversations are occurring that will result in the child living in the community as soon they can safely (emotional, personal and community safety). CPS Specialists can support this kind of planning by scheduling frequent case plan reviews, and asking specific questions

during the case plan review sessions about the timing for the child's transition to the community.

Personally admit or arrange for another ACYF representative familiar with the case to admit the child to the residential treatment facility, completing all necessary paper work including authorization for treatment, and providing information on the child's background, legal status, and reasons for the admission.

Ensure that the residential treatment facility is aware of department policies and procedures regarding contact between the child, the child's parents and siblings, family members, other relatives, friends and any former foster parents.

BEST PRACTICE TIP:

There are times when the CPS Specialist has to be a strong advocate for the child's opportunity to interact with their family, siblings, friends and former caregivers on a frequent and ongoing basis. Sometimes the facility may want to limit visitation based on their "rules" or require the child to achieve a certain "level" before the child can visit. It can be very challenging to move residential facilities that have a long history of program planning. CPS Specialists will need support by their supervisors, program administrators and central office staff if their advocacy is met with resistance.

Provide the residential treatment facility with the names and addresses of all parties including the child's attorney and guardian at litem.

If the child remains placed in a residential treatment facility for at least 60 days or longer, the court will review the child's continuing need for residential treatment services every 60 days from the date of the treatment order. See 60 Day Review of Residential Treatment (Exhibit 49). The residential treatment facility must submit a written progress report to the court **at least five days before the review** and to all parties including the child's attorney and guardian ad litem.

The progress report shall include recommendations and all of the following:

- § the nature of the treatment provided, including any medications and the child's current diagnosis;
- § the child's need for continued residential treatment services, including the estimated length of the services;
- § a projected discharge date;
- § the level of care required by the child and the potential placement options that are

available to the child on discharge; and

§ a statement from the medical or clinical director of the residential treatment services facility or the director's designee as to whether residential treatment services are necessary to meet the child's needs and whether the facility that is providing the residential treatment services to the child is the least restrictive available alternative.

To transfer from one residential treatment facility to another residential treatment facility:

§ Participate fully in discharge planning for transfer.

§ Do not complete a new inpatient assessment or outpatient assessment.

§ Contact the assigned Assistant Attorney General to discuss the notice of transfer, unless the court orders otherwise due to an emergency.

§ Complete the Motion for Placement CT03300, found in the Court Document Detail, including the attached Addendum Report to Juvenile Court to file a notice of transfer with the juvenile court. The notice must include the following:

o the name and address of the facility to which the child is being transferred;

o the date of transfer; and

o a statement from the medical or clinical director of the receiving residential treatment facility or the director's designee that the receiving is an appropriate facility to meet the child's mental health needs and that the facility is the least restrictive available alternative.

- Fax the Motion for Placement, Addendum Report and statement from the medical or clinical director or designee to the assigned Assistant Attorney General.

To notify the court of the child's discharge from the residential facility:

- Obtain or request a copy of the discharge summary including a statement of services being provided to the child and the child's family from the residential treatment facility.
- Contact the assigned Assistant Attorney General to discuss the child's discharge to a group care facility, an unlicensed provider, or to the parent or guardian, and complete the following:

§ the Motion for Placement, CT03300, found in the Court Document Detail, including the attached Addendum Report to Juvenile Court; and

§ obtain the parties' position on the motion for change of physical custody.

Fax the Motion of Placement, Addendum Report and the discharge summary to the assigned Assistant Attorney General.

DOCUMENTATION :

Document all court hearings using the Hearing Documentation window.

Document participation in treatment staffings using the Case Notes window designated as Case Conference type.

Update CHILDS to reflect the change in the placement needs of the child in the Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Participant Education Condition, Participation Education Detail, Hospitalization Detail, and Child Assessment and Special Rate Evaluation windows.

Document the child's placement in a residential treatment facility using the Placement/Location Detail window, or completion of the Service Authorization Request, Service Authorization Approval and Service Authorization Provider Match windows.

Update the Address and Phone Number window to reflect any change in placement of the child.

Document Assistant Attorney General approval of all motions using the Case Notes window designated as AG Contact type.

For More Information: See Title XIX Behavioral Health and Substance Abuse Services (Exhibit 20) for more information on initiating a referral for Title XIX behavioral health services.

For More Information: See Selecting an Out-of-Home Care Provider (Chapter 6 Section 5) and Placing Children in Out-of-Home Care (Chapter 6 Section 7) for more information on therapeutic residential programs.

For More Information: See Notice to Residential Care and Acute Psychiatric Facilities on Reporting Requirements (Exhibit 50).

Revision History:
DES(07-2006)

Next

8-2

Legal Basis: ARS §8-271 provides definitions to clarify and broaden commonly used terms that apply to children's mental health services regarding admission and treatment.

ARS §8-273 describes the circumstances and procedures under which an outpatient or inpatient assessment and inpatient psychiatric acute care services (hospitalization) will be provided.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 8: Section 2

Arranging for Inpatient Psychiatric Assessment or Inpatient Psychiatric Acute Care Services of a Dependent Child

Legal Basis

Policy: The department shall seek inpatient psychiatric acute care services (hospitalization) for a child who is a danger to self or others or may suffer from a mental disorder.

The department shall obtain court approval for an inpatient psychiatric assessment or acute care services (hospitalization) of a dependent child.

When a dependent child requires inpatient psychiatric acute care services (hospitalization), the department shall participate in planning and decision making involving the child's treatment and discharge.

When a dependent child requires inpatient psychiatric acute care services (hospitalization), the department shall engage the child's family and if appropriate temporary caregiver in the planning process.

If the child is dually adjudicated, the department shall notify the other agency provider of all notices, motions, hearings or other proceedings related to the provision of inpatient psychiatric acute care services.

To determine if an inpatient psychiatric assessment is needed, consider the following:

Does the child display risk of harm to self or others or is there an emergent or continuance of recent, recurring or intermittent episodes of risk of danger to self or others as evidenced by:

- § suicidal ideation, behavior or intent, or
- § homicidal or significant assaultive ideation, behavior or intent, or
- § physiologic jeopardy, or
- § self injurious behaviors.

Has a psychiatrist, psychologist or physician determined the child requires an inpatient assessment due to a mental disorder or other personality disorder or emotional condition?

Has the local RBHA crisis team recommended an inpatient assessment?

Implementation and Procedures Guide

If the child is dually adjudicated, notify the other agency provider of all notices, motions, hearings or other proceedings related to the provision of inpatient psychiatric acute care services.

If an outpatient assessment recommends an inpatient assessment or psychiatric acute care services and the child is Title XIX eligible, obtain RBHA authorization.

If the child is not Title XIX eligible or the RBHA has denied authorization admission, obtain CMDP Behavioral Health Unit authorization.

Consult with the RBHA or CMDP, as appropriate, to determine the hospital and the arrangements for transportation of the child and any further instructions.

Personally admit the child to the hospital, completing all necessary paper work and providing information on the child's background, legal status, and reasons for the admission.

Upon admission of a child for an inpatient psychiatric assessment:

Contact the Attorney General's Office to discuss the motion for psychiatric inpatient assessment.

Complete the Motion for Placement, CT03300 found in the Court Document Detail including the attached Addendum Report to the Juvenile Court **within 24 hours** of the child's admission excluding weekends and holidays. The Addendum Report must include all of the following information for inclusion in the motion:

- § name and address of the inpatient assessment facility;
- § name of the psychiatrist, psychologist or physician who will perform the inpatient assessment;
- § the date and time the child was admitted to the inpatient facility; and
- § a short statement explaining why the child needs an inpatient assessment. (A written report from a psychiatrist, psychologist, or physician is not required for this

motion).

Obtain the written report of the inpatient psychiatric assessment from the psychiatrist, psychologist or physician **within 72 hours** of admission, excluding weekends and holidays. Determine what services, if any are recommended.

Fax the Motion for Placement and the Addendum Report to the assigned Assistant Attorney General.

If the inpatient psychiatric assessment does not recommend inpatient acute services:

- Immediately pursue the level of care recommended by the psychiatrist, psychologist or physician.
- Immediately arrange to discharge the child from the hospital.

If the inpatient assessment recommends inpatient acute care services:

- Obtain RBHA or CMDP authorization, and determine the hospital and arrangements for transportation of the child, if not already hospitalized.
- Contact the Attorney General's Office to discuss the motion for psychiatric acute care services.
- Complete the Motion for Placement, CT03300, found in the Court Document Detail including the attached Addendum Report to the Juvenile Court. The motion must be filed **within 24 hours** of completion of the inpatient psychiatric assessment or the child will be discharged from the facility. The motion shall include all of the following:
  - a copy of the written report of the results of the Inpatient Assessment Report (Exhibit 46) or Outpatient Assessment Report (Exhibit 47) , which addresses:
    - the reason why inpatient psychiatric acute care services is in the child's best interests;
    - the reason inpatient psychiatric acute care services are the least restrictive available treatment;
    - a diagnosis of the child's condition that requires inpatient psychiatric acute care services and list of medications; and
    - the estimated length of time that the child will require inpatient psychiatric acute care services (hospitalization).
  - A Written Statement From The Medical Director/Designee Of The Proposed

Inpatient Psychiatric Acute Care Facility (Exhibit 48) that the facility's services are appropriate to meet the child's mental health needs.

þ Fax the Motion for Inpatient Psychiatric Acute Care Services, written report of the results of the inpatient assessment or outpatient assessment, and the written statement from the medical director or designee to the assigned Assistant Attorney General.

þ Attend the hearing on the motion for inpatient psychiatric acute care services which will be held **within 72 hours** of the filing of the motion.

þ Pending the hearing on the motion for inpatient psychiatric acute care services, the child may remain at the inpatient assessment facility, if already hospitalized.

Upon admission of a child to an inpatient psychiatric acute care facility for inpatient treatment:

þ Participate in weekly hospital staffings including discharge planning in person, by telephone, or through a substitute ACYF representative familiar with the case.

þ Notify the District Mental Health Specialist or designee of any disagreements among professionals regarding the need for continued treatment or discharge planning.

þ If the child is expected to remain hospitalized for 60 or longer days, the court will review the child's continuing need for inpatient psychiatric case services at least **every 60 days** after the date of the treatment order. See 60 Day Review of In- Psychiatric Treatment (Exhibit 49). The facility will submit a written progress report to the court at least five days before the review and to all parties including the child's attorney and guardian ad litem. The progress report shall make recommendations and include the following:

§ a description of the treatment provided, including any medications and the child's current diagnosis;

§ the child's need for continued inpatient psychiatric acute care services, including the estimated length of the services;

§ a projected discharge date;

§ the level of care required by the child and the potential placement options available to the child on discharge; and

§ a statement from the medical director of the inpatient psychiatric acute care facility or the director's designee as to whether inpatient psychiatric acute care services are necessary to meet the child's mental health needs and whether the facility that is providing the inpatient psychiatric acute care services to the child is the least restrictive available alternative.

þ Provide the facility the names and addresses of all parties including the child's

attorney and guardian ad litem.

þ If you have not received a copy of the written progress report five days prior to the hearing to review the child's continued need for inpatient psychiatric acute care services, contact the facility and notify the assigned Assistant Attorney General.

To transfer from one inpatient psychiatric acute care facility to another inpatient psychiatric acute care facility:

þ Participate fully in discharge planning for transfer.

þ Do not complete a new inpatient assessment or outpatient assessment.

þ Contact the assigned Assistant Attorney General to discuss the notice of transfer, unless the court orders otherwise due to an emergency.

þ Complete the Motion for Placement, CT03300, found in the Court Document Detail including the attached Addendum Report to the Juvenile Court to file a notice of transfer with the juvenile court. The notice, which must be filed with court at least **five days before** the transfer of the child, shall include all of the following:

§ the name and address of the facility to which the child is being transferred;

§ the date of the transfer;

§ a statement from the medical director of the receiving psychiatric acute care facility or the medical director's designee that the receiving facility is an appropriate facility to meet the child's mental health needs and that it is the least restrictive available alternative; and

§ a statement that the department has contacted the child's attorney or guardian ad litem and whether the child or the child's attorney or guardian ad litem opposes the transfer.

þ Fax the Notice for Transfer, Addendum Report and statement from the medical director or designee to the assigned Assistant Attorney General.

To arrange for discharge from an inpatient psychiatric acute care facility:

þ **Within 15 days** after the child is discharged, obtain a copy of the discharge summary. Ensure that the summary includes recommendations for placement and services.

þ Contact the assigned Assistant Attorney General:

§ to file a notice of discharge with the Juvenile Court. The notice, which must be filed with the court **within 20 days** after discharge of the child, shall include the following:

- a statement of the child's current placement;
- a statement of the mental health services that are being provided to the child and child's family; and

- a copy of the discharge summary prepared by the mental health professional.

§ to file a motion for change of physical custody, if necessary. If the child is being discharged to a placement that is different from the placement prior to the hospitalization, or a group care facility, an unlicensed provider, or a parent or guardian, complete the following:

- the Motion for Placement, CT03300 found in the Court Document Detail, including the attached Addendum Report to the Juvenile Court, and
- obtain the parties' position on the motion.

þ Fax the applicable documents to the assigned Assistant Attorney General.

DOCUMENTATION :

Document all court hearings using the Hearing Documentation window.

Document participation in hospital staffings using the Case Notes window designated as Case Conference type.

Update CHILDS to reflect the change in the placement needs of the child in the Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Participant Education Condition, and Hospitalization Detail, and Child Assessment and Special Rate Evaluation windows.

Document the child’s hospitalization using the Placement/Location Detail window.

Update the Address and Phone Number window to reflect any change in placement of the child.

Document Assistant Attorney General approval of all motions using the Case Notes window designated as AG Contact type.

For More Information: See Title XIX Behavioral Health and Substance Abuse Services (Exhibit 20) on initiating a referral for Title XIX behavioral health services.

Revision History:
DES(07-2006)

Previous

9-1

Legal Basis: The federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that every child in out-of-home care has a case plan and delineates federal requirements regarding case plans.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) clarifies and modifies the reasonable efforts requirements of P.L. 96-272 and adds additional case plan requirements.

ARS §8-813(A)(1) requires the development of a case plan for children in out-of-home care.

ARS §8-824(G)(10) requires the department to present to the court at the Preliminary Protective Hearing a proposed case plan for services to the family.

Rules: 45 CFR Part 1356.21 requires children in out-of-home care or at risk of out-of-home placement to have a case plan in order to be eligible for Title IV-E federal foster care maintenance reimbursement, and describes the required components of the case plan .

Revision History:
DES(07-2006)

Chapter 9: Section 1

Developing the Family Centered Case Plan

Legal Basis

Policy: Every child and family receiving ongoing services from ACYF shall have an individualized family centered case plan, consistent with the requirements of federal and state law.

The family centered case plan shall be a discrete document that includes the following components:

§ *the child's safety plan*, specifying ongoing actions that will be taken to ensure the child's continued safety at home, and demonstrating the child's health and safety is of paramount concern;

§ *permanency goal for the child*, and expected date of achievement; Permanency goal options include reunification, adoption, legal guardianship and another planned living arrangement. Include a concurrent permanency plan for children who have been assessed as unlikely to reunify with their parent within 12 months of the child's initial removal;

§ *family intervention plan*, specifying for all parents (whose parental rights have not been terminated), and guardians, the kinds of services and supports that will be offered to their family in order to achieve the case plan permanency goal. The services and supports are to be tailored to meet the specific needs of the family;

§ *out-of-home care plan*, specifying for every child in out-of-home care:

o the child's special needs;
o the child's educational status;
o how the placement type meets those needs;
o services provided to the child;
o services provided to the caregiver to help them meet the child's needs;
o actions the CPS Specialist will take to ensure safety in the out-of-home setting;
o when applicable, tasks and services to achieve a concurrent permanency goal or a permanency goal other than family reunification; and
o for any child placed substantially distant from the parent's home or out-of-state, the reason the placement is in the best interest of the child.

§ *health care plan,* specifying for each child, the child's health status and actions to assure the child's health needs are met;

§ *contact and visitation plan,* specifying for every child in out-of-home care the plan for frequent and consistent visitation between the child and the child's parents, siblings, family members, other relatives, friends, and any former (family) resource family, especially those with whom the child has developed a strong attachment; and

§ specific documentation of how the family and other team members actively participated in the development of the plan.

The department shall encourage the participation of parents, children, out-of-home care providers and when appropriate, extended family members in the case planning process.

The department shall conduct a case plan staffing **within 60 days** of case opening for all cases **open for more than 60 days or within 10 working days** of a child's placement into voluntary foster care. The meeting prior to the Preliminary Protective Hearing or any other family team meeting may be considered a case plan staffing if all service team members have been identified, notified and provided an opportunity to participate.

All members of the service team shall be invited to participate in the case plan staffing. Parents, children age 12 or older, and out-of-home care providers shall be members of the service team. To every extent possible, and when appropriate, extended family members may also participate as members of the service team.

Implementation and Procedures Guide

BEST PRACTICE TIP:
Family engagement and the perception the family has of the CPS Specialist's desire to hear their thoughts and ideas has a direct relationship to the family's success in carrying out the action steps within the plan. Plans that are crafted in the office and brought to the family are less successful in achieving outcomes, than plans crafted with the family—from start to finish. Sometimes CPS Specialists try to save time by drafting the plan first, and then taking it to the family for their review and modification. It is critical for CPS Specialists to understand that the power imbalance that is inherent in the system minimizes the family's ability to provide feedback to a previously drafted plan—even in "draft" form. The family must be actively involved from the very beginning in identifying how their needs will be met through the case plan.

For dependency cases, including in-home intervention, in-home dependency and out-of-home dependency, a proposed case plan must be developed and submitted to court prior to the first scheduled hearing. This plan will be developed with limited information about the family's strengths and needs and should be revised during the process of creating the permanent plan with the family and service team. An exception to this may be a case in which the department has been working with the family and comprehensive information about the family's strengths and needs are already known. In these cases, the proposed case plan may be used as the permanent case plan if a case plan staffing was held to develop the plan and family members, extended family and others with whom the family has a strong relationship were part of the planning process.

For cases involving In-Home Services (Family Preservation and Supports Moderate and Intensive), the provider service plan may substitute for the case plan.

Otherwise, when preparing the permanent case plan, ensure that a comprehensive assessment of the family's strengths and needs using the Family Strengths and Risks Assessment (Exhibit 15) protocol has been completed with the family.

Review and update the Medical Condition, Practitioner Detail and Examination Detail windows if necessary. Update the Family Relationship, Person Detail, Participant Detail and American Indian Detail windows at the same time.

To conduct a case plan staffing:

- Schedule the case plan staffing, making an effort to accommodate the needs of parents, out-of-home care providers and children.

- Use the Notification window to create the case plan staffing invitation and agenda and to invite members of the service team to the staffing. Include:
    - o parents;
    - o child, if age 12 or older;
    - o extended family members;
    - o the out-of-home care provider;
    - o the licensing worker;
    - o other service providers working with the family, including the parent aide;
    - o the tribal social service representative, if applicable;
    - o the Court Appointed Special Advocate (CASA);

o the child's and/or parent's Regional Behavioral Health Authority (RBHA) case manager;

o the child's attorney and/or guardian ad litem;

o the parent's attorney and/or guardian ad litem; and

o the Assistant Attorney General assigned to the case.

- Other individuals who may be invited include, but are not limited to:

o other significant individuals with whom the child may be placed or who have knowledge of or an interest in the welfare of the child;

o the CPS Specialist's supervisor;

o school personnel;

o law enforcement personnel including probation and parole officers; and

o other DES personnel or contracted staff.

BEST PRACTICE TIP
It is important that the CPS Specialist encourage the parents to invite individuals to the case planning meeting who the parents and child trusts. Families involved in the child welfare system frequently feel intimidated and uncertain about how much they have the right to "speak up" and disagree with the plan. By having extended family or individuals who have a strong relationship with the parents in attendance, the parents have an advocate and another person to help voice their concerns and needs.

Request that service team members who cannot attend the case plan staffing provide a written report, a verbal report, or participate by conference call.

Facilitate the case plan staffing, seeking comments, concerns and recommendations from members of the service team.

Based on the needs and risks identified in the Family Strengths and Risks Assessment, develop the permanent case plan with the family and other service team members. See Ensuring A Meeting With The Family Is Family Centered (Exhibit 27). Also See Cultural Competence: Starting Where the Family Is At (Exhibit 39).

Request that participants sign the Case Plan Agreement indicating whether they agree or disagree with the case plan.

Provide a copy of the case plan to all members of the service team, whether they attended the staffing or not.

As changes are needed in the case plan, see Reassessing and Revising the Case Plan. (Chapter 9 Section 7)

DOCUMENTATION :

Update the Family Relationship windows at the same time that the case plan is revised.

Document the proposed and permanent case plans using the windows associated with the Case Plan Directory.

Identify any members of the service team who were invited but did not attend on the Case Plan Agreement window. Indicate any member who refused to sign the Case Plan Agreement.

File the original signed Case Plan Agreement in the child's hard copy record.

For More Information: On creating a case plan in CHILDS see the CHILDS Guide for Field Users, Entering a Revised Case Plan and Entering a New Case Plan, found in Public Folders.

Revision History:
DES(07-2006)

Next

9-2

Legal Basis: The federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires states to make reasonable efforts to keep families together whenever possible, to reunify families if out-of-home placement is necessary, and, if reunification is not possible, to pursue permanent placement for a child through adoption or other alternatives.

The Federal Adoption and Safe Families Act of 1997 (P.L. 105-89) defines circumstances under which reasonable efforts to reunify families are not required. In these circumstances, reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete steps necessary to finalize the permanent placement of the child.

ARS §8-845 requires the court to reunify families insofar as possible. If reunification services are not ordered, the court is required to order a plan of adoption or another permanent plan that is in the child's best interest. Reasonable efforts to place a child for adoption may be made concurrently with reasonable efforts to reunify the family.

ARS §8-846 delineates circumstances where reunification services are not required.

ARS §8-862 requires the court to determine at the Permanency Hearing within 30 days after the Disposition Hearing if reunification services were not ordered or within 12 months from the child's removal from home. The court is also required to determine whether reasonable efforts have been made to finalize the permanency plan in effect. If the court determines that termination of parental rights, adoption or some other permanent legal status is the most appropriate plan for the child, the court will order the plan to be accomplished within a specified time period.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 2

Determining the Permanency Goal for A Child

Legal Basis

Policy: In selecting the permanency goal for the child, the department shall seek to maintain and support the child's relationship to his or her biological parents, extended family members and other individuals with whom the child has an emotional attachment.

Unless the court finds that aggravating circumstances exist, agency preference for consideration of permanency goals shall be as follows:

- § remain with family;
- § family reunification;
- § adoption;
- § legal guardianship;
- § Independent Living as Another Planned Permanent Living Arrangement; and
- § Long Term Foster Care as Another Planned Permanent Living Arrangement

The permanency goal shall be specified in the child's case plan and submitted to the court for approval.

For children who remain in their home, the permanency goal shall be to remain with family.

Unless the court finds that aggravating circumstances exist, the initial permanency goal for children receiving out-of-home care services shall be family reunification.

If it is determined that reunification services are contrary to the child's best interests or that reunification services are not reasonable due to an aggravating circumstance, the department shall recommend that the court order reasonable efforts to reunify the family not be provided.

If, as a result of a case plan staffing, it is determined that no available services or interventions will enable the family to address the safety and risk factors that prevent the child from living safely at home within a timeframe that meets the needs of the child, the department shall recommend to the court that the permanency goal be changed from family reunification to another permanency option.

The department shall not change the permanency goal or discontinue reunification services unless ordered by the court. Pending court approval of a change in the permanency goal, the department shall increase efforts to implement the concurrent plan.

Concurrent case planning shall occur for all children placed in out-of-home care with a permanency goal of family reunification where the prognosis of achieving family reunification is poor and unlikely to occur within 12 months of the child initial removal.

Extreme caution shall be exercised in determining that a child will not benefit from a plan of adoption or legal guardianship.

A permanency goal of long term foster care as another planned permanent living arrangement shall be approved by the Program Manager or designee and reviewed annually.

Implementation and Procedures Guide

Whenever possible, prior to the case plan staffing, discuss and stress the importance of permanency in a child's life with the parents. Inform the parents of all available alternatives to achieve permanency for the child, including family reunification through successful participation in services, consent to adoption, consent to guardianship, and adoption through termination of parental rights. Engage the parents in a discussion of the alternatives to achieve permanency and obtain their input into the selection of the permanency goal.

Select a case plan goal consistent with the preferences previously listed, the needs of the child, and aggravating circumstances, taking into account any specific directions from the court and the input from the parents and other service team members.

BEST PRACTICE TIP:
When a child must be removed from their family, reunification of the child with their family is the goal of child welfare services. However, there are times when the family circumstances will not allow this to occur. When this is the case, another permanency goal must be established to ensure that the child has permanent connections with adults who love the child and remain connected as the child enters adulthood. The legal permanency options under ASFA other than reunification include legal guardianship or adoption. There are those rare times when neither reunification, adoption nor legal guardianship can occur. In those instances ASFA allows for the CPS Specialist to develop a plan for something called "Another Planned Living Arrangement". Even when this is the plan the CPS Specialist should continue to look for kin who can serve as a permanent adult connection for the child. It is never too late for a child to be adopted!

Additionally, while planning a permanency option other than reunification, it is important that the CPS Specialist consider what the optimal connection between the child and their biological family might look like. When the child cannot return home on a permanent basis, consider the level of connection that is best for the child. Can the child and birth family maintain contact

with one another? Can they write to one another and share pictures? Can they share holidays and special occasions? For each child, the answer may be different. When a child cannot live with their family this DOES NOT mean that they cannot have a relationship.

Identify and actively pursue a concurrent case plan for all children in out-of-home care with a permanency goal of family reunification where the prognosis of achieving family reunification is poor and unlikely to occur within twelve months of the child's initial removal. Use the Reunification Prognosis Assessment Guide (Exhibit 28) to assist in assessing the prognosis for family reunification.

Concurrent case planning means that while the CPS Specialist is actively supporting and assisting the family in their efforts to reunify with their child, another option for permanency is implemented in the event that reunification is not successful. When the CPS Specialist is concurrently planning for two different permanency options, it is crucial to explore the possibilities of placement with relatives, others with whom the child has a close relationship as well as existing caregivers such as foster parents.

Consult your supervisor if you believe that there is reason to select a permanency goal other than remain with family or family reunification.

Consult with the supervisor and the Attorney General to determine that there is sufficient documentation to recommend that the court order reasonable efforts to reunify the family not be provided due to aggravating circumstances.

Aggravating circumstances in which the court is not required to order reasonable efforts to reunify families includes:

§ The identity of the parent continues to be unknown after three months of diligent search.

§ The parent has expressed no interest in reunification with the child for at least three months after the filing of the dependency petition.

§ The parent or guardian is suffering from a mental illness or mental deficiency of such magnitude that renders the parent or guardian incapable of benefiting from reunification services, and if such services were provided, the parent or guardian would not be able to adequately care for the child within 12 months from the date of the child's removal from the home.

§ The child was removed and adjudicated dependent due to physical or sexual abuse, was returned to the custody of the parent or guardian and subsequently removed within 18 months due to additional physical or sexual abuse.

§ A child is the victim of serious physical or emotional injury as defined in state law, by the parent or guardian or by any person known by the parent or guardian, if the parent or guardian knew or reasonably should have known that the person was abusing the child.

§ The parent's rights to another child have been terminated and the parent has not successfully addressed the issues which led to the termination and is currently unable to discharge parental responsibilities.

§ A dependent child has been removed from the parent or guardian on at least two previous occasions, reunification services were offered or provided to the parent or guardian after the removal, and the parent or guardian is unable to discharge parental responsibilities.

§ The parent or guardian of a child has been convicted of murder or manslaughter of a child or of sexual abuse, sexual assault of a child, sexual conduct with a minor, molestation of a child, commercial sexual exploitation of a minor, sexual exploitation of a minor or luring a minor for sexual exploitation, or the parent or guardian of a child has been convicted of aiding or abetting or attempting, conspiring or soliciting to commit any of these crimes.

Select adoption as the permanency goal when any of the following occur:

F The court has determined the child to be an abandoned infant.

F The parent has been convicted of murder or manslaughter of another child of the parent or of aiding or abetting, or attempting, conspiring or soliciting to commit murder or manslaughter of another child of the parent.

F The child is a ward of the court, committed to the care, custody and control of the department and has been in out-of-home care for a cumulative total period of 15 of the most recent 22 months, unless:

§ the department did not comply with court ordered reasonable efforts by providing services which would enable the child to return home safely, or

§ there is a compelling reason that termination of parental rights is not in the child's best interests and the reason is documented in the case plan.

o The above requirement does not apply when the child is being cared for by a relative; unless it is determined that adoption is in the child's best interests.

Change the permanency goal only after discussion with service team members during a case plan staffing and approval by the court. (Remember that a case plan staffing can be convened whenever case circumstances indicate a need; you do not need to wait until the next regularly-scheduled six month staffing.)

If the permanency goal is being changed to long term foster care as another permanent planned living arrangement, request review and approval of the goal by the Program Manager or designee.

BEST PRACTICE TIP:
Making the decision regarding the permanency goal for a child in care is one of the most complicated and important decisions a CPS Specialist makes. As such, it is important that the CPS Specialist ensure that the team including the birth family, extended family, those with whom the child and family have significant relationships, other team members including community providers and existing caregivers, play an active part in the decision making process. Regardless of the decision, the CPS Specialist must find ways to minimize trauma and subsequent loss by the child. If the child has made a strong connection with the foster family, and the child's plan is to return home or go to another permanent placement, the CPS Specialist should actively plan for how the child will maintain his/her connection with the foster family. If the child has made friends at one school and is moving to another school, the CPS Specialist should actively plan for how the child will maintain connections with his/her friends. We should not allow children served by the child welfare system to experience additional losses.

DOCUMENTATION :

Document the selection and revision of the proposed permanency goal using the Permanency Goals window.

Document justification for selection or revision of the permanency goal using the Case Notes window, Staffing type; and in the next Progress Report to the Juvenile Court or Permanency Hearing Report to the Juvenile Court following the case plan staffing.

Document the concurrent permanency goal using the Permanency Goals window.

Document the compelling reason that termination of parental rights is not in the child's best interests by checking the Compelling Reason check box located on the Permanency Goals window. Document the justification using the Explain window.

Document the request for Program Manager or designee review and approval of a Long Term Foster Care as Another Planned Permanent Living Arrangement goal using the Case Notes window designated as Management Contact type.

Program Manager or designee:

Document approval of a Long Term Foster Care as Another Planned Permanent Living Arrangement goal using the Case Note Comment window.

For More Information: On implementing concurrent permanency planning, see Developing and Implementing a Concurrent Permanency Plan (Chapter 9 Section 3)

For More Information: On termination of parent-child relationships see Consent and Termination for Adoption, (Chapter 12); and Adoption and Placement (Chapter 13).

Revision History:
DES(07-2006)

Previous / Next

9-3

Legal Basis: Title IV-E of the Social Security Act states reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts to reunify the child and family.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires that reasonable efforts be made to place the child in a timely manner in accordance with the permanency plan and to complete steps necessary to finalize the permanent placement of the child.

ARS §8-845 requires the court to reunify the family insofar as possible. If reunification services are not ordered, the court is required to order a plan of adoption or another permanent plan that is in the child's best interest. Reasonable efforts to place a child for adoption may be made concurrently with reasonable efforts to reunify the family.

Rules: 45 CFR 1356.21(4) states reasonable efforts to finalize an alternative permanency plan may be made concurrently with reasonable efforts to reunify the child and family.

Revision History:
DES(07-2006)

Chapter 9: Section 3

Developing and Implementing a Concurrent Permanency Plan

Legal Basis

Policy: Concurrent permanency planning shall occur for all children in out-of-home care with a permanency goal of family reunification where the prognosis of achieving family reunification is poor and unlikely to occur within 12 months of the child's initial removal.

Agency preference for concurrent permanency goals shall be as follows:

- § adoption, or
- § legal guardianship.

When the identity and whereabouts of the parents are known, the department shall provide written notification of the concurrent permanency goal to the parents.

In cases where concurrent permanency planning is occurring, the department shall simultaneously actively pursue the family reunification permanency goal and the concurrent permanency goal.

In cases where concurrent permanency planning is occurring, the department shall identify and pursue placement of the child in a suitable and potentially permanent family placement.

No child shall have a concurrent permanency goal of long term foster care as another permanent planned living arrangement.

Implementation and Procedures Guide

Actively pursue the family reunification permanency goal by providing all services specified in the Family Intervention Plan and making all reasonable attempts to engage the family in services.

As early as the Removal Review Conference but no later than 90 days from case opening, and whenever significant information related to the prognosis for achieving family reunification is received, consult with the supervisor to assess the prognosis for successfully achieving family reunification. Use the Reunification Prognosis Assessment Guide (Exhibit 28) for guidance in making this assessment.

When the prognosis of achieving family reunification is assessed as poor and unlikely to occur within 12 months of the child's initial removal, identify a concurrent permanency goal and related tasks and outcomes.

BEST PRACTICE TIP:
Concurrent planning is a foreign term to birth families. It needs to be fully explained. CPS Specialists can expect that parents will be concerned that the CPS Specialist is not really supportive of reunification; not really trying to help the family succeed when concurrent planning is described. It is up to the CPS Specialist to help the family understand: 1) that the CPS Specialist has hope in their ability to succeed and will support the family to be successful and, 2) the family has control over whether or not the concurrent permanency plan becomes the primary permanency plan. If the parent engages in the process, they are more likely to succeed in carrying out the reunification plan

At or before the initial case plan staffing and all subsequent case plan staffings, the department shall discuss and stress the importance of permanency with the parents, and shall inform the parents:

- of all available alternatives to achieve permanency for the child, including family reunification through successful participation in services, consent to adoption, consent to guardianship, and adoption through termination of parental rights;

- that if significant progress toward the outcomes listed in the case plan is not made by the time of the Permanency Hearing, the department may recommend, or the court may order the permanency goal be changed from family reunification to another permanency goal, such as adoption or guardianship.

BEST PRACTICE TIP:
In order to help the family fully understand the importance of their active involvement in the services described in the case plan, it is often effective to provide a visual chart depicting the court process. The chart might include the date the child was removed from their home, the date of the first court hearing, the dates of administrative reviews and case planning staffings and the date when the court will consider alternate permanency options if progress is not evident. This visual aid helps parents to better understand how the different meetings and court appearances tie together. Going over this chart from time to time, pointing out where the family is in the process, encourages attention to the "ticking clock" and creates a level of urgency that can be effective in motivating parents.

As appropriate considering the child's age and developmental capacity, and for all children age 12

or older, at or before the initial case plan staffing and all subsequent case plan staffings, ensure the child is:

§ informed about the department's goal of achieving permanency for the child in a safe home;
§ informed of all available alternatives to achieve permanency for the child, including family reunification through the parents successful participation in services, consent to adoption, consent to guardianship, and adoption through termination of parental rights;
§ made aware that individualized services addressing the reasons for child protective involvement are made available to families;
§ informed about their parents' activities and progress toward reunification, unless returning home is not a possibility;
§ helped to identify significant adults with whom relationships should be maintained; and
§ encouraged to maintain optimal contact with the birth family and kin, or others with whom the child has a close relationship. It will be up to the CPS Specialist and the child to determine what optimal connection with their birth family will look like including frequency of visits, visitation on special occasions, letter writing and sharing of pictures, e-mailing, etc.

Encourage the participation of parents, children, and, when appropriate, extended family members in the concurrent permanency planning process.

Provide written notification of the concurrent permanency goal to the parents at the earliest opportunity.

Identify tasks and outcomes related to the concurrent permanency goal in the Out of Home Care Plan component of the case plan.

BEST PRACTICE TIP:
The results of a national survey of workers involved in Concurrent Planning suggest that successful implementation of Concurrent Planning requires the following components of good social work practice and system's designs:

- Intensive casework with birth families.
- Frequent, meaningful visitation between the children and their birth families. See Making the Most of Visitation Between Children and Their Families (Exhibit 25).
- Full disclosure with the birth families about the importance of permanence in the lives of children, the various options for permanency planning, and consequences of their actions or inactions, and consistent communication with birth families throughout the life of a case

regarding feedback on positive case progress or the need to confront planning ambivalence.

- Diligent search efforts to find absent parents and address all paternity issues such as blood tests, child support, etc.
- Aggressive diligent searches for and assessment of relatives who might have an interest in caring for or planning for permanence for the child.
- Frequent and substantive case reviews, that carefully assess the efficacy of services being provided to assist the family to achieve case plan goals and modification of the service plan as required.
- Use of permanency planning resource families who can work towards reunification and [1] be able to serve as permanency resources if needed.

When a potential permanent kinship home has not been identified, complete an exhaustive search for such a home, following the procedures as outlined in Finding Missing Parents, Relatives, and Other Significant Persons (Chapter 6 Section 2). Also see, Relative Search Best Practice Guide (Exhibit 12) for best practice options.

When a potential permanent kinship home is identified, determine if the placement is appropriate by completing the assessment procedures in Providing Kinship Care Services (Chapter 6 Section 6).

At each subsequent case plan staffing, reassess the prognosis for successfully achieving family reunification and review, and revise as needed, the concurrent permanency goal and the related tasks and outcomes.

DOCUMENTATION :

Using the Case Notes window, document discussions with each parent and child regarding the importance of permanency, the available alternatives to achieve permanency, and the possibility the permanency goal may change if significant progress toward the case plan outcomes is not made by the time of the Permanency Hearing.

Document the concurrent permanency goal using the Permanency Goal window.

Document the outcomes and tasks related to the concurrent permanency goal using the Case Plan Tasks window, Out of Home Care Plan type.

Document progress toward completing the tasks and reaching the outcomes related to the concurrent permanency goal using the Case Notes window.

Document the reassessment and development of the revised case plan tasks by completing the Case Plan Tasks window.

Document written notification to the parents of the concurrent permanency goal by obtaining their signature on the Case Plan Agreement page of the case plan and/or by filing a copy of the written correspondence to the parents in the hard copy case record.

Document the search for a potential permanent kinship foster family home as described in Finding Missing Parents, Relatives and Other Significant Persons (Chapter 6 Section 2).

Document the assessment of a potential permanent kinship foster family home as described in Providing Kinship Care Services (Chapter 6 Section 6).

CPS Supervisor:

Document the initial and subsequent assessments of the prognosis for achieving family reunification using the Case Notes window, designated as Supervisory type, and/or by completing the Reunification Prognosis Assessment Guide (Exhibit 28).

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[1] Excerpt from Concurrent Planning: Tools for Permanency. (2000). National Resource Center for Family Centered Practice and Permanency Planning.

Revision History:
DES(07-2006)

Previous / Next

9-4

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) sets forth federal case plan requirements.

ARS §8-824(G)(10) requires the department to present to the court a proposed case plan for services to the family.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 4

Planning and Implementing Services and Supports Necessary to Achieve the Permanency Goal

Legal Basis

Policy: The family centered case plan shall specify services or interventions necessary to achieve the permanency goal.

When the permanency goal is remain with family or family reunification, the Family Intervention Plan component of the case plan shall specify:

- services aimed at addressing the safety and risk factors that caused the child to be removed from the home and/or prevent the child from living safely at home without the department's involvement; and

- the responsibilities of the department, other professionals, the parent, the child, and/or other family members as applicable, in achieving the outcomes necessary to enable the family to care for the child without the department's involvement.

When a permanency goal of adoption, guardianship, independent living or long term foster care as another planned permanent living arrangement, the Out of Home Care Plan or Independent Living Plan component of the case plan shall:

- identify services aimed at achieving the specified permanency goal as quickly as possible, and
- specify the responsibilities of the department, other professionals, the parent, the child, and/or other family members as applicable, in reaching the outcomes necessary to achieve the permanency goal.

Throughout the case, the CPS Specialist shall monitor progress towards achieving the permanency goal, any barriers towards achievement, and/or any significant changes in risk to the child or the family's situation.

If the permanency goal is remain with family or family reunification, CPS Specialists shall have face-to-face contact with all parents at least once a month, including any alleged parents, parents residing outside of the child's home, and incarcerated parents.

Exceptions to monthly face-to-face contact with parents may be made on a case-by-case basis

based on the unique circumstances of the family.

If the child's permanency goal is *not* family reunification or remain with family, CPS Specialists shall consult with their supervisor to develop a plan for contact with parents whose parental rights have not been terminated and whose whereabouts are known.

To determine the services necessary to achieve a permanency goal of *remain with family or family reunification*, review the Family Strengths and Risks Assessment—paying particular attention to family strengths—and related protective capacities, family resources, and areas where the child is at risk of future harm. It is the responsibility of the CPS Specialist, with the support of his/her supervisor to assess if and how the protective capacities of the parent mitigate the risk factors identified.

BEST PRACTICE TIP:
Family Centered case planning requires that CPS Specialists have a comprehensive understanding of the parents, their circumstances, their decision making processes, their needs and what they want for their family. Without this understanding, case plans look very much the same from family to family—and as a result have minimal potential to result in family change. One size does not fit all in family centered case planning.

For each critical risk factor, ask yourself:

§ What *outcome* has been identified as acceptable in relation to the safety or risk factor - that is, what behaviors or circumstances would lead you to believe that the child can now live safely at home without DES involvement?

§ What are the protective capacities that the family has that mitigate the risk factors?

§ What changes must take place in order for the family to achieve or move closer to the acceptable outcome?

§ What services or interventions can best promote the necessary changes?

§ What are the tasks that must take place to implement the services or interventions?

§ What specialized assessments may be necessary to identify appropriate service needs?

§ Who should be responsible for each task? What is a reasonable time frame for their completion?

For other permanency goals, ask yourself:

§ What *outcome* are we trying to achieve in relation to the permanency goal at this stage of the case work process (for example, termination of parental rights, selection of a legal guardian, and development of a long term foster care agreement)?

§ What does the family say are the tasks they believe must be accomplished to achieve the desired outcome? Do you agree? If not, talk to the family about your concerns with their plan.

§ Who should be responsible for each task? What is a reasonable time frame for its completion?

§ How will the outcome be measured?

To determine when an exception to monthly face-to-face contact is appropriate, when the permanency goal is remain with family or family reunification, consider these factors:

§ What has been the parent's frequency of contact with CPS and participation in visitation, services, staffings, etc. within the last six months?

§ What has been the parent's stated interest in reunification or visitation?

§ Is reunification with the parent a viable plan?

§ Have there been changes in the parent's circumstances which require face-to-face observation?

§ If incarcerated, does the anticipated release date preclude a normal parent-child relationship? See **Services to Incarcerated Parents** (Chapter 9 Section 8).

§ Does the location of the parent's residence substantially hinder monthly face-to-face contact (such as out-of-state)?

§ Has the parent, court, or other team member requested monthly face-to-face contact continue?

§ Will lack of monthly face-to-face contact jeopardize the family's ability to carry out the requirements of the case plan?

Implementation and Procedures Guide

In consultation with the family, child and other service team members, determine the services or interventions that are most appropriate to achieving the necessary outcomes.
Consult your supervisor if you have questions concerning which services or interventions are most appropriate to facilitate the achievement of a particular outcome.

Services may be provided either by the CPS Specialist, other department staff, contract providers, extended family members or those with whom the family has a strong connection, community resources and/or volunteers, depending on the needs of the child and family, the resources available, and the accessibility of services.

All services and activities specified in the case plan shall be time-limited. The case plan shall clearly describe what will occur if the family participates in the services and supports outlined within the plan, and does what is required for the child to be safe in their home, and what will occur if the family does not participate in services and supports as outlined in the plan and does not make the changes required to ensure child safety.

Arrange for ACYF-funded services, and/or make referrals to community resources according to district procedures.

BEST PRACTICE TIP:
There are promising practices around the country that suggest a "warm hand off" is critical to family engagement in community services. Rather than the CPS Specialist simply making the referral to a community agency, and the agency or the family calling to schedule an appointment, the family is more likely to engage in the service if the CPS Specialist arranges a meeting with the agency and the family and discusses the goals of the service, how the success of the service will be jointly evaluated and the need for either the family or the community provider to contact the CPS Specialist if the service does not appear to be achieving the desired results. Some states have seen a significant (up to 50%) increase in family participation when this kind of transitional meeting occurs.

Confirm that services have been initiated as scheduled, are appropriate and satisfactory.

Contact with Parents
If the permanency goal is remain with family or family reunification, make face-to-face contact with all parents at least once a month, including any alleged parents, parents residing outside of the child's home, and incarcerated parents.

BEST PRACTICE TIP:
There is a correlation between the frequency that CPS sees the parent, talks to them about their

progress in meeting the case plan goals, and the success families experience. Around the country families talk about the difference that their worker makes in their lives, and the fact that their worker believed in them and told them they could make the necessary changes is often the "only reason that they were able to get their children back." The CPS Specialist is often the primary person that provides the family with hope and encouragement, leading to success.

Obtain prior supervisory approval for exceptions to monthly face-to-face contact with a parent whose child's permanency goal is remain with family or family reunification. Ongoing exceptions to monthly face-to-face contact shall be reviewed with the parents, team members and the supervisor at the time the case plan is developed and revised.

At a minimum, maintain quarterly telephone contact or written correspondence with all parents whose whereabouts are known and whose rights have not been terminated.

This telephone contact or written correspondence shall provide the parent the following information:

- Name, address, and phone number of the CPS Specialist;
- A description of services the parents must complete prior to return of their child;
- Dates, locations, and contact information for any upcoming staffings and hearings; and
- Information on the well-being and status of the child, including type of placement, health status, and any significant events, progress, or concerns.

During your contact with the family and other service team members, monitor and evaluate the success of the family in meeting the goals as described in the case plan. In consultation with the supervisor, implement changes in tasks or services necessary to achieve the goal. It is not necessary to convene a case plan staffing unless there is a significant change in case circumstances or a change in permanency goal is considered, although the family should always be involved in discussions about changes to the plan.

Follow up at least every three months with the service provider and with the person receiving services to assess progress and need for continued services. Immediately respond to any complaints or problems that develop in the delivery of services.

Convene case conferences when necessary to discuss issues that arise in the implementation of the case plan. A case conference does not include all the members of the service team and may not be substituted for a regular case plan staffing.

BEST PRACTICE TIP:
Using the language "compliance" and "non-compliance" with the case plan may alienate families we are trying to engage in the process. The case plan is an evolving document that reflects the needs of the family at that time. More success has been achieved when framing the discussion in terms of the family's success as described in the plan. A family can be "non-compliant" and successful, and a family can be "compliant" and still not be able to care for

their children safely. The point of the case plan staffing should be to assess family progress in being able to safely care for their children, not necessarily compliance to a plan.

Ensure the following information is documented in case notes:

- All contacts with clients, department personnel, out-of-home care providers, members of the service team, tribal social services representatives and/or other interested parties regarding the case. Provide accurate information on dates, places, individuals involved, and the nature of the contact.
- Observations of the family's interactions and environment, written in behavioral terms and designated clearly as professional judgment or fact.

BEST PRACTICE TIP:
A good case note should assist the supervisor and any other CPS Specialist who may subsequently serve the family in understanding the progress that the family is making in achieving the goals outlined in the family centered case plan. A good case note includes the following:

§ Date and Time of Family Interaction;
§ Individuals Participating;
§ The specific goals that were discussed and worked on during the interaction with the family (A case note should link explicitly to the case plan—and the case plan should link to the Strength and Risk Assessment and the Child Safety Assessment);
§ The voice of the family or the child (including child/family perspectives, concerns, fears, hopes, etc.);
§ Observations by the CPS Specialist--and they should be documented as observations;
§ Progress the child/family is making toward goals;
§ Barriers to progress; and
§ Modifications of the case plan based on family interaction.

DOCUMENTATION :

Document the initial selection of services or interventions by completing the Case Plan Tasks window. Document the concurrent case plan outcomes and tasks using the Case Plan Tasks window.

For each revised case plan, document the selection of services or interventions by completing the Case Plan Tasks window.

Document all contacts with parents and family members using the Case Notes window, designated as the appropriate type. Document face-to-face contacts by selecting the *In Person*

Contact type radio button and highlighting, in the *Contact With* list, the names of all parties present.

Document consultation with the supervisor and the plan for contact with a parent whose child's permanency goal is not family reunification or remain with family in the Case Notes window designated as Supervisory Contact type.

Use the Explain box on the Case Plan Tasks window, Family Intervention Plan type, to document any exception to monthly contact with a parent.

File a copy of all written correspondences with a parent in the hard copy case record.

Document the progress made toward achieving outcomes specified in the case plan using the Case Notes window.

Supervisor:

Document supervisor approval of any exception to monthly contact with a parent whose child has a permanency goal of family reunification or remain with family using the Case Notes window designated as Supervisory Contact type.

Revision History:
DES(07-2006)

Previous / Next

9-5

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) sets forth federal case plan requirements.

ARS §8-813(A)(1) requires the department to develop a case plan for children in out-of-home care.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9 Section 5

Developing the Child's Safety Plan

Legal Basis

Policy: Every child receiving services from ACYF shall have an individualized Safety Plan as a component of his or her case plan. The child's Safety Plan shall identify services and supports that will enable the child to remain at or return home safely or shall indicate the need for out-of-home care.

If the child is *at home* at the time the case plan is developed, consider these questions in developing the child's Safety Plan:

§ What types of services or supports are currently in place that enhances the child's safety at home while the family addresses safety and/or risk factors that necessitated DES involvement? In particular, are there reliable individuals, such as extended family members, teachers, therapists, or school counselors, who have contact with the child on a regular basis and can monitor his or her safety?

§ Are existing services or supports adequate to conclude that the child appears to be safe in the home? If not, are there additional services or supports that can be accessed to enhance the child's safety?

If the child is in *out-of-home care* when the case plan is developed, consider these questions in developing the child's Safety Plan:

§ Can provision of specific services or supports reduce the level of risk at home to allow the child to return home safely at the present time? In particular, are there extended family members or community resources that can have contact with the child on a regular basis and can monitor to ensure his or her safety?

§ Are the necessary services available and accessible? Is the parent willing to participate in these services?

If available services or supports cannot reasonably ensure that the child is likely to be safe at home at the present time, out-of-home care is necessary.

Implementation and Procedures Guide

Review the results of the child safety assessment and the initial safety plan, if applicable. If the identified safety threats (factors) have not been eliminated, the protective actions initiated in the initial safety plan must be carried over to the case plan.

In consultation with the family, child and other service team members, determine the interventions (actions) that are most appropriate to ensure the child's continued safety.

All interventions and actions identified in the safety component of the case plan shall be immediately accessible, specific and time-limited.

For additional information about child safety assessment and safety planning refer to Completing the Child Safety Assessment, (Chapter 2 Section 2), and Safety Planning (Chapter 3 Section 1).

DOCUMENTATION :

Document the child's Safety Plan, using the Case Plan Tasks window.

For each revised case plan, document the child's Safety Plan, using Case Plan Tasks window.

Revision History:
DES(07-2006)

Previous / Next

9-6

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) is the federal law that governs child welfare services to children and families, including the concept of least restrictive placement.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) authorizes the child welfare system access to the Parent Locator Service to assist in locating parents.

ARS §8-513(C) sets forth the right of children in out-of-home care to maintain contact with siblings, relatives and friends, unless the court determines that the contact is not in the child's best interests.

ARS §8-813 requires the department to develop policies and procedures to allow a child in out-of-home care to maintain contact by telephone, mail or visits with the child's parents, family members, friends, other relatives and any former foster parent, unless the court determines that the contact is not in the child's best interest.

ARS §8-824(G)(8) requires the department to report to the court any efforts made to facilitate communications among siblings.

ARS §8-824(G)(9) requires the department to report to the court, a proposal for visitation for children in out-of-home care and their families.

Rules: Rules concerning licensed foster parents maintenance of a working relationship with a foster child's family are found in R6-5-5829.C of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 9: Section 6

Developing the Out-of-Home Care Plan, Health Care Plan, Contact and Visitation Plan

Legal Basis

Policy: Every child in out-of-home care shall have an individualized Out-of-Home Care Plan that specifies:

- the child's educational status;
- any special needs of the child;
- the child's placement type;

- services provided to the child and or out-of-home caregiver to meet the child's needs;
- ways that the child will maintain contact with his family and extended family while in placement;
- actions to assure the child's safety in out-of-home care;
- indication of whether the child is placed**:**
  - in close proximity to a parent's home, and if not why not;
  - in the least restrictive placement consistent with the child's special needs and best interests,
  - with siblings in out-of-home care, whenever possible, (if applicable)
  - with a caregiver who speaks the same language;

- for any child placed substantially distant from the parent's home or out-of-state, the placement reason must be because it serves the needs of the child in the most appropriate and effective way;

- indication the child is placed with a relative, or of the efforts that have been undertaken to identify a relative, or an individual with whom the child has a significant relationship where the child might be placed;

- indication of whether the child is attending their school in their home school district; and if not the plans to help the child transition into the new school setting;

- outcomes and tasks to achieve a concurrent permanency goal or a permanency goal other than family reunification, such as efforts to identify and place the child in permanent placement; and

- explanation associated with any of the above.

Every child in out-of-home care shall have an individualized Health Care Plan as a component of the case plan.

Every child in out-of-home care shall have an individualized Visitation Plan as a component of his or her case plan.

Implementation and Procedures Guide

During face-to-face and other contacts with the child's parents and/or extended family, the caregiver, and other service team members, request the information to assess:

§ the child's physical health status and needs;
§ the child's educational status and needs;
§ the child's emotional and behavioral health status and needs; and
§ the need for services and support to maintain the provider's ability to meet the child's needs.

At the time of initial placement into out-of-home care, and when significant examinations or treatments have occurred, request medical, educational, and mental health records on the child.

To develop comprehensive Out-of-Home Care and Health Care Plans, complete the following steps at the time of each case plan staffing, prior to freezing/activating the permanent or revised case plan:

§ Review information on the child's physical health, educational, and emotional and behavioral health status and needs obtained through ongoing contacts with family and service team members and through hard copy records.

§ Using information provided by the out-of-home care provider and other sources, document the child's health status, educational status, and the child's special needs by updating the following windows: Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail**,** Examination Detail, Practitioner Detail, Participant Education Detail, Participant Education Condition, and Hospitalization Detail.

Prior to and during the case plan staffing, provide service team members comprehensive information on the status and needs of the child, and the services and support needs of the out-of-home care provider. Elicit the comments and recommendations of the service team members, and reach consensus, whenever possible, on:

- the outcomes, tasks and services required to meet the child's needs;
- the outcomes, tasks and services or supports required to maintain the out-of-home caregiver's ability to care for the child;
- the frequency of face-to-face and telephone contact by the CPS Specialist required to meet the child's and provider's needs;
- actions necessary to assure the child's safety in out-of-home care**;** and

- if applicable, outcomes and tasks to achieve a concurrent permanency goal; and if the permanency goal is not family reunification, steps to be taken to achieve the permanency goal, such as efforts to:

  - F find an adoptive family or other permanent living arrangement for the child, including child specific recruitment efforts;
  - F place the child with an adoptive family, a relative, a legal guardian, or in another planned permanent living arrangement; and
  - F finalize the adoption or legal guardianship.

BEST PRACTICE TIP:
It is critical that the caregivers are actively involved in all planning meetings, review meetings and that they receive copies of the case plan with clear descriptions of their roles and responsibilities in helping meet the child's needs and in helping the birth family develop skills to safely parent their children. The very best scenario is that the birth parents and the caregivers are working together to ensure that the needs of the children are met. Families who are engaged by the CPS Specialist during the safety assessment process provide the most helpful information to assist the new caregiver in meeting the needs of the child.

Print the updated Medical Summary Report and attach it to the case plan prior to distributing the case plan to the family and service team members. Ensure the out-of-home care provider receives an updated Medical Summary Report on the child in his or her care at least once every six months.

In consultation with the supervisor, implement changes in tasks or services necessary to meet the child's needs or maintain the out-of-home care provider's ability to care for the child. It is not necessary to convene a case plan staffing unless there is a significant change in case circumstances that may impact upon goals, services and needs, or a change in permanency goal is considered.

Complete extensive and documented searches for extended family members, other relatives, and other significant persons as placement resources for children in out-of-home care.

Use the Arizona Parent Locator Service to assist in locating missing parents, relatives and other significant persons. Complete the Request for Parent Locator Service form and process according to district operating procedures.

Develop the Visitation Plan in accordance with guidelines in Ensuring Visitation Between Children and Their Family (Chapter 7).

BEST PRACTICE TIP:
A child who has been placed in an out of home setting may display an array of reactions and behaviors as a result of the placement, the loss and the adjustments to a new environment. It is critical that the CPS Specialist support the child during the initial days of placement—as the CPS Specialist is in many instances the only familiar face to the child.

DOCUMENTATION :

Using the **Out of Home Characteristics window,** indicate whether:

- the child is placed in close proximity to at least one parent;
- the child is placed in the least restrictive environment consistent with his or her special needs and best interest;
- the child is placed with siblings in out-of-home care, if applicable;
- at least one of the child's caregivers speaks the same language as the child;
- efforts have been made to identify a relative placement;
- the child is attending his or her home school district.

If "No" is indicated for any of the above, use the Explain window on the Out of Home Characteristics window to explain why the placement or school setting is in the child's best interest, or barriers to obtaining a placement or school setting that meets the criteria listed above.

Using the Case Plan Tasks window, Out of Home Care Plan type, document the outcomes, tasks, services, supports and actions identified prior to and during the case plan staffing. Provide explanations associated with any of the outcomes, tasks, services, supports, or actions.

Using the Case Plan Tasks window, Health Care Plan type, document the outcomes, tasks, services, supports and actions identified to address the child's medical, dental or behavioral health needs. Include the outcome of "Medical Needs Met" and the tasks to accomplish this outcome in every child's Health Care Plan. Provide explanations associated with any of the outcomes, tasks, services, supports or actions.

File hard copy medical, educational, and mental health records in the hard copy case record.

Document the child's special needs and medical, educational and mental health status and needs, using the Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psych/ Behavioral Condition Detail, Examination Detail, Practitioner Detail, Participant Education Detail, Participant Education Condition, and Hospitalization Detail windows**.**

Document the Out-of-Home Care Plan using the Case Plan Tasks and the Out of Home Characteristics windows. Document the Health Care Plan using the Case Plan Tasks, Health Care type. Document the Visitation Plan using the Visitation window.

For each revised case plan, document the Out-of-Home Care Plan using the Case Plan Tasks and the Out of Home Characteristics windows. Document the Health Care Plan using the Case Plan Tasks, Health Care type. Document the Visitation Plan using the Visitation window.

If the permanency goal is not family reunification, document steps taken to achieve the permanency goal using the Out of Home Plan including child specific recruitment efforts to:

- § find an adoptive family or other permanent living arrangement for the child;
- § place the child with an adoptive family, a relative, a legal guardian or in another

planned permanent living arrangement; and
§ finalize the adoption or legal guardianship.

Document efforts to identify extended family members or other significant persons as placement resources using the Case Notes window.

For More Information: On using the Arizona Parent Locator Service, **Finding Missing Parents, Relatives and Other Significant Persons** (Chapter 6 Section 2).

For More Information: On determining the required frequency of contact with children in out-of-home care and out-of-home providers, see **Providing Supervision to Children in Out-of-Home Care** (Chapter 6 Section 8).

Revision History:
DES(07-2006)

Previous / Next

9-7

Legal Basis: ARS §8-516(E) requires the department to report to the court an assessment of the extent to which the purpose of foster care for the child is accomplished and an assessment of the appropriateness of the case plan.

Rules: Not applicable

Revision History:

DES(07-2006)

Chapter 9: Section 7

Reassessing and Revising the Case Plan

Legal Basis

Policy: The department shall ensure that every child and family receiving ACYF services are engaged in a reassessment of their case plan at least every six months. A reassessment of the case plan should occur when a change in permanency goal is being considered or when there is a significant change in case circumstances.

The reassessment of the case plan shall occur during the case plan staffing. Any family team meeting may be considered a case plan staffing if all service team members have been identified, notified and provided an opportunity to participate.

Implementation and Procedure Guide

Assessment is ongoing throughout the case and the case plan review process. For children whose parents' rights have not been terminated, review the safety and/or risk factors that were identified in the most recent Child Safety Assessment and Strengths and Risks Assessment. If evidence or case circumstances indicate a change in child safety or an increase in the level of risk in any of the life domains since the time of the last assessment, complete a reassessment of child safety and the family strengths and risks using the Child Safety Assessment, PS05400 (CSA) and the Strengths and Risks Assessment window (SRA).

Completion of the CSA and the SRA at the time of case plan reassessment can assist the case manager in determining what domains indicate changes in strengths or risks. Additionally, the SRA can assist the case manager in identifying what services are needed or what currently provided services are no longer needed in the case plan.

For children whose parents' rights have been terminated, do not complete the Strengths and Risks Assessment window (unless the supervisor believes it is appropriate because of continuing involvement of the family).

The CPS Specialist should use the information gathered during contacts with the parents, the child, extended family, the out-of-home provider, and other service team members and through written reports or evaluations to assess the progress made in addressing the concerns identified during the Child Safety Assessment and Strengths and Risks Assessment process.

Refer to the PS05401, Family Centered Strengths and Risks Assessment Interview and Documentation Guide (Exhibit 16) to assist in gathering information in a non-confrontational and open-ended manner. Ask as few or as many questions as necessary to gather information on the family's current functioning in each of the life domains. If necessary, conduct additional interviews with extended family members and other significant persons.

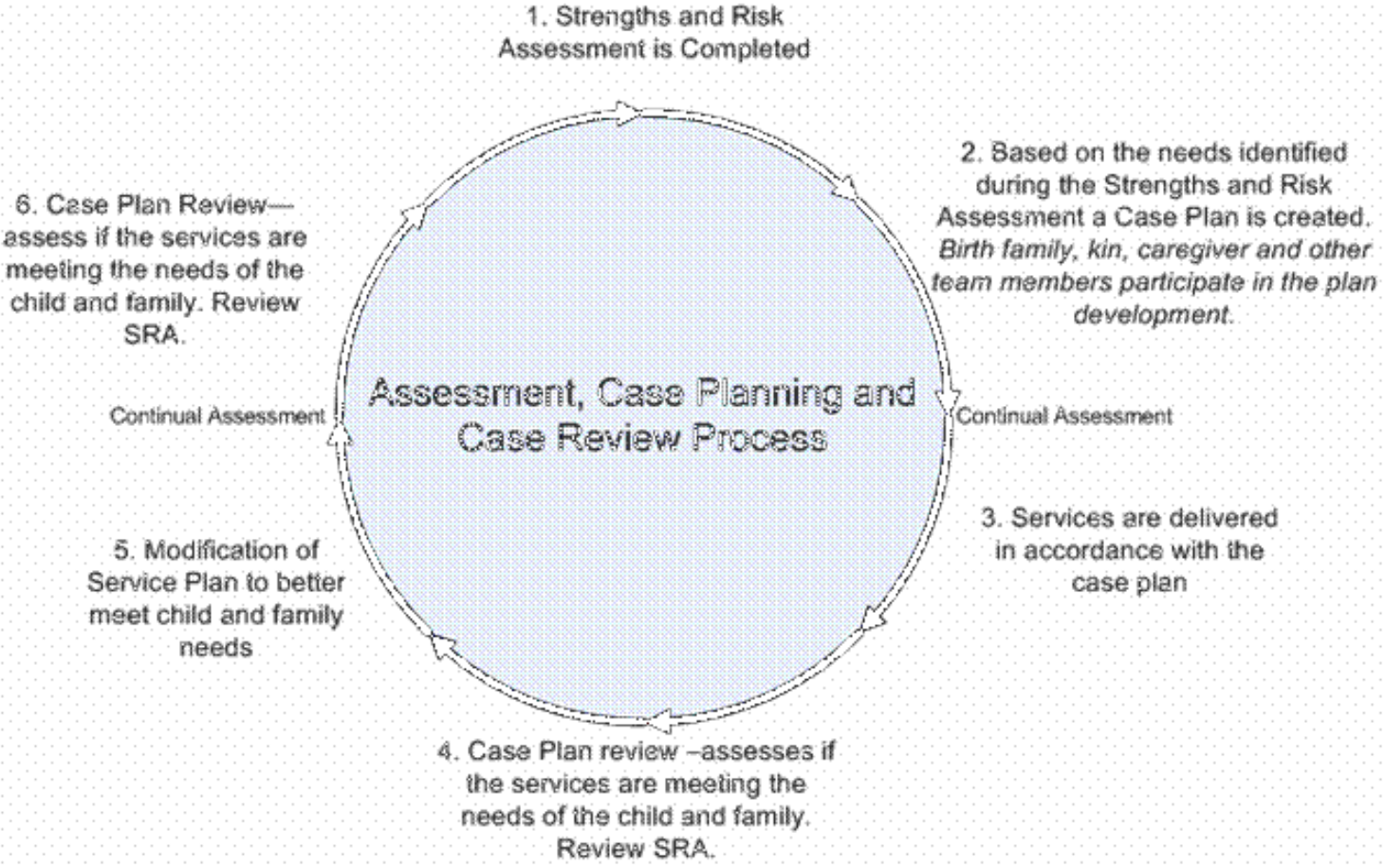
BEST PRACTICE TIP:
A case plan is a well-informed hypothesis. We believe by providing a specific array of services that a family's functioning and ability to safely care for their children will improve. Providing services tests that hypothesis. Is the mix and match of services accomplishing what was intended? If not, we need to work with the family to change the case plan.

Sometimes when the family is not responsive to services we use language like "non-compliant" to describe the family's behavior. The reality may be that the service providers are not engaging the family in the process, or the services are not addressing the immediate needs of the family, or are lacking in quality. CPS Specialists and families need to be good consumers of services and be active partners in evaluating service efficacy.

Finally, the family's needs for services and supports change over time. Are the needs presented by the family during

the Safety and Strengths and Risks Assessment process still issues for the family? Have the family's needs changed? The more relevant the services are to the family's actual needs, the more likely they will be to use the services.

The visual on the following page depicts a strong assessment and case plan review process.



Review the case plan during the case plan staffing at least every six months to determine whether:

- § the service successfully addressed the identified safety or risk factors;
- § further service or intervention is necessary to address safety or risk factors;
- § the same services or interventions should be continued for a specified period of time;
- § the service or intervention should be changed; or
- § no available service or intervention will enable the parent to adequately address the safety or risk factors within a timeframe that meets the needs of the child, and a change in permanency goal should be considered.

For additional information on facilitating the case plan staffing, refer to Chapter 9 Section 1, Developing the Family Centered Case Plan.

During the case plan staffing ensure that the family and involved professionals have the opportunity to contribute to the development of the case plan. Facilitate open communication about goals, services and expectations documented in the case plan.

Using the information gathered during the reassessment and input gathered from the family and service team during the case plan staffing, revise the case plan.

Plan Forward the Active Case Plan. Obtain supervisory approval to freeze/activate the revised case plan prior to

freezing/activating the case plan. Provide a copy of the case plan to all members of the service team.
Ensure that a case plan staffing occurs when a change in permanency goal is being considered or when there is a significant change in case circumstances that may impact upon goals, services or needs.

DOCUMENTATION :

Document the reassessment and development of the revised case plan by completing the windows associated with the Case Plan Directory.

Document the reassessment of child safety using the Child Safety Assessment, PS-05400, and the Child Safety Assessment Summary Window.

Document the reassessment of the family's strengths and risks using the Strengths and Risks Assessment window.

Revision History:
DES(07-2006)

Previous / Next

9-8

Legal Basis: The federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that every child in out of home care has a case plan and delineates federal requirements regarding case plans. It requires states to make reasonable efforts to keep families together whenever possible, to reunify families if out-of-home placement is necessary, and, if reunification is not possible, to pursue permanent placement for the child through adoption or other permanent plans.

The Adoptions and Safe Families Act of 1997 (P.L. 105-89) clarifies and modifies the reasonable efforts requirements of P.L. 96-272 and adds additional case plan requirements. The Act defines circumstances under which reasonable efforts to reunify families are not required.

ARS 8-824(G)(10) requires the department to present to the court a proposed case plan for services to the family.

ARS 8-845 requires the court to reunify families insofar as possible. If reunification services are not ordered, the court is required to order a plan of adoption or another permanent plan that is in the child's best interest. The court may only relieve the department of its responsibility to provide a parent reunification services if the court finds, by clear and convincing evidence, that one or more of seven "aggravating circumstances" delineated in ARS 8-846(B) exists.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 8

Services to Incarcerated Parents

Legal Basis

Policy: Reunification services shall be provided to a parent who is incarcerated and a party to a dependency case unless the court relieves the department of the responsibility to provide services based on a finding of aggravating circumstances.

ACYF staff shall communicate with incarcerated parents and appropriate correctional service staff to inform them of case plan, service needs, and to determine what reunification services may be provided at the correctional facility. Reunification services may be provided by the correctional facility, if available, the inmate eligible and allowable by Arizona Department of Corrections (ADC) regulations. Otherwise, the department must provide reunification services if allowable by ADC regulations.

The parent, to the extent possible, shall participate in case plan staffings, visitation, and services.

Have you discussed with the assigned Assistant Attorney General whether the parent's criminal history and length of incarceration might justify pursuing an order waiving reunification services and/or pursuing a permanency goal other than reunification with the incarcerated parent?

While seeking an order waiving reunification services based on aggravating circumstances, will the lack of or discontinuation of services compromise implementation of another permanent plan for the child?

If the court has ordered reunification services, consider the following questions:

- What services are necessary to achieve a permanency goal of family reunification and which of those services can the parent receive while incarcerated?

- What tasks need to be completed in order to facilitate the parent's participation in case plan staffings, court and Foster Care Review Board hearings and other activities associated with the case?

- Can the planning meetings and visitation between the parent and child be held in the correctional facility?
- What arrangements need to be made with the correctional facility in order to ensure that parent/child visits occur?
- Is the caregiver willing to transport the child to the facility for visitation with the parent? Can the CPS Specialist help alleviate any anxieties they may have?

§ Does the location of the correctional facility substantially hinder visitation between the child and parent? If so how can the team address this barrier?

§ Does the security status of the parent prevent visitation between the parent and child? If so, is there any opportunity for flexibility at the correctional facility? If not, can phone calls and mail be used as a means to ensure child-parent interaction?

§ Has the parent or any other team member requested or has the court ordered contact with the child?

§ Will lack of contact between the child and parent compromise achievement of the case plan goal?

§ Has a mental heath professional indicated that visitation between the parent and child would be detrimental to the child?

§ If contact between the parent and child is not appropriate or feasible, can the parent-child relationship be maintained in other ways?

§ What can be developed to assist the parent to maintain or establish a parental relationship?

Implementation and Procedures Guide

If reunification services will not enable the parent to adequately address the risk factors within a timeframe that meets the permanency needs of the child, consult with your supervisor and the assigned Attorney General regarding filing a motion with the court requesting a judicial finding that reunification services not be provided. This consultation may occur as early as the filing of the dependency petition. Continue to provide reunification services until the court relieves the department of this responsibility.

Provide the parent with the name and addresses for the court and their assigned attorney handling

the dependency proceedings.

Notify the parent of court and Foster Care Review Board hearings and case plan staffings, and make certain that his/her voice and perspective are represented during these hearings and staffings.

Invite the parent and, whenever possible, facilitate the parent's participation in case plan staffings.

Contact the correctional service facility staff to arrange for the parent to participate in case plan staffings and Foster Care Review Board hearings telephonically or in-person.

Develop a family intervention and a contact and visitation plan with the parent. Consider the following factors when developing the visitation plan: age of the child, distance to the prison, the potential impact of in-person prison visits on the child, and appropriateness of the parent/child during previous visits.

Include in plan the frequency of contact between the parent and the CPS Specialist. See Chapter 9, Section 4 Planning and Implementing Services and Supports Necessary to Achieve the Permanency Goal to determine when an exception to monthly face-to-face contact with the parent is appropriate.

Ensure that the parent is fully aware of the case plan tasks that must be completed in order to maintain the parent-child relationship, to facilitate family reunification and the consequences if the parent fails to complete the tasks. Provide a copy of the case plan to the parent.

To obtain services for a parent who is incarcerated at the ADC, contact with the parent's Correctional Officer III. Coordinate contact between the parent and the Correctional Officer III. For those parents detained in county jail facilities, contact the program coordinator.

Make a written request for available services in the prison facility. If services are not available, request permission for the department to provide on-site reunification services to the parent. Request any assessments, evaluations, or other information to further explore service needs as appropriate.

Request that the parent complete a release of information with ADC to share the results of any assessments or evaluations.

Complete the Consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information (ACY-1125FORNAZ) to allow the agencies to share information regarding mental health and/or substance abuse treatment for a parent participating in these services.

Request from the parent and/or Correctional Officer III confirmation of the parent's participation in services.

In carrying out the visitation plan, consult your supervisor if restrictions or concerns regarding in-person prison visitations arise. If the child is being negatively impacted by in-person prison visits, consult with a psychologist to assist in determining the appropriateness of continuing the visits. If it is determined that the visitation is detrimental to the child and not in the child's best interests, facilitate the parent/child relationships through other means such as letters, phone calls, gifts, etc.

BEST PRACTICE TIP:
The incarceration of a parent does not mean that the child and parent cannot (or should not) have an ongoing relationship. It does mean that the CPS Specialist has to work diligently to ensure that parent-child interactions occur. Distance and perceptions about how the child will react to visiting their parents in prison, often impact the frequency of parent-child face-to-face interaction. The team needs to address the planning for parent-child visits early in the planning process to determine if and how these interactions are to occur. If the CPS Specialist has fears or concerns about taking a child to visit a parent in prison, the supervisor should discuss these fears or concerns during supervision or staff meetings.

If reunification services provided will not enable the parent to adequately address the risk factors within a timeframe that meets the permanency needs of the child, consult with your supervisor and the assigned Assistant Attorney General regarding filing a motion with the court requesting a judicial finding that reunification services be discontinued. Consider whether lack of or discontinuation of reunification services will compromise implementation of another permanent plan for the child, especially a permanent plan of adoption.

If a decision is made to file such a motion, the report to the court should specifically address:

- the aggravating circumstance you believe exists, justifying why services should be discontinued;
- specific supportive facts regarding your conclusion;
- a discussion of:

  - the age of the child and the relationship between the child's age and the likelihood that incarceration will deprive the child of a permanent living arrangement;
  - the relationship of the child and parent prior to incarceration;
  - the degree to which the parent-child relationship can be continued and

nurtured during incarceration;

- § the effect of deprivation of parental presence on the child;
- § the nature of the felony;
- § the length of the sentence;
- § the availability of another parent or caregiver to provide a normal home life.

If the court enters an order that the department is not required to provide reunification services, implement another permanent plan for the child.

DOCUMENTATION :

Document all contact with the incarcerated parent including their participation in and completion of reunification services using the Case Notes window.

Document efforts made to communicate with correctional staff regarding services provided at the facility, the parent's service needs, and the availability of family reunification services to the parent using the Case Notes window, Collateral Contact.

Document any exception to monthly contact with a parent and the reason for the exception using the Explain window in the Case plan Task window, Family Intervention Care Plan type in the Case Plan Tasks window.

Document services provided in the correctional facility necessary to achieve the permanency goal by completing the Case Plan Tasks window, Family Intervention Plan type.

Document notification of the case plan staffing to the parent using the Notification window.

Document the outcomes the family must achieve in order to care for the child safely and services that are aimed at facilitating achievement of the outcomes using the Case Plan Tasks window Family Intervention Plan type.

Document the contact and visitation plan using the Contact and Visitation Plan window.

Document provision of a copy of the case plan to the incarcerated parent using the Case Notes window.

Document the case conference using the Case Notes window designated as Case Conference type.

Supervisor:

Document approval of any exception to monthly contact with the parent using the Case Notes window designated as Supervisory Contact type.

Revision History:
DES(07-2006)

Previous / Next

9-9

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 9

Accessing Services: Parent Aide Services

Legal Basis

Policy: To the extent that resources allow, the department shall utilize the services of parent aides to provide a range of supportive services aimed at preserving, stabilizing and reuniting families.

Parent aide services shall be provided at the discretion of the department in conjunction with needs identified in the family's case plan.

Parent aide services may be provided by ACYF staff or by a contract provider.

Parent aides shall not manage family finances or administer medication.

Parent aides shall not serve Temporary Custody Notices to parents or other caretakers.

A family shall not receive parent aide services for more than 180 days unless there is a review of the continued need for service.

Consider using parent aide services when a family assessment indicates that a family needs assistance in the areas of:

- § parenting skills;
- § home management, including budgeting, nutrition, time management and personal care skills related to the case plan;

BEST PRACTICE TIP:
Adults learn in many different ways. It is important to understand how the parent processes information so that the services provided have maximum benefit. There are many adults who do not learn by listening to a presentation; therefore, classes in a group setting on how to parent, budget, plan meals, etc. may not be an effective tool to improve parenting skills. In these instances, the use of parent aide services that provide “hands on” teaching and support may be most effective. Under the Adoption and Safe Families Act there is a very short time for the parents to make the changes required to safely parent their children.

- § transportation; or

§ supporting the visitation process.

BEST PRACTICE TIP:
If the parent aide is going to be active in the visitation process, it is critical that they understand the importance of 1) helping create a warm and welcoming stage for the visitation, 2) explain to the parents that they are there to help them and NOT to judge them, 3) ensure that the parent understands that it is not only acceptable but encouraged to ask for their advice as needed. They are there to support, educate, and role model. The parent aide should be sensitive to the fact that the parent is most likely feeling ashamed, embarrassed or judged, and this may make them reluctant to ask for help.

If the parent appears lost or uninterested in the child during the visit, the parent aide should actively teach the parent how to play and interact with their child. If the visitation room/site has no toys, then the parent aide should be encouraged to help the parent identify which toys to bring from home for the visits.

Implementation and Procedure Guide

Meet with the assigned parent aide to discuss the case. Be specific about the permanency goals and services identified in the case plan. Provide the parent aide a copy of the case plan.

Introduce the parent aide to the family and be sure that the family understands what services will be provided.

Review the parent aide's monthly report to assess case progress and determine if a case plan revision may be necessary. Consult with the parent aide, as necessary. Include the parent aide as a member of the service team.

In an emergency, make a verbal request for a parent aide from the parent aide supervisor. Complete the Service Authorization and Provider Match Process within two working days.

Consult with your supervisor if it appears that services may need to be extended beyond 180 days.

Notify the parent aide of termination of parent aide services or case closure.

Notify the family verbally or in writing of the discontinuation of parent aide services. Meet with the family and parent aide at least five working days prior to discontinuation of services to review progress and identify areas in which further assistance is needed.

DOCUMENTATION :

Complete PS-067, Request for Services and route according to district procedures. Make certain to outline clearly with whom parent aide is to work and the tasks to be accomplished.

Ensure authorization for the service is completing according to district operating procedures.

Keep a copy of the PS-067 in hard copy record.

Maintain the parent aide's monthly reports in the hard copy record.

Document approval for an additional service authorization from your supervisor using the Case Notes window, Supervisory type.

Revision History:
DES(07-2006)

Previous / Next

9-10

Legal Basis: ARS §46-139 allows the department to provide housing assistance to families and details eligibility requirements for program participation.

This statute requires the department to produce annual Housing Assistance reports containing district specific information.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 10

Accessing Services: Housing Assistance

Legal Basis

Policy: The department may provide housing assistance to families in which lack of safe and adequate housing is a significant barrier to family preservation, family reunification or achievement of the permanency plan for at least one child involved in an open Child Protective Services case.

Housing assistance may be provided by the department *only* after other sources of housing assistance have been explored and exhausted. Efforts to obtain housing assistance through all other means possible shall be documented in the record.

Housing assistance may *only* be used to assist a relative or significant other in cases in which return to the parent has been ruled out and the case plan reflects that the relative or significant other is seeking permanent placement of the child through adoption or legal guardianship.

Housing assistance may *only* be used for the following:

- rent;
- •rent arrears;
- rental or utility deposits;
- utility installation and payments; and
- utility arrears.

The Housing Assistance program shall not be used to make mortgage payments.

Housing assistance for each family for an incident shall not exceed $1,800 during a consecutive six month period, based on family need and determined by the CPS Specialist.

Lack of adequate housing must be identified as a risk factor in the Family Strengths and Risks Assessment.

The case plan must identify adequate housing as an outcome and include actions taken by the family or other significant permanent caretaker to achieve economic self-sufficiency. The documentation in the case record shall identify:

- barriers to obtaining adequate housing;
- a specific, time oriented plan for phasing out the need for housing assistance; and
- financial resources of the family or other significant permanent caretaker, including

housing related expenses, income and entitlements.

A family receiving benefits from this program must receive case planning and case management services including monitoring the family's financial situation throughout the duration of the benefits. Housing Assistance shall *not* be continued after the CPS case is closed.

To determine if a family is eligible for this program, confirm all the following are true:

- at least one child in the home is a participant in an open Child Protective Services case;
- the assistance will expedite permanency placement for the child;
- lack of safe and adequate housing is a significant barrier to family preservation, family reunification or achievement of the permanency plan for at least one child participant in the home;
- family income, including entitlements, is insufficient to cover housing expenses;
- the family is willing to develop and participate in a time oriented plan which will enable housing obtained through this program to be maintained after the benefit period ends;
- this will be the first time this family has ever received housing assistance from this program; and
- all other sources of assistance, including the Short Term Crisis Services program (STCS), have been fully explored and utilized before considering this program.

Implementation and Procedures Guide

If the family is eligible, refer them to the local community action agency for assistance under the STCS program. Eligibility criteria include:

- the child is a U.S. citizen or legal resident; and
- the household family income must not exceed 125% of the Federal Poverty Guidelines; or not exceed 150% of the Federal Poverty Guidelines with an elderly or disabled household member; and
- the need for housing assistance was caused by a crisis or emergency situation such as:
  1. separation of the family due to domestic violence;
  2. loss of income due to theft, abandonment, death, divorce, incarceration or incapacitation of the wage earner, or illness, reduction of workforce, loss of employment

due to layoff or involuntary termination, or due to voluntarily quitting employment with good cause;

3. unforeseen circumstances or increased expenditures making it difficult to meet the following month's budgeted household expenses;
4. the physical condition of the home presents a health and safety hazard to a child;
5. special needs are necessary to secure or maintain employment, such as assistance in obtaining tools, car repair, dental assistance or eye glasses.

If the family's situation meets or appears to meet the eligibility criteria for the STCS program, have the family schedule an appointment with the local community action agency by calling Community Services Administration at (602)542-6600. The receptionist will refer the caller to his/her local community action program office.

If the family is not eligible for the STCS program, assist the family to identify, contact, and apply for housing assistance from other available resources by completing the following tasks:

§ identify which resources have the potential to meet some or all of the family's housing needs;
§ provide thorough referral information about identified resources to the family; and
§ if needed, assist the family to contact the resources and complete any application processes.

If all efforts to locate housing assistance within the family and community have been exhausted and assistance remains unavailable, refer the family to the Housing Assistance program.

Identify lack of safe adequate housing as a significant barrier to family preservation, family reunification or permanent placement using the Case Plan Tasks Explain window. Identify adequate housing as an outcome in the Case Plan Tasks window.

Obtain from the vendor the first billing with a statement that specifies:

- name;
- address;
- federal employer identification or social security number;
- type of service;
- amount; and
- date payment is due.

Obtain from the vendor the original completed and signed Request for Taxpayer Identification Number and Certification, W-9. Housing Assistance payments will not be made without receipt of the W-9.

Send the above information, including the original W-9, to the appropriate district staff. District staff will enter the vendor as a CHILDS provider.

DOCUMENTATION :

Prior to authorizing housing assistance, enter a Case Note that contains all of the following:

- a statement that the family has never received assistance through the Housing Assistance Program;
- a statement that family preservation, reunification, or permanent placement cannot occur without housing assistance;
- identification of family barriers to obtaining adequate housing;
- a complete financial picture of the family which includes all income, entitlements and housing related expenses;
- a statement that the family and CPS has explored and utilized all other sources of housing assistance, identifying what services were sought and the results of the inquiries or applications;
- the family's specific, time oriented plan for maintaining housing after housing assistance through this program ends;
- actions taken by the family to achieve economic self-sufficiency; and
- if this is a case where children are not wards of the court, a statement that a dependency petition would be filed without this housing assistance, and information as to the number of children who would be included in the petition.

To authorize housing assistance, complete the Service Authorization Request window.

The supervisor and Assistant Program Manager will complete the Service Authorization Approval window for cases involving children who *are* wards of the court.

The Program Manager or designee will complete the Service Authorization Approval window for cases involving children who are *not* wards of the court.

When housing assistance is approved, have clients provide you with a bill from the provider each month. Rental billings must be received **21 days prior to the first day of the month**; utility bills should be presented when received.

Use the Find Provider in Registry window to identify the provider. Select the provider from the Provider Registry window. Use the Service Authorization Provider Match window to make the final selection. When services end with the provider prior to the authorized end date or the selected provider refuses to provide the approved services, end date the service authorization using the Provider Service Authorization window.

If the provider changes, complete the above described processes. Do not complete the Service Authorization Request window and Service Authorization Approval window. If the amount

changes, end date the previous service authorization and complete a new service authorization using the Service Authorization Request window. The supervisor and Assistant Program Manager will complete the Service Authorization Approval window.

***Supervisors, Assistant Program Managers, and Program Managers or designee*:**

Prior to authorizing housing assistance payments, review the Case Notes to verify that the requesting CPS Specialist has addressed program requirements identified earlier in this Guide; particularly that the family has explored other housing resources prior to applying to this program, that the family has a specific time oriented plan to achieve economic self-sufficiency; and that the CPS Specialist is providing case planning and case management services including monitoring the family's financial situation throughout the duration of the benefits.

ACYF Central Office:

Randomly monitor the Housing Assistance program to ensure the appropriate use of the program.

Revision History:
DES(07-2006)

Previous / Next

9-11

Legal Basis: Not applicable

Rules: Rules concerning use of CPS Child Care services are found in R6-5-49 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 9: Section 11

Accessing Services: CPS Child Care

Legal Basis

Policy: CPS child care services shall be made available at the discretion of the department to families with children ages 12 or younger.

Services may be provided to maintain and strengthen families:

- whose cases are opened for investigation and closed at investigation;
- who are receiving voluntary child protective services; or
- whose children are dependent wards of the court but remain in the parent's physical custody.

CPS child care services may also be provided as a support service for out-of-home care providers. Birth and/or adopted children of foster parents are not eligible for CPS child care.

CPS child care services may be requested up to **maximum of 23 days per month per child**, through the Child Care Administration (CCA). CCA staff will contact the identified child care provider to authorize payment.

There is no financial eligibility requirement for CPS child care. DES reimburses child care providers up to a maximum reimbursement rate negotiated by each provider. Families/foster parents are responsible for paying child care providers the difference between the child care provider's rate and the DES reimbursement.

CPS child care may be provided to prevent abuse or neglect. The objectives of these services are:

- to relieve stress of the caretaker (respite);
- to provide monitoring of a child by child care personnel; or
- to provide a child with opportunities for socialization/structure when such opportunities do not exist in the home. This is a clinical or case management decision which must be documented in the case plan.

CPS child care may be provided for out-of-home care providers for the following purposes:

- to enable an out-of-home care provider to work;
- to enable an out-of-home care provider to participate in educational activities; or
- to enable an out-of-home care provider to attend medical, dental or behavioral health

appointments, case plan staffings, administrative case reviews, court and FCRB hearings or participate in activities associated with visitation with another foster child.

CPS child care may not be requested for the sole purpose of documenting that a service has been offered/accepted or if it is determined that the caregiver is not in need.

Implementation and Procedures Guide

Either the parent or caretaker should consult with the Child Care Resources and Referral (CCR&R), 1-800-308-9000 to identify a child care provider. Verify that an identified provider has a current DES registration agreement and has a vacancy for the child.

Submit all requests for CPS child care services to the DES Child Care Administration for authorization.

To request CPS child care for a case which has been opened and closed at investigation:

§ Obtain supervisor approval to request CPS child care services up to a maximum of six months, using the CPS Child Care Referral, CC-224.
§ The Child Care Administration will contact the child care providers to authorize payment. Please do not contact child care providers to authorize payment for child care**.**

For voluntary child protective services cases, in-home dependency cases, or in-home intervention and out-of-home care cases:

- Identify the need for child care in the case plan using the Case Plan Task window.
- Obtain supervisor approval to request CPS child care services up to **a maximum of six months** using the CPS Child Care Referral, CC-224.
- Review the continued need for child care at least **every six months** and/or at the case plan staffing.
- Obtain supervisor approval prior to requesting a second six month period of child care services.
- If requesting a third referral for child care services within a 24 month period, in addition to the above two steps, send an E-Mail of explanation to the Program Manager or designee if you are requesting a third referral within a 24 month period. Include this E-Mail approval with the CC-224.

In emergency situations, contact the local child care office to arrange for child care. Send a completed CPS Child Care Referral, CC-224, to the office within two working days.

A new CPS Child Care Referral, CC-224 must be submitted to:

- Indicate any changes in providers.
- Indicate any change in hours to be authorized.
- Request that child care services be reauthorized.

DOCUMENTATION :

Document the need for and use of child care services in the child's case record using the Case Notes window and the foster care licensing record, if applicable.

Specify use of child care services in the child's case plan using the Case Plan Tasks window.

File a copy of the CC-224 in the hard copy record.

Document request for Program Manager or designee approval of a third referral within a 24 month period using the Case Notes window designated as Management Contact type.

Program Manager or designee:

Document approval of a third referral within a 24 month period using E-mail notification to the assigned CPS Specialist.

Revision History:
DES(07-2006)

Previous / Next

9-12

Legal Basis: Title XIX of the Social Security Act provides federal funding for behavioral health and substance abuse services for eligible individuals.

ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

Rules: Rules concerning AHCCCS, Arizona's federally approved Medicaid-alternative, are found in Section R9-22 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 9: Section 12

Accessing Services Required by the Case Plan:

Title XIX Behavioral Health and Substance Abuse Services

Legal Basis

Policy: The department shall seek to ensure that all children and families served by ACYF receive appropriate behavioral health and substance abuse services.

The department shall utilize the Department of Health Services, Division of Behavioral Health Services (DBHS), Regional Behavioral Health Authority (RBHA) system to obtain Title XIX covered services to address behavioral health and substance abuse service needs for eligible individuals.

All requests for behavioral health services for Title XIX eligible individuals must be made to the RBHA.

The CPS Specialist is responsible for providing the DCYF Eligibility Unit with information necessary to make a prompt determination for Title XIX eligibility for children in out-of-home placement.

Upon filing the dependency petition or accepting a Voluntary Foster Placement Agreement, the CPS Specialist shall refer all individuals (adults and children) to the appropriate RBHA provider for an assessment.

The CPS Specialist shall participate (and the caregiver is encouraged to participate) in the assessment process in person and provide information pertinent to an effective assessment.

The CPS Specialist shall monitor the appropriateness and timeliness of services being provided by the RBHA provider to all individuals (adults and children) and advocate for client service needs.

Implementation and Procedures Guide:

Title XIX Eligibility Determination

The Regional Behavioral Health Authority (RBHA) is federally funded to provide behavioral health services to children who are Title XIX eligible. ACYF is not funded to provide behavioral health services for Title XIX eligible children. It is essential that Title XIX eligible children receive behavioral health services through the RBHA.

Ensure that eligibility information in CHILDS is accurate and current. The DCYF Eligibility Unit uses this information to determining Title XIX eligibility, on a case-by-case basis, for children in out-of-home care.

Most children in out-of-home placement are Title XIX eligible; however, Title XIX requires a case-by-case eligibility determination.

All children determined eligible under Title IV-E or SSI (Supplemental Security Income) are automatically eligible for Title XIX. In addition, children in out-of-home care who are U.S. citizens or qualified non-citizens are eligible for Title XIX if the child does not have substantial income.

To determine if a child in out-of-home placement is Title XIX eligible, refer to the Eligibility Directory window in CHILDS, or contact the DCYF Eligibility Unit at 602-235-9358.

The Eligibility Directory window will reflect the child's Title XIX status as following:

- A indicates that Title XIX eligibility has been approved as of the date indicated;
- D indicates that the child's Title XIX eligibility has been denied;
- R indicates that the child's Title XIX eligibility is being reviewed for continued eligibility; treat as approved; or
- N indicates that there is no current Title XIX eligibility determination; contact the DCYF Eligibility Unit at 602-235-9358.

Selecting the Appropriate RBHA

Determine which RBHA to contact as follows:

- If the child is a court ward in out-of-home placement, contact the RBHA serving the location of the child's court jurisdiction.
- If the child is not a court ward, contact the RBHA serving the current residence of the child's parent or legal guardian.
- In a crisis situation involving a child who is not enrolled for Title XIX services, contact the RBHA serving the area where the child is at the time of the crisis for emergency services.

Refer children for an assessment of behavioral health needs to the appropriate RBHA immediately after filing a dependency petition according to District Operating Procedures

If the child is a ward of the court on an in-home petition, call the DCYF Eligibility Unit to determine the child's Title XIX eligibility status. If the child is eligible, contact the RBHA serving the current residence of the child.

Accompany the child and the parent to the intake and assessment appointments, provide information and pertinent records, and sign the consent to treatment document.

The CPS Specialist shall monitor and ensure that the Title XIX enrolled eligible child is obtaining services in a timely manner. The RBHA has to provide timely access to services. See Standards for Timeliness of Behavioral Health Services (Exhibit 29).

Include the RBHA provider on the FC-064-A, Attachment A, for reports to the Juvenile Court. Provide copies of reports to the court and CPS case plan to RBHA provider.

Notify the RBHA provider of all case plan staffings.

Individual Service Plan (ISP)

Every client receiving Title XIX services will have an Individualized Service Plan (ISP) developed by the RBHA provider for behavioral health services. The CPS Specialist should participate in the development of the ISP See Twelve Principles to Develop the Individualized Behavioral Health Plan (Exhibit 21). Ensure that the ISP identifies:

- § measurable goals and objectives;
- § dates by when achievement of those goals and objectives is expected;
- § specific services and activities intended to assist the client in achieving those goals; and
- § name of providers involved in the delivery of services.

The CPS Specialist should ensure that services are based on the family strengths and culture, and be directly related to the family plan and the behavioral health safety/crisis plan. See Title XIX Covered Services (Exhibit 20).

Questions that will assist in developing good ISP are:

- § What are the specific services being provided to meet the child and family's individual behavioral health needs?

- Why will these services meet the child and family's behavioral health needs?
- When will the services begin?
- What is the behavioral health safety/crisis plan if child behavior worsens, disrupts or becomes a danger to self or others?

For children, the following documents and assessment information will be considered in the development of the ISP:

- Individual Education Plan (IEP);
- CPS case plan;
- Juvenile probation or parole plan;
- Medical plan from the primary care physician;
- DD individual service program plan; and
- Any other plans of care designed to meet the needs of the **child.**

The CPS Specialist or case coordinator must ensure that the RBHA provider develops the ISP within specific time frames. For persons who receive Title XIX covered services, time frames are:

- non-acute service needs, within two weeks of completion of the initial evaluation and assessment; and
- acute service needs, the interim service plan within twenty-four hours of the screening and/or evaluation.

Child Enrolled For Title XIX Services Moves Out-of-District

When a child enrolled for Title XIX services moves out-of-district and the child's case and court venue are not transferred between districts, the current RBHA will continue to provide services.

When a child enrolled for Title XIX services moves out-of-district and the child's case and court venue are transferred between districts, facilitate transfer of Title XIX services by:

- contacting the current RBHA within two work days of confirming the child's case and court venue will be transferring between districts to notify of the change and request a transfer of services;
- providing a copy of the court order indicating the change of court venue to the current RBHA;
- continue to coordinate with the referring RBHA for case management and provision of service until the client is enrolled in the receiving RBHA; and
- participating in RBHA discussion regarding transfer of services, if requested.

Monitoring Appropriateness and Timeliness of Behavioral Health Services

Ensure that a copy of the assessment and other pertinent information on services and progress reports from the RBHA are filed in the hard copy case record.

Monitor the appropriateness and timeliness of the all behavioral health services provided to the child.

Level I, II and III Service

Level I, II, and III services are higher levels of care. They are covered by Title XIX and include acute hospitalization, RTC and behavioral health therapeutic group home. These are costly levels of care and should be paid through Title XIX, in order to maximize the use of Title XIX behavioral health services for the child and the child's family.

BEST PRACTICE TIP:
These services also are the most intensive services offered by the department. While children and youth should not have to "fail" in less restrictive services in order to receive the *most appropriate* level of services, CPS Specialists should carefully consider the use of services that remove the child from the community and place them in institutions. While the child and the community need to be safe, intensive institutional services should be utilized only when it is assessed that the child cannot be served safely in any other environment.

When a child requires a Level I, II or III service and is denied the service by the RBHA provider, the CPS Specialist shall follow the procedure outlined below:

- Make sure that the child is enrolled with the appropriate RBHA.
- If the child needs acute hospitalization, RTC and therapeutic group home (Level I, II, or III behavioral health services), request the service in writing from the RBHA provider.
- If the RBHA provider denies your request for service, obtain a written denial.
- In order for DCYF to pay the cost of Level I, II, or III placement, advise the District Mental Health Specialist or designee of the denial of service. The CPS Specialist shall follow your District Operating Procedures to place the child.

District Mental Health Specialist

The District Mental Health Specialist or designee must take one of two actions (after deciding which is the most appropriate for the case):

- Complete an Issue Resolution and submit it to DBHS.
- File an Appeal.

Behavioral Health Services that are Changed, Denied and/or Terminated by the RBHA/ Provider

There are two processes available to resolve problems with the behavioral health services children are receiving--the Issue Resolution Process and the Appeal Process. These processes provide mechanisms for DCYF staff to advocate for client behavioral needs and appropriate services. Consult with your Mental Health Specialist on which to use.

Issue Resolution Process

Issue Resolution (also known as Problem Resolution) is a mechanism established for DBHS to resolve and track problems reported by enrolled persons, their families, other agencies, and the public. It is an informal process that can be used to assist in resolving problems with the RBHA. DBHS will work with the RBHA to resolve problems reported to the DBHS.

If a RBHA/provider has reduced, terminated, suspended, denied services, and/or lacks timeliness in providing services, the CPS Supervisor or Mental Health Specialist can use the Issue Resolution Process. See Issue Resolution Information Sheet (Exhibit 30) and Issue Resolution Process (Exhibit 31).

Appeal Process

If a RBHA provider has reduced, terminated, suspended, denied services, and/or lacks timeliness in providing services, the CPS Mental Health Specialist can use the Appeal Process. (see the Appeal Compliant form). To continue RBHA funding services, the Appeal must be filed **within ten days** of termination notice. For reimbursement, the Appeal must be filed **within 60 days.**

The appeals process is used to ensure that disputes concerning behavioral health services are handled competently, expeditiously and equitably for all participants. It is a legal process that requires both RBHA and DCYF staff to participate in a hearing.

If you have questions about the Issue Resolution Process or the Appeals Process as it applies to your case, call you District Mental Health Specialist. If you have a general question about the Issue Resolution Process, contact the Behavioral Health Coordinator. If your general question is about the Appeals Process, contact the Appeals Process Consultant at 602 542-1946.

Revision History:
DES(07-2006)

Previous / Next

9-13

Legal Basis: ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 13

Accessing Services Required by the Case Plan:

CMDP Behavioral Health Services

Legal Basis

Policy: The department shall seek to ensure that all children and families served by ACYF receive appropriate behavioral health services.

The department may utilize CMDP funded behavioral health services for CMDP eligible children who are not eligible for Title XIX services, and for 18-20 year olds in extended foster care.

The department shall utilize the following behavioral health services available through CMDP for eligible clients when indicated:

- inpatient hospitalization;
- psychiatric evaluation and diagnosis;
  - laboratory and radiology services for medication regulation and diagnosis;
- psychotropic medication;
- psychological evaluations for eligible children in an inpatient hospital setting; and
- psychological evaluations and therapy for eligible children residing outside of Arizona.

Implementation and Procedures Guide:

To access behavioral health services through CMDP for Non-Title XIX eligible children:

§ Obtain prior authorization by contacting the CMDP Behavioral Health Coordinator.
§ Monitor provision of services and program toward goals.
§ Make DES case records available to CMDP and the service provider, as necessary.
§ Notify the CMDP Behavioral Health Coordinator upon termination of behavioral health services.
§ Notify CMDP of any changes that may affect the child's eligibility status.
§ Notify the CMDP Behavioral Health Coordinator of the decision for a child to participate in extended foster care, prior to the child's 18th birthday.

Hospitalization for Title XIX Eligible children

CMDP may provide hospitalization for a Title XIX eligible child that has been referred to the RBHA for hospitalization and been denied this service. To access hospitalization through CMDP for Title XIX children:

§ Obtain the written denial of hospitalization from the RBHA.
§ Email CMDP and the Mental Health Specialist with the name of the child hospitalized, the date of the hospitalization and the date of the denial of the service by the RBHA.
§ Request assistance with the process of hospitalization from CMDP.
§ Continue all case management duties and responsibilities.

During the hospitalization, CMDP will:

§ Pay the cost of hospitalization for up to 72 hours per admission and 12 days per year.
§ Assist the CPS Specialist by answering questions about the process of hospitalization when necessary.
§ Conduct a Review of Hospitalization concurrently with RBHA.
§ Share information with the CPS Specialist and Mental Health Specialist.
§ Send documents of verbal and written communication to the Mental Health Specialist.
§ Assist and support the CPS Specialist's request for clear discharge plans from the RBHA and hospital.
§ Support the Expedited Appeal process including attending the Administrative Hearing if necessary.

CMDP will compile a daily list of all ACYF children that have been hospitalization and email the list to each Program Manager and District Mental Health Specialist.

ACYF Mental Health Specialist:

§ Initiate the filing of an Expedited Appeal to dispute the RBHA denial of the hospitalization which is necessary in order for CMDP to pay the cost of hospitalization.
§ Fax the completed Appeal Compliant to the RBHA, DCYF Appeals Consultant and Assistant Attorney General.
§ Request clear discharge plan from RBHA and hospital.
§ Notify CMDP, CPS Specialist, Appeals Consultant and Assistant Attorney General of Notice of Hearing.

§ Maintain the documentation in the Appeal hard copy record.

§ Send documents to the DCYF Appeals Consultant including current report, progress report **within the last 90 days** and hospital records.

§ Consult with the DCYF Appeals Consultant and Assistant Attorney General during the hospitalization and Expedited Appeal processes.

§ Participate in all conferences and Administrative Hearings scheduled for the Expedited Appeal.

Revision History:
DES(07-2006)

Previous / Next

9-14

Legal Basis: ARS §8-514.05(B) directs a health care provider, health plan or a health care institution to provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and nonprescription drugs, medications, durable medical equipment, devices and related information to department employees who are involved in the child's case management.

Rules: Not applicable

Revision History:

DES(07-2006)

Chapter 9: Section 14

Accessing Services Required by the Case Plan:

ACYF Behavioral Health Services Non Title XIX

Legal Basis

Policy: The department shall seek to ensure that all children and families served by ACYF receive appropriate behavioral health and substance abuse services.

The department may utilize ACYF-funded services for clients who are not eligible for Title XIX behavioral health and substance abuse services.

In some cases, ACYF may cover specific services for individuals that are Title XIX eligible, but have been denied that specific service by the Regional Behavioral Health Authority (RBHA) provider.

ACYF shall utilize the following contracted behavioral health services for clients when indicated:

- individual therapy/counseling,
- group/family therapy/counseling,
- evaluation and diagnosis,
- in-home moderate services,
- in-home intensive services,
- substance abuse assessment, and
- substance abuse treatment.

Districts may also contract with individuals or agencies for professional consultation, including:

- developing and monitoring treatment plans,
- screening children and families to determine their needs,
- conducting assessments or clinical interviews,
- staff training,
- participation in case staffings, and
- providing technical assistance to providers of counseling and assessment services.

Implementation and Procedure Guide

If a psychological evaluation (assessment) is requested, specify the appropriate level. See Psychological Assessment Levels (Exhibit 32) to determine the level.

Access services according to the documentation procedure described below.

Monitor the provision of services and provide information to the service provider.

Contact the provider if:

- The provider does not provide the required initial treatment plan **within 30 days** of the initial counseling session.
- The treatment plan does not reflect the case plan goal and objectives.
- The provider does not provide the required monthly treatment report.

Consult the District Mental Health Specialist or designee if there are concerns regarding the provision of services or reports.

Continue to request all other services through the Title XIX RBHA provider.

DOCUMENTATION :

To access ACYF funded Behavioral Health Services for clients who are not eligible for Title XIX behavioral health and substance abuse services complete the Request for Services PS-067 and route according to District procedures.

File a copy of the PS-067 in the hard copy record.

Revision History:
DES(07-2006)

Previous / Next

9-15

Legal Basis: ARS §8-881 et. seq. established the Joint Substance Abuse Treatment Fund (Arizona Families F.I.R.S.T.) which is administered jointly by the Department of Economic Security (DES) and Department of Health Services (DHS). The DES and DHS are required to coordinate the provision of services to eligible participants, which include:

§ A parent, guardian or custodian of a child who is named in a report to Child Protective Services as a victim of abuse or neglect and whose substance abuse is a significant barrier to maintaining, preserving or reunifying the family; or
§ A person whose substance abuse is a significant barrier to maintaining or obtaining employment if the person is receiving cash assistance pursuant to Title 46, Chapter 2, Article 5.

ARS §8-812 established the Expedited Substance Abuse Treatment Fund to provide substance abuse services to expedite permanency of dependent children when parental substance abuse is a significant obstacle to family reunification.

Title XIX of the Social Security Act provides federal funding for behavioral health and substance abuse services for eligible individuals.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) allows for the exchange of Protected Health Information (referred to as PHI) between covered entities for purposes of treatment, payment and health care operations; limits the use and disclosure of Protected Health Information; establishes an individual's right to control access to and use of their Protected Health Information; and, balances health information protection and individual rights against public health and safety needs.

Rules: 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse, protects the confidentiality of alcohol and drug abuse participant records and restricts communications about identifiable individuals by programs that provide substance abuse diagnosis, treatment, or referral for treatment.

Rules concerning AHCCCS, Arizona's federally approved Medicaid alternative, are found in Section R9-22 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 9: Section 15

Accessing Services Required by the Case Plan:

Adult Substance Abuse Services

Legal Basis

Policy: The department shall seek to ensure that all adults served by ACYF receive appropriate substance abuse treatment services. Substance abuse treatment services are coordinated and provided through a statewide continuum of substance abuse services including:

- § referral;
- § screening;
- § assessment;
- § substance abuse treatment, i.e., education, outpatient, intensive outpatient and residential;
- § service coordination;
- § aftercare; and
- § additional supportive services to support the family in recovery from substance abuse.

Implementation and Procedures Guide

When meeting with a family where substance abuse may be a concern, utilize Exhibit 6, Substance Abuse Behavioral Indicator Checklist and Exhibit 8, Guide and Instructions to Assessing Risk Factors for Substance Exposed Newborns. Utilize the information gathered to complete the strengths and risks assessment tool. If the tool indicates that parental substance abuse is a barrier to maintaining or reunifying the family, initiate a referral for substance abuse assessment or treatment from Arizona Families F.I.R.S.T., or another substance abuse resource. Refer to Exhibit 9, Arizona Families F.I.R.S.T. for a description of services and expected time frames for outreach, assessment and treatment available through Arizona Families F.I.R.S.T.

Refer the parent, guardian or custodian directly to the contracted provider for the continuum of services by sending to the provider a completed Request for Services (PS-067), and any other supporting documents, or relevant corroborating information to assist in the treatment planning process.

The Arizona Families F.I.R.S.T. contract provider will coordinate the receipt of services through

Title XIX and Arizona Families F.I.R.S.T.

Ensure that the parent, guardian or custodian signs the *Consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information* (ACY-1125AFORNA) so that substance abuse assessment and treatment information can be shared among interested persons. See What CPS Specialists Should Know About Substance Abuse Confidentiality (Exhibit 33) for more information on confidentiality related to substance abuse assessment, treatment and client records.

Participate in ongoing case conferences, service planning activities and Individual Service Plan (ISP) development facilitated by the provider or RBHA. These ongoing coordination activities will help to maximize successful client interventions. Participation may be telephonic if unable to attend in person.

Monitor progress to ensure timely services.

Include the contracted substance abuse provider, or Arizona Families F.I.R.S.T. provider or RBHA provider on the FC-064-A, Attachment A, for reports to the Juvenile Court. Provide copies of the CPS Specialist's written report to the court to RBHA provider and/or Arizona Families F.I.R.S.T. provider. Do not include the FC-064 (Foster Care Plan and Progress Report), FC-064-A (Attachment A) or other provider reports.

Review the provider's monthly reports to assess case progress and determine if a case plan revision is necessary.

Consult with the service provider or other treatment team members as necessary**.**

DOCUMENTATION :

File a copy of the completed ACY-1125AFORNA, *Consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information* in the hard copy case record.

When parental substance abuse is a barrier to maintaining or reunifying the family, document the occurrence of substance abuse as a risk factor in the Family Strengths and Risks Assessment window.

File a copy of the Request for Services (PS-067) in the hard copy case record.

Maintain the referral, assessment, provider's monthly report, service planning documents, or

other information received in the hard copy case record.

Document the progress made toward achieving outcomes specified in the case plan using the Case Notes window.

For More Information: On behavioral health services for children or adults who are not Title XIX eligible, see ACYF Behavioral Health Services Non-Title XIX (Chapter 9 Section 14).

For More Information: On responding to reports of substance exposed newborns, see Reports Concerning Substance Exposed Newborns (Chapter 2 Section 5).

Revision History:
DES(07-2006)

Previous / Next

9-16

Legal Basis: Title XIX of the Social Security Act provides federal funding for behavioral health and substance abuse services for eligible individuals.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) allows for the exchange of Protected Health Information (referred to as PHI) between covered entities for purposes of treatment, payment and health care operations; limits the use and disclosure of Protected Health Information; establishes an individual's right to control access to and use of their Protected Health Information; and, balances health information protection and individual rights against public health and safety needs.

Rules: Rules concerning AHCCCS, Arizona's federally approved Medicaid-alternative, are found in Section R9-22 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 9: Section 16

Accessing Services Required by the Case Plan:

Adult Behavioral Health Services

Legal Basis

Policy: The department shall seek to ensure that all families served by ACYF receive appropriate behavioral health services. The CPS Specialist shall refer adults to the appropriate RBHA provider for an assessment.

The department shall utilize the Department of Health Service, Division of Behavioral Health Services, Regional Behavioral Health Authority (RBHA) system to obtain Title XIX covered services in order to address behavioral health and substance abuse service needs for eligible individuals.

All requests for behavioral health services for Title XIX eligible individuals must be made to the RBHA.

The CPS Specialist shall monitor the appropriateness and timeliness of services being provided by the RBHA provider services to all individuals (adults and children) and advocate for client service needs.

Implementation and Procedures Guide:

To access Title XIX services for adults, ages 18 and older including young adults in extended foster care:

- Assist the client in applying for general mental health or SMI services through his or her local RBHA.
- Accompany the client to the intake appointment, when requested. Ensure that the parent, guardian or custodian signs a consent for release of assessment and treatment information so that information can be shared among interested persons.

While clients are receiving Title XIX Behavioral Health Services:

- Maintain primary case management responsibility and make DES records available

to the behavioral health provider, complying with confidentiality requirements;

§ Participate in all RBHA treatment staffings and Individual Service Plan (ISP) development.

§ Participation may be telephonic if unable to attend in person.

§ Follow the Case Management Hierarchy, Exhibit 34.

§ Monitor progress to ensure timely services.

The CPS Specialist shall ensure that a copy of the assessment and other pertinent information on services and progress reports from the RBHA or behavioral health provider are filed in the hard copy case record.

Include the RBHA provider on the FC-064-A, Attachment A, for reports to the Juvenile Court. Provide copies of the CPS Specialist's written report to the court to RBHA provider and/or Arizona Families F.I.R.S.T. provider. Do not include the FC-064 (Foster Care Plan and Progress Report), FC-064-A (Attachment A) or other provider reports.

Notify the RBHA provider of all case plan staffings.

For More Information: On psychiatric hospitalization or therapeutic residential programs, see Residential and Acute Care Services (Chapter 8).

Revision History:
DES(07-2006)

Previous / Next

9-17

Legal Basis: ARS §8-1001 established the Family Group Decision Making Program (FGDM) to provide an opportunity to help families find solutions to problems that threaten their family's stability.

Rule: Not Applicable

Revision History:
DES(07-2006)

Chapter 9: Section 17

Accessing Services Required by the Case Plan: Family Group Decision Making

Legal Basis

Policy: The FGDM Program shall seek to facilitate the family's development of safety and permanency plans for children who have been subjected to abuse or neglect.

A family who is the subject of a Child Protective Services (CPS) emergency intervention shall be eligible for the FGDM Program.

FGDM conferences shall include the investigative and ongoing CPS Specialist, supervisor, the FGDM Specialist, a co-facilitator, parents and/or guardians, and significant others.

In all cases being considered for referral to the FGDM Program, a pre-referral meeting shall be held with the FGDM Specialist, the assigned CPS Specialist and the supervisor. The purpose of this meeting is to determine if participation in the FGDM Program is likely to produce a plan which will provide for the safety of the child and that is acceptable to CPS.

Preparation for and arrangement of the FGDM conference shall be shared between the FGDM Specialist and the contract facilitator. See Ensuring a Meeting With a Family is Family Centered (Exhibit 27).

FGDM conferences shall occur in the family's primary language and with careful attention to cultural issues and values.

Participating family members shall be provided sufficient relevant information as needed by resource professionals, to assist in reaching adequate and accurate decisions during the conference.

The FGDM plan shall be made by the family during family private time. At no time shall the FGDM Specialist, facilitator, or CPS staff become a part of the decision making during the private family time or advise the family as to what decisions should be made.

During the private family time, the family shall develop a back-up (alternative) plan which describes what the family proposes should be done if a significant part of the family plan fails.

CPS Specialists shall have authority to accept or reject the family plan. Should the plan be rejected, the CPS Specialist who rejects the plan shall provide an explanation as to why, and the family shall be allowed the opportunity to strengthen the plan.

In cases where a child's placement has been identified using the FGDM process, the case shall remain open for follow-up support and contact for at least six months after the child's placement with the caregiver to ensure child safety and well-being. Each district shall determine who will provide the follow-up support and contact. The case shall be closed when the assigned CPS Specialist and supervisor agree the case is appropriate for closure after the six month period.

A home study shall be conducted on all identified placements using the Assessment for Kinship Foster Care or Significant Person Placement, CT01100, found in the Court Document Detail. If a non-custodial, out-of-state placement is identified, a home study shall be requested from the receiving state after completion of the CPS and criminal background.

The family is eligible for a follow-up FGDM conference and services for up to one year after the initial conference, regardless of the case status.

To determine if a case is appropriate for the FGDM Program, consider these questions:

§ Does the assigned CPS Specialist believe the child's safety, permanency and family support can be achieved through the FGDM process?

§ Is the assigned CPS Specialist willing to share decision making regarding child safety and permanency with the family?

BEST PRACTICE TIP:
Shared decision making requires that the CPS Specialist share their power with the family. This ability to share power is paramount in family engagement and in assisting families in making effective decisions for their own lives. CPS Specialists who are willing to share power understand:

§ that families often hold the solutions to their own problems if asked
§ that families are experts on what they need, what is working and what is not working in their system
§ that families have resiliency and incredible capacity to heal and recover

§ that the job of the CPS Specialist is made easier when families are active vital parts of the team.

When CPS Specialists are reluctant to share power then they have the responsibility to do all of the planning, make all of the decisions –with little family support and buy in.

CPS Specialists who will not share power with parents, extended family and community members are not as effective in protecting children.

§ Is the parent willing to share decision making regarding the care of the child with kin and other significant persons (extended family, friends, etc.)?

§ Is the parent motivated to participate in the FGDM process?

§ Is there a serious risk of domestic violence that could be exacerbated due to the FGDM process?

§ Is a child likely to suffer abuse or neglect due to information shared during the FGDM conference?

§ Are the abuse and/or neglect issues clear and supported by evidence?

§ Do some of the potential FGDM participants believe the child is at risk and are willing to participate in the process? (If no one in the family believes the child was or is at risk in the home or is unwilling to participate in the process, the FGDM process is unlikely to be successful.)

Implementation and Procedures Guide

Assess whether the goals of safety, permanency, and well-being are likely to be achieved through the FGDM process.

Consult with the FGDM Program to determine if participation in the FGDM Program is likely to produce a plan which will provide for the safety of the child and that is acceptable to CPS.

If FGDM is appropriate, discuss the FGDM Program with the family. The FGDM Specialist will be available upon request to assist the CPS Specialist with this discussion.

In cases where a dependency petition has not been filed:

§ Present specific evidence of abuse and/or neglect to the parent.
§ Inform the parent that the FGDM process may be used to develop child safety and permanency plans prior to the filing of a dependency petition.

In cases where a child is a dependent ward of the court, present the option of the FGDM Program to the family and explain the benefits of participation.

Before proceeding, confirm the parent's willingness to participate in a conference and obtain the names and contact information for at least two adults who may be willing to participate in a conference. If the parent is unwilling to participate or unwilling or unable to identify at least two adults to participate, then do not refer the family to the FGDM Program.

BEST PRACTICE TIP:
There are times when parents are unwilling to identify other adults due to their shame or guilt about being involved in the child welfare system. It is important for the CPS Specialist to take the time to help the family sort out these feelings so that they and their children can benefit from the Family Group Decision Making process.

When ready to proceed:

§ Provide the parent with the FGDM brochure which can be obtained from the district FGDM Specialist.
§ Inform the parent:

- If the parent is uncomfortable sharing information (name, phone number and address) about potential participants with the assigned CPS Specialist, the FGDM Specialist will discuss this issue with them.
- CPS will accept the family's plan if the plan ensures the safety and permanency of the child.
- A FGDM Specialist will contact the parent and the identified participants within a few days in preparation for the FGDM conference.
- In dependency cases, parties to the court action will be invited to participate, as appropriate.
- The FGDM Specialist will invite a Child and Family Team Facilitator to the family meeting. This will be a resource for continuing follow-up and support for the children and family involved in the meeting.
- The FGDM process may take several weeks before the conference is held.
- A home study and family assessment will be required on all identified placements.

The assigned CPS Specialist shall make no mention to the family of financial assistance for the FGDM conference. This topic will *only* be discussed with the family by the FGDM Specialist.

Within two working days after the parent agrees to a FGDM conference, complete the Family Group Decision Making Referral Form, found in the Forms Registry, and submit to the district FGDM Specialist.

Continue to identify potential meeting participants and provide the names and contact information to the FGDM Specialist.

Perform all case management responsibilities, making no decisions that may affect the FGDM conference unless discussed with, and agreed upon by, the FGDM Specialist.

Case Management Responsibilities Prior to the FGDM conference:

§ If applicable, share case information with the ongoing CPS Specialist to whom the case will transfer after completion of the conference; and
§ Participate in a pre-conference meeting with the FGDM Specialist to review the following preparation steps:

- Review the case record and be able to answer the family's questions regarding process, legal status, and non-negotiable items.
- Be prepared to present the case in an impartial manner.
- Be prepared to articulate any non-negotiable issues to the family so that these issues are included in the family plan.

Case Management Responsibilities During the conference:

§ Attend the entire FGDM conference.
§ Be prepared to present the requirements for the family plan.
§ Remain available outside of the meeting room during the family's private time and provide input as appropriate and requested.
§ At the conclusion of the family's private time, approve the family's plan or explain to the family why the plan is not acceptable.

Case Management Responsibilities Following the conference:

§ Complete all tasks assigned during the conference.
§ Ensure that all parties to the dependency action receive a copy of the report to the court. If the family does not want the strengths and concerns section shared with all

parties, provide the information directly to the Judicial Officer, who will determine its release.

§ If the identified caregiver is in Arizona, complete the family assessment on the selected family member and initiate fingerprinting and the Child Protective Services records search **within one working day** of the FGDM conference.

§ Prepare a home study and family assessment check on the identified caregiver using the Assessment for Kinship Foster Care or Significant Person Placement CT01100, found in the Court Document Detail (see CT01101 in the Forms Registry for instructions for completing the Assessment for Kinship Foster Care or Significant Person Placement). In cases where a dependency petition has been filed and the identified placement resource is an unlicensed kinship or significant person, complete a home study.

§ If the identified caregiver is located in another district, follow request a courtesy home study be completed by the receiving district prior to placement.

§ In cases where a child is a dependent ward of the court and in out-of-home placement, and the proposed placement is located in another state, initiate an Interstate Compact on Placement of Children (ICPC) home study request and obtain ICPC and court approval for the placement prior to placing the child, see Interstate Compact on the Placement of Children (Chapter 10).

§ In cases where a child is a dependent ward of the court, attach a copy of the FGDM Summary to the next report to the court, including the strengths and concerns section.

§ In cases where the child is *not* a ward of the court and the proposed placement of the child is located out-of-state, request a courtesy home study from the home state and complete the following tasks prior to the child leaving the state:

- Complete the Checklist for Assessment of Kinship Care and Significant Person Placement, FSC-1015A, found in Forms Registry.
- Check and document current or prior involvement with CPS for each adult household member in the home state. Document in the case notes if the state refuses to provide any information.
- Advise the potential caregiver that each adult household member must be fingerprinted for and cleared by the home state and federal criminal history record check with the results sent to the FGDM Specialist. If the fingerprint check reveals a criminal record, the FGDM Specialist will discuss the matter with the District Program Manager or designee to determine the best course of action.
- Mail a letter to the caregiver with the name and phone number of the FGDM Specialist indicating the family may contact this person if needed.

§ Inform the identified caregiver of available financial and non-financial services

and eligibility requirements; assist the family in completing the necessary applications, and make referrals to appropriate community services to help the family meet the special needs of the child.

§ Keep the case in open status and provide follow-up support and contact with the family plan to ensure implementation of the family plan for a **minimum of six months**. Each district will determine who will provide this follow-up. Case follow-up shall include phone contact with the designated caregiver and family monitor once **every six weeks** to determine if:

- o There have been periods without significant incident.
- o Care arrangements are stable.
- o The family is self-sustaining, well-linked to the extended family group and other supports.
- o Legal aspects of care arrangements are satisfactorily resolved (i.e. guardianship and/or custody are established and functional).
- o The child knows how/where to seek help if problems arise in the future and is likely that he/she will do this.
- o Needed services are in place and parties are participating in services.

• Upon request of any participant, provide guidance and, if needed, a follow-up conference to address the goals or tasks if any aspect of the family plan fails. For cases:

- o open with CPS, follow-up FGDM conferences will be scheduled upon request from the assigned CPS Specialist and family; and
- o closed with CPS, the FGDM Specialist will schedule the FGDM conference upon request by the family without CPS involvement**.**

If a family is experiencing problems that threaten the placement of the child, the family may contact the FGDM Specialist for up to one year after the conference to request additional services to help strengthen the stability of the placement. If approved by the FGDM Specialist, the service will be provided by the FGDM contract provider.

If disagreement arises during the process of sharing a case, the assigned CPS Specialist, supervisor, and FGDM Specialist will hold a case conference to resolve the matter. If the disagreement can not be resolved, elevate the disagreement to the District Program Manager or designee for resolution.

DOCUMENTATION :

Document the names, addresses, phone numbers and relationship to the child of potential FGDM meeting participants using the Case Notes window.

Document attendance at the FGDM conference and the child placement decision using the Case Notes window.

Do not document any discussions held with family members or significant others during the FGDM conference.

File a copy of the FGDM Summary in the hard copy case record (without the strengths and concerns on non-court cases).

In cases where a child is a dependent ward of the court, attach a copy of the FGDM Summary to the next report to the court including the strengths and concerns section. Ensure that all parties to the dependency action receives a copy of the report to the court.

Revision History:
DES(07-2006)

Previous / Next

9-18

Legal Basis: The Child Abuse Prevention and Treatment Act (P.L. 104-235), as amended by the Keeping Children and Families Safe Act (P.L. 108-36), requires states to refer a child under the age of three, who is the subject of a substantiated report of child abuse or neglect, for early intervention services available through the Individuals with Disabilities Education Action, Part C.

ARS §8-652(C) implements the Arizona Early Intervention Program (AzEIP) through coordination with the Department of Economic Security, the Department of Education, the Department of Health Services, the Arizona Health Care Cost Containment System Administration and the Arizona State School for the Deaf and Blind. These agencies are required to develop and implement a comprehensive, coordinated system of early intervention programs and services for infants and toddlers with or at risk of developmental delays with their families.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 18

Referring a Child to the Arizona Early Intervention Program (AzEIP)

Legal Basis

Policy: The department shall refer all children under the age of three who are the subject of a substantiated report or who have been removed and in CPS custody for early intervention services. A substantiated report includes the following findings: proposed substantiated, proposed substantiated-perpetrator deceased and proposed substantiated-perpetrator unknown.

The department shall refer all children under the age of three:

- who have been removed and in CPS custody, to the Regional Behavioral Health Authority (RBHA) for a developmental screening and a behavioral health assessment;
- children who are not in CPS custody, to the AzEIP for early intervention services.

Implementation and Procedures Guide:

Gather available information including clinical and medical reports on the child from previous medical and behavioral health care providers.

Obtain health insurance information (i.e., AHCCCS, etc.) from the parent, guardian or custodian.

Within 24 hours of the removal, refer all children under the age of three to the RBHA for a developmental screening and behavioral health assessment. Fax or mail any reports from previous medical, clinical or behavioral health assessments or evaluations to the RBHA.

If the child's primary care provider (PCP) has completed the EPSDT examination and identifies a developmental concern, provide this information to the RBHA.

Ensure that the parent and/or out-of-home caregiver is aware of the referral for early intervention services.

If the RBHA screening or assessment indicates that the child has a developmental concern, the RBHA will:

- Make the referral to AzEIP for early intervention services.
- Notify the CPS Specialist and the child's primary care physician (PCP) of the results and

of the AzEIP referral.
- Include AzEIP in the Child and Family Team.

Ensure that the out-of-home care provider is aware of the developmental concern and AzEIP referral.

If the RBHA screening or assessment indicates that the child does not have a developmental concern, the RBHA will notify the case manager of the results. The RBHA will provide necessary behavioral health services to the child, the child's family and out-of-home provider.

If the child is ***not*** eligible for Title XIX services, complete and fax the CPS Referral to Arizona Early Intervention Program (AzEIP), found in the Forms Registry, to the designated AzEIP regional contractor. The referral to AzEIP may also be completed on the DES website at www.azdes.gov/azeip. Ensure that the concerns and/or reasons for the referral are documented in the Reason for Referral/Concerns Section of the referral. It is not necessary to make a referral if the referral has already been made by another source, or the child is receiving AzEIP services.

- Ensure that the child's legal status and eligibility for AHCCCS or CMDP is recorded on the CPS Referral to Arizona Early Intervention Program (AzEIP) or in the Concerns Section of the internet referral.

- Fax or mail any reports from previous medical, clinical or behavioral health assessments or evaluations to the AzEIP regional contractor.

- List all services the family is receiving or has been referred to on the CPS Referral to Arizona Early Intervention Program (AzEIP) or in the Concerns Section of the internet referral. AzEIP will ensure that services are not duplicated.

If the child is in out-of-home care and changes placement during the referral process, ensure that the AzEIP regional contractor is aware of the change in placement. Provide the name, address and telephone number of the new caregiver to the AzEIP contractor.

Identification of a Surrogate Parent:

A surrogate parent must be appointed to represent the child's special educational interests under IDEA, Part C if the parent, guardian, step-parent or relative with whom the child resides is not available, willing and able to perform this function**.** If the child is a ward of the court and a surrogate parent is required to represent the child's special educational needs [see page 2 of the CPS Referral to Arizona Early Intervention Program (AzEIP)], contact the Assistant Attorney General to file a motion to appoint the identified person as the child's surrogate parent.

DOCUMENTATION :

Document the outcome of any previous assessments or medical examinations including a diagnosis of a developmental delay or established condition in the Participant Education Condition Detail window.

Document the referral to the AzEIP by filing a copy of the CPS Referral to Arizona Early Intervention Program (AzEIP) or a printed copy of the AzEIP internet referral in the hard copy record. To obtain a copy of the internet referral, you must print the screen prior to submitting the referral. If the referral was made by another source, document the referral by obtaining and filing a copy of the referral in the child's case record, or by documenting verbal confirmation of the referral using the Case Notes window, designated as Collateral Contact type. If the child is receiving AzEIP services, document this in the case notes.

Revision History:
DES(07-2006)

Previous / Next

9-19

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 19

Accessing Services Required by the Case Plan: Provision of After Care Services

Legal Basis

Policy: Prior to closing a case, the department shall complete an assessment with the family to determine if there are any unmet needs that may improve family functioning. The department will assist the family to develop an aftercare plan to address these identified needs.

Implementation and Procedure Guide:

Gather information during contacts with family and service team members to assess whether the safety and risk factors necessitating department involvement have been adequately addressed.

Complete a reassessment of the child's safety and risk of harm using the Child Safety Assessment (PS-05400) and Family Strengths and Risks Assessment window.

Hold a clinical supervision conference with the supervisor to determine whether case closure is appropriate.

At least 30 days, but no more than six months prior to case closure, meet with the child, the child's caregiver, and other service team members as appropriate, to determine whether aftercare services are needed, and whether the child and caregiver desire aftercare services**.**

If the reassessment identifies an unmet need that may improve family functioning, or if the child or caregiver wishes to participate in aftercare services:

- § Develop a plan to meet the identified needs, considering the comments, recommendations, and requests of the child, the caregiver, and other service team members.
- § Include specific plans for obtaining any identified services.
- § When appropriate, and with the permission of the child and caregiver, explore suitable resources and make contact with the service providers.
- § Ensure the child and caregiver are provided sufficient information to enable them to contact the service provider and initiate services.

DOCUMENTATION :

Document the aftercare plan using the Case Closure window. Ensure detailed information is included, identifying the child's or caregiver's aftercare needs and services or referrals provided to address those needs.

Document information gathered during contacts with family and service team members to assess whether the risk factors necessitating department involvement have been adequately addressed using the Case Notes window.

File written reports and evaluations in the hard copy case record.

Document the clinical supervision conference with the supervisor using the Case Notes window, Supervisory type.

Document the meeting with the child and the child's birth parent, adoptive parent, or guardian and other service team members as appropriate to determine whether aftercare services are needed, and whether the child and caregiver desire aftercare services using the Case Notes window. Include documentation of the outcome of the meeting.

Ensure that the case information is current as of the date of case closure. Ensure completion of the Determination of Case Status and Case Closure windows.

For More Information: On closing the electronic case record in CHILDS, see Closing Case Records in CHILDS (Chapter 19 Section 5).

Revision History:
DES(07-2006)

Previous / Next

9-20

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 20

Arranging for Courtesy Supervision

Legal Basis

Policy: When courtesy supervision is necessary, districts shall share information and work collaboratively to ensure that the needs of the child and family are met.

Courtesy supervision may be provided when a child and/or family member lives in one district and the legal responsibility for the case remains with another district. The decision to provide courtesy supervision shall be based upon the child's needs.

The district with legal jurisdiction remains responsible for case planning, updating of CHILDS, and payment for services.

The CPS Specialist from the receiving district shall be considered to be a service team member and shall participate in case plan staffings and case conferences.

Implementation and Procedures Guide

To request courtesy supervision, the Program Manager or designee from the sending district submits an E-Mail to the Program Manager or designee from the receiving district. The request should include:

- case name and case number;
- name, date of birth, of the child;
- the most critical factors concerning the child or family;
- supervision services requested;
- other services the child or family is to receive, along with payment arrangements;
- copies of relevant case information not available through the electronic record, including but not limited to psychological evaluations, provider reports, etc.
- copies of relevant hard copy case information shall be forwarded to the receiving Program Manager or designee. The request is not complete until relevant hard copy case information is received.

The receiving Program Manager or designee completes a review of the electronic record and hard copy information. The Program Manager or designee must approve or deny the request for courtesy supervision by E-Mail **within ten working days** of receipt of the request.

A case conference must be held **within 15 working days** after the receiving district accepts a case for courtesy supervision or case transfer. The case conference may be conducted in person or by conference call.

A case conference must be held **within ten working days** if the sending and receiving districts disagree regarding the case plan. If resolution cannot be reached, the decision shall be made by the ACYF Program Administrator.

DOCUMENTATION :

The sending Program Manager or designee is to document the request for courtesy supervision using the Case Notes window designated as Management Contact type.

Document the approval or denial of the request using the Case Note Comment window.

The supervisor from the sending district designates the CPS Specialist from the receiving district as a support CPS Specialist using the Case Assignment window.

The CPS Specialist from the sending district documents the case reference using the Case Notes window designated as Case Conference type specifying the responsibilities of both the sending and receiving CPS Specialists within three (3) days of receipt of approval from the receiving district.

The CPS Specialist from the receiving district documents the following using the Case Notes window:

- dates and types of contact;
- progress towards the case goal;
- changes in individual or family functioning; and
- review of the case plan and recommendation for any changes in goals, tasks or services.

Revision History:
DES(07-2006)

Previous / Next

9-21

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 9: Section 21

Transferring Cases

Legal Basis

Policy: When case transfer is necessary, districts shall share information and work collaboratively to ensure that the needs of the child and family are met.

Case transfer may occur when the child and family have lived in the new district for three months or longer or if the child and family live in different districts and there are plans to reunite the family.

The district requesting a case transfer must receive approval from the receiving district prior to transferring the case or requesting that the court transfer legal jurisdiction.

In most cases, the district with legal jurisdiction remains responsible for payment for services. However, when the case transfer results from a court order to change venue (without the agency's involvement), the Program Managers of the sending and receiving districts may make special payment arrangements by mutual agreement.

Unless special arrangements are made, the receiving district is fully responsible for the case once the transfer is completed.

Implementation and Procedure Guide

To request case transfer, the Program Manager or designee from the sending district must send an E-Mail to the Program Manager or designee from the receiving district. The request should include the information previously listed and the reason for case transfer. The request is not complete until relevant hard copy case information is received.

The receiving Program Manager or designee completes a review of the electronic record and hard copy information. The Program Manager or designee must approve or deny the request for case transfer by E-Mail **within ten working days** of receipt of the request.

A case conference must be held **within 15 working days** after the receiving district accepts a case for case transfer.

If approved by the Program Manager, the supervisor in the receiving district for the identified worker is to assign the worker as the Primary Case Manager in Case Assignment window **within three (3) working days** of receipt of the hard file. The sending district is responsible for the case up until this time.

BEST PRACTICE TIP:

When a family is being transferred from one CPS Specialist to another, this can be extremely upsetting and challenging for the family, especially if the family has developed a strong bond with the CPS Specialist. It is very important to the ongoing involvement and engagement of the family, and to the case outcomes, that the following occur:

§ the old and new CPS Specialists spend time discussing the family safety, strengths and risk assessment, where the family is in their case plan, progress that has been made to date and what still needs to occur. Many families in the child welfare system express significant concerns that when their case is transferred, the progress that they have made is not recognized and they feel like they are “starting from scratch”.

§ the old and new CPS Specialists meet with the family to conduct a “warm hand off”. This case transition process is critical to the family’s perception that their needs and issues are understood by the new CPS Specialists. They also need the time to say good bye to their first CPS Specialist.

DOCUMENTATION :

Document the request for case transfer using the Case Notes window designated as Management Contact type.

Document the receiving Program Manager or designee's approval or denial of the request using the Case Note Comment window.

Document the case conference using the Case Notes window designated as Case Conference type specifying the responsibilities of both the sending and receiving CPS Specialists.

CPS Specialist Sending District:

Document the case conference using the Case Notes window designated as Case Conference type specifying the responsibilities of both the sending and receiving CPS Specialists.

Revision History:
DES(07-2006)

Previous

10-1

Legal Basis: The Interstate Compact on the Placement of Children (ICPC) is a contract between and among the 50 states, which standardizes national procedures to ensure suitable placement and supervision for children placed across state lines. There are eight federal regulations that have been approved by all 50 states.

ARS §8-548 enacts the Interstate Compact on the Placement of Children in Arizona.

Rules: Sections R6-5-8001 through R6-5-8003 of the Arizona Administrative Code address the goals, objectives and authority of the ICPC.

Revision History:
DES(07-2006)

Chapter 10: Section 1

Overview of ICPC

Legal Basis

Policy: The State of Arizona will comply with the terms and procedures specified in the Interstate Compact on the Placement of Children (ICPC). These procedures include:

- how referrals for interstate placements are to be made;
- which state or agency is responsible for support of the child and for supervision of the placement; and
- how information regarding the status of the child is to be shared.

The Director of the Department of Economic Security serves as ICPC Compact Administrator. The Deputy Compact Administrator is a designated individual within the Administration for Children, Youth and Families.

The ICPC applies when:

- a child in agency custody is to be placed in another state with a parent or relative, or in a foster home or group care facility;
- a child in foster care is to move to another state with his or her foster parents;
- a child is to be placed on a pre-adoptive basis in a home in another state;
- a child in a pre-adoptive home is to move to another state with his or her prospective adoptive parents;
- an individual with custody of a child wishes to arrange for that child to live in another state. *(Please note the following exception*: *ICPC does NOT apply when the custodian is the child's parent, step-parent, grandparent, guardian, adult aunt or uncle, or adult sibling, and it is intended for the child to live out of state with the custodian, a different relative or a non-agency guardian.)*

The ICPC does not apply when:

- a child is placed in a hospital or any other medical facility;
- a child is placed in an institution that is primarily educational;
- a child is placed in an institution for the mentally ill, mentally defective or epileptic;
- a child is sent to another state for a visit of less than 30 days with no expectation of interstate placement, request for home study, or request for supervision;
- a child is placed in another state under the provisions of the Interstate Compact on Placement of Juveniles or any other agreement between states which has the force of law; or
- an individual, agency or institution makes a routine inquiry, which is not expected to result in interstate placement.

Revision History:

DES(07-2006)

Next

10-2

Legal Basis: Article III of the Interstate Compact for the Placement of Children, as enacted by ARS §8-548, discusses referral for ICPC placement.

Rules: Section R6-5-8005 of the Arizona Administrative Code specifies when ICPC applies; Section R6-5-8007 specifies when ICPC does not apply.

Revision History:
DES(07-2006)

Chapter 10: Section 2

Referring a Child for Placement through ICPC

Legal Basis

Policy: Any person, court, or public or private agency wishing to place an Arizona child for care in another state must proceed through the ICPC. Similarly, any person, court, public or private agency in another state wishing to place a child for care in Arizona must proceed through the ICPC.

The local agency of the sending state is responsible for initiating referrals for placement through the ICPC by providing required information to their Deputy Compact Administrator. Their Deputy Compact Administrator is responsible for initiating contact with the receiving state.

Implementation Guide:

Prior to a child's placement in another state, the CPS Specialist and the potential placement should discuss the child's ongoing medical and dental care. For further information, refer to Chapter 10, Section 6, Medical Coverage for Children through the ICPC.

The CPS Specialist should complete a referral packet to refer a child for out-of-state placement through the ICPC. The referral packet should include the following:

ü "Interstate Compact Application Request to Place a Child," ICPC-100-A;

ü a cover letter to the receiving state's Compact Administrator; the letter should include all of the following information:

- the reason for the proposed out-of-state placement;
- a request for home evaluation or facility placement approval;
- information available on the family or group care facility with whom the child is to be placed;
- any special needs of the child (this may be summarized, if stated elsewhere);
- the permanent plan(s) for the child (this may be summarized, if stated elsewhere);
- the individual or agency assuming financial responsibility, including medical

expenses, and the plan for meeting these financial obligations; and

- a request for licensing, certification or approval, according to the standards of the receiving state, if foster care payments or medical coverage will be provided by Arizona, the sending state.

ü a social history of the child, which includes:

- any identifying information;
- the reason why the child is in agency care, if applicable;
- a description of the child's appearance, including any unusual features;
- a description of the child's personality (emotional adjustment, interpersonal relationships, etc.);
- a summary of the child's life experiences (home, foster home, institutional, etc.);
- a brief summary of the child's present living situation;
- a description of the child's developmental history;
- identification of any known family relationships or special circumstances involving parents, siblings or other family members; and
- a copy of the case plan and permanency goal information.

ü at least two of the most recent court orders and court reports (when available);

ü any available recent or significant Foster Care Review Board reports, psychological or psychiatric evaluations, and other similar reports;

ü medical history and other related reports;

ü summary of educational background and/or school records and a statement identifying educational needs (for all school age children); and

ü a copy of a recent photograph (recommended, but not required).

After completing the referral packet, the CPS Specialist should do the following:

ü Make three copies of the packet;

- Retain one copy in the hard copy of the case file;

- Forward the original and two copies of the packet and the Interstate Compact Transmittal Form, FW-155, to the Arizona Deputy Compact Administrator, Site Code 030C-1

After sending the referral packet in triplicate, the CPS Specialist may be notified of additional state-specific requirements. The CPS Specialist should send any necessary information to satisfy these additional requirements.

DOCUMENTATION :

Keep a copy of the ICPC referral packet in the hard copy case file.

Revision History:

DES(07-2006)

Previous / Next

10-3

Legal Basis: Article III of the Interstate Compact for the Placement of Children, as enacted by ARS §8-548 discusses conditions for ICPC placement.

Rules: Section R6-5-8008 of the Arizona Administrative Code addresses approval of placements.

Revision History:
DES(07-2006)

Chapter 10: Section 3

Reviewing, Evaluating and Approving ICPC Placements

Legal Basis

Policy: The Arizona Deputy Compact Administrator is responsible for reviewing ICPC referrals and sending them to the Compact Administrator in the receiving state. The Arizona Deputy Compact Administrator is also responsible for referring requests for placement in Arizona to a local receiving agency. The local receiving agency is responsible for overseeing the evaluation of the referral and notifying the sending state's Compact Administrator of the placement approval or denial.

Placement of a child may not be made until the sending state's Compact Administrator has been notified in writing by the receiving state that the placement does not appear to be contrary to the interest of the child and does not violate any applicable laws in the receiving state. (ARS §8-548)

Once a requested placement is approved, the sending and receiving agencies shall negotiate placement and supervision arrangements.

Placement of a child in violation of the terms in the ICPC is a violation of the laws of both states and may be punished or subject to penalty in either jurisdiction. In addition, any such violation shall be grounds for the suspension or revocation of any license, permit or other legal authorization held by the sending agency. (ARS §8-548)

Implementation and Procedures Guide

When an Arizona child is being placed in another state through ICPC, the process is completed as follows:

After receiving the original and two copies of the referral packet, the Arizona Deputy Compact Administrator reviews the packet, signs the "Interstate Compact Placement Request," ICPC-100-A, and sends two copies of the referral packet to the receiving state's Compact Administrator and retains a copy of the referral in the office of the Arizona Deputy Compact Administrator's file.

The receiving state's Compact Administrator receives the two copies of the referral packet and arranges for an evaluation of the potential placement. After the evaluation is completed, the receiving state's Compact Administrator reviews the evaluation, signs the Interstate Compact Placement Request, ICPC-100-A, and forwards both the evaluation and the signed ICPC-100-A to the Arizona Deputy Compact Administrator.

After receiving the ICPC-100-A and evaluation from the receiving state, the Arizona Deputy Compact Administrator retains the originals and sends one copy each of the form and the evaluation to the individual or agency that initiated the referral.

If the placement is approved, the CPS Specialist may at that time place the child in the receiving state. After the placement, the CPS Specialist should complete the Interstate Compact Report on Child's Placement Status, ICPC-100-B. One copy should be retained in the hard copy record; the original and two copies should be sent to the Arizona Deputy Compact Administrator.

When a child comes from another state and is being placed in Arizona, the process is completed as follows:

The Arizona Deputy Compact Administrator receives the referral packet from the sending state and forwards a copy of the packet to the local receiving agency.

The local receiving agency completes an evaluation. The evaluation shall include a(n):

- ü description of the family's relationship with the child and their prior knowledge of the child;
- ü evaluation of the family's capacities to meet the needs of the child as described in the referral packet;
- ü description of the health and education needs of the child;
- ü identification of any community resources needed by the child; and
- ü recommendation to approve or deny placement.

The local receiving agency sends three copies of the evaluation to the Arizona Deputy Compact Administrator **within 30 working days** of when the request was received in the local office.

The Arizona Deputy Compact Administrator reviews the evaluation and signs the Interstate Compact Placement Request, ICPC-100-A, indicating whether placement is

approved or denied. The Arizona Deputy Compact Administrator sends the evaluation and two copies of the ICPC-100-A to the Compact Administrator in the sending state.

If an Arizona local agency receives a referral directly from another state, the agency shall forward a copy of the referral **immediately** to the Arizona Deputy Compact Administrator. The agency may proceed with the evaluation, sending all responses in triplicate to the Arizona Deputy Compact Administrator, or may choose to wait for a referral from the Arizona Deputy Compact Administrator.

When an out-of-state child is placed in Arizona, the local receiving agency should create a case record containing the following information: the approved "Interstate Compact Placement Request, ICPC-100-A," the placement evaluation, and the "Interstate Compact Report on Child's Placement Status," ICPC-100-B.

Revision History:

DES(07-2006)

Previous / Next

10-4

Legal Basis: Article V of the Interstate Compact for the Placement of Children, as enacted by ARS §8-548, discusses jurisdiction over placements.

Rules: Section R6-5-8009 of the Arizona Administrative Code addresses placement.

Revision History:
DES(07-2006)

Chapter 10: Section 4

Supervising ICPC Placements and Communicating Information

Legal Basis

Policy: The local receiving agency is responsible for supervision of the placement, and shall provide:

- ü services to the child as indicated in the referral;
- ü visits with the child and caregiver in their home (placement) at least once every three months;
- ü other services which are agreed to in writing with the sending agency; and
- ü written supervisory reports to the local sending agency.

Both the sending and receiving agencies are responsible for informing the other state of any changes in the status of the interstate placement.

Services within Arizona may be provided by ACYF staff or by a contract provider.

Implementation and Procedures Guide

The CPS Specialist should communicate directly with sending or receiving agencies in other states, as appropriate. All significant verbal information should be documented and forwarded to the Deputy Compact Administrator, as described below.

Written Supervisory Reports, ICPC-100-A:

When a child from another state is placed in Arizona through the ICPC, the receiving agency representative should write a supervisory report at least once every three months. The original report should be retained in the hard copy of the case file. Three copies of supervisory reports should be sent to the Arizona Deputy Compact Administrator.

Interstate Compact Report on Child's Placement Status, ICPC-100-B:

Any significant changes regarding any child placed through the ICPC should be documented using the Interstate Compact Report on Child's Placement Status, ICPC-100-

B. Such changes include:

- § cancellation of the referral;
- § change of placement/address;
- § discharge from care; or
- § change of legal status or custody.

The original ICPC-100-B is retained in the originating state's case record. Three copies are forwarded to the originating state's Deputy Compact Administrator.

Other Documentation:

For any children placed through ICPC, any significant verbal communication with agencies in other states should be documented using the Case Notes window designated as Collateral Contact Type.

Copies of all written interstate correspondence should be forwarded to the Arizona Deputy Compact Administrator, Site Code 030C-1.

Revision History:

DES(07-2006)

Previous / Next

10-5

Legal Basis: Article V of the Interstate Compact on the Placement of Children, as enacted by ARS §8-548, discusses jurisdiction over placements.

Rules: Section R6-5-8006 of the Arizona Administrative Code addresses financial responsibility under the ICPC.

Section R6-5-8010 of the Arizona Administrative Code addresses jurisdiction over placement.

Revision History:
DES(07-2006)

Chapter 10: Section 5

Jurisdiction and Financial Responsibility for ICPC Placements

Legal Basis

Policy: The sending person or entity shall retain jurisdiction over the child as it would have if the child had remained in state. The sending person or entity shall determine all matters in relation to the custody, supervision, care, treatment and disposition of the child.

Jurisdiction ends when the child is adopted, deceased or discharged, or when the child reaches the age of majority. (Please note: Discharge may only occur with the concurrence of the Compact Administrator in the receiving state.)

When a compact placement is terminated for any reason, the Compact Administrators of both states shall be notified.

If the child is in the custody of the Arizona Department of Economic Security, the department is responsible for the financial support and planning for the child, and for the cost of sending the child to another state. If it becomes necessary to return the child to Arizona, the department is responsible for the cost of returning the child.

If the child is in the custody of another person, agency or court, that individual or entity is responsible for the activities and costs mentioned above.

Revision History:

DES(07-2006)

Previous / Next

10-6

Legal Basis: The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 addresses medical coverage for Title IV-E eligible foster children who move across state boundaries.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 10: Section 6

Medical Coverage for Children through ICPC

Legal Basis

Policy: To protect the interests of foster children who move across state lines, the department will follow all rules and procedures required by the Interstate Compact on the Placement of Children (ICPC)

When an Arizona child is being placed in another state through the ICPC:

If the child has special health care needs, contact CMDP Medical Services Unit prior to placing the child to coordinate the child's health care needs.

Out-of-state foster parents of a Title IV-E eligible child who is a dependent ward of Arizona must enroll that child in Medicaid in the state of residence.

If the receiving state's Medicaid does not pay for any service that is normally covered by Arizona's Comprehensive Medical and Dental Program (CMDP), CMDP will prior authorize and cover that service.

Foster children who are ineligible for Title IV-E will retain their CMDP coverage when they move to another state. (ARS §8-512)

Every 12 months, the DCYF Eligibility Unit is responsible for redetermining IV-E eligibility (for Arizona foster children who are placed out of state through ICPC.

When a child from another state is placed in Arizona through the ICPC:

The DCYF Eligibility Unit is responsible for verification of Title XIX eligibility, transmitting initial eligibility information to the Arizona Health Care Cost Containment System (AHCCCS), and transmitting eligibility redetermination information to AHCCCS **every 12 months**.

Implementation and Procedure Guide

To prevent interruption in the child's medical coverage, when an Arizona child is to be placed

out of state, the CPS Specialist should instruct the potential placement to do the following, prior to the child's move:

- If the child is IV-E eligible, medical and dental coverage will be through Medicaid in the receiving state. The foster caregiver must enroll the child in the Medicaid program.
- If the child is not IV-E eligible, and therefore not Title XIX eligible, the foster caregiver should identify a doctor or dentist who will agree to register with Arizona as a CMDP provider. The doctor and dentist must be willing to become a CMDP provider and accept the AHCCCS fee schedule. The foster caregiver must notify CMDP who the selected health care providers are.

If Medicaid in the receiving state does not pay for a service that is normally covered by CMDP and CMDP has previously authorized that service forward the doctor's and dentist's name and contact information to the CMDP Provider Services Unit, 3225 N. Central Ave., Ste. 91, Phoenix, Arizona 85012-2410, or fax: 602-264-3801.

If the out of state resource family initially selects a doctor or dentist who is not willing to register as a CMDP provider they need to search further for a doctor or dentist who is willing to register with CMDP. If the family has difficulty finding a doctor or dentist who is willing to enroll as a CMDP provider, the family should contact the CMDP Medical Services Unit in order to co-ordinate care.

The CMDP Provider Services unit will subsequently contact the out-of-state doctor and dentist and send them each an AHCCCS Registration Packet. Once they have returned the completed packet to CMDP, the Provider Services Unit will forward it to AHCCCS. AHCCCS will then register the providers and assign them each an ID number.

For Title XIX eligible children, who require behavioral health services, utilize the Medicaid providers in the receiving state.

For children who are not Title XIX eligible, and require behavioral health services, contact your District Mental Health Specialist to assist in coordinating contracted behavioral health services.

Revision History:

DES(07-2006)

Previous / Next

10-7

Legal Basis: Provisions of Article VI of the ICPC, as enacted by ARS §8-548, apply to the interstate placement of a child who has been adjudicated delinquent.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 10: Section 7

Placement of Adjudicated Delinquents

Legal Basis

Policy: For adjudicated delinquents, the ICPC only addresses placement in privately-operated institutions, such as residential treatment centers. The Interstate Compact on Juveniles provides for the placement of adjudicated delinquent children with a parent or in foster care in other states.

The ICPC provides for the placement of adjudicated delinquent children in an institution in another compact jurisdiction if:

- ü The child is given a court hearing.
- ü The child's parent or guardian is given an opportunity to be heard.
- ü The court finds that equivalent facilities for the child are not available in the sending agency's jurisdiction.
- ü The court finds that institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

Revision History:

DES(07-2006)

Previous

11-1

Legal Basis: The federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires states to make reasonable efforts to return children to their families if removal from home is necessary.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) reinforces the requirement to make reasonable efforts to reunify families, but further defines circumstances under which reasonable efforts to reunify families are not required. In these circumstances, reasonable efforts must be made to place a child in a timely manner in accordance with the permanency plan and to complete steps necessary to finalize the permanent placement of the child. The act further requires states to file termination of parental rights actions under certain circumstances and to concurrently identify and approve qualified families for children under the state's responsibility.

ARS §8-845 requires the court to reunify families insofar as possible. If reunification services are not ordered, the court is required to order a plan of adoption or another permanent plan that is in the child's best interest. Reasonable efforts to place a child for adoption may be made concurrently with reasonable efforts to reunify the family.

ARS §8-846 delineates seven aggravating circumstances, if present by clear and convincing evidence, a presumption exists that reunification services should not be provided.

ARS §8-861 requires the court to hold a Permanency Hearing not more than 12 months after the child's initial removal from the parent or guardian. The court must reunify the family at the Permanency Hearing, if such reunification would not create a substantial risk of harm to the child's physical, mental or emotional health or safety. If reunification services are not ordered at the Disposition Hearing, the court is required to schedule a Permanency Hearing within 120 days and to order the department to finalize a permanent plan for the child.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 11: Section 1

Providing Services to Facilitate Family Reunification

Legal Basis

Policy: The child's health and safety shall be the paramount concern when making permanency planning decisions and providing services.

When out-of-home placement is necessary to ensure a child's health and safety, the department's first priority shall be to facilitate family reunification as quickly as possible, unless reunification is contrary to the child's best interests due to aggravating circumstances.

Concurrent case planning shall occur for all children placed in out-of-home care with a permanency goal of family reunification where the prognosis of achieving family reunification is poor and unlikely to occur within 12 months of the child's initial removal. This includes children in out-of-home care under a Voluntary Foster Placement Agreement. See Chapter 9; Section 3 Developing and Implementing Concurrent Permanency Planning.

The department shall involve parents and other family members in developing a case plan aimed at enabling the family to care for the child safely at home, and when applicable, shall involve them in developing a concurrent plan aimed at finalizing a permanent placement for the child.

To facilitate family reunification, the department shall provide services which support families in developing their strengths and address the risk factors that necessitate the child's out-of-home placement. Services may be delivered either directly by DES staff or through referral to community resources.

To determine the services necessary to facilitate reunification, consider these questions:

- What are the specific behaviors or situations that place the child at risk?
- What does the family perceive as the cause of these risk factors?
- What services or other interventions may help the family to address these risk factors?

§ What specialized assessments may be necessary to identify appropriate service needs?

§ To what extent are these services available, either through the department or through community resources?

§ What steps must be taken to assure that the parent has adequate access to the necessary services?

BEST PRACTICE TIP:

The theory supporting family-centered practice and family reunification services is a family-systems approach. Inherent in this systems approach is the belief that the welfare of any single child or family member is inseparable from the psychological and social functioning of other members of the family. Thus, when a family needs assistance, CPS Specialists, who are family centered, intervene not only with the individual child but also with the systems to which the child belongs. They understand that in order to successfully make changes in the family system they must: 1) listen to the voice of the family and understand their perspectives, values and decision making processes, 2) believe in and respect the expertise of families in understanding their own needs and identifying their own solutions, and 3) honor the culture, race and ethnicity of the family they are serving.

Implementation and Procedures Guide

Develop and implement the case plan for family reunification as described in Family Centered Case Planning (Chapter 9). Identify and actively pursue a concurrent plan for each child placed in out-of-home care with a permanency goal of family reunification where the prognosis of achieving family reunification is poor and unlikely to occur within 12 months of the child's initial removal.

Focus the case plan on services that will help parents address risk factors identified in the Family Strengths and Risk Assessment and achieve the outcomes identified in the case plan.

To do so:

§ Build on the parent's strengths and develop those strengths into protective capacities; (A protective capacity is a skill or capacity of the parents to provide safe and nurturing care of their children), utilize extended family and community resources whenever possible.

§ Provide or arrange for specific services that directly address the family's needs; and ensure that the family has the transportation and child care services required to access specified services.

§ Encourage the family to develop or strengthen ties with extended family, friends and community support networks that can provide ongoing assistance after DES is no longer involved with the family.

§ Ensure that the out-of-home caregivers are partners in the process of reunification and that they support and maintain the child's frequent and consistent connections with the parents.

Place particular emphasis on visitation. Follow the procedures for visitation outlined in Ensuring Visitation Between Children in Care and Their Families (Chapter 7 Section 1).

See Making The Most of Visitation Between Children and Their Families (Exhibit 25) for additional tips on improving the practice of visitation.

BEST PRACTICE TIP:

The foundation of a successful visitation program is the people who establish and monitor visits—CPS Specialists must be properly informed about the benefits of visitation and trained about visitation procedures.

The first step in facilitating visitation should be to set up a regular, written visitation schedule. Written schedules encourage birth parents to adhere to the visitation plan and often lead to more visits. Since they are essential to visits, birth and foster parents should be directly involved in setting up visitation schedules. Involving them and respecting their preferences for visitation times and locations demonstrates to parents that they are important members of the team.

Increasing evidence also suggests that when the first visit is held immediately following placement (within 48 hours), birth parents may be more likely to show up for visits and more inclined to see their value. Successful visitation also relies on accurate assessment of birth parents' strengths and needs.

The CPS Specialist has the responsibility to create an environment that will allow children and their parents to play together, interact and have as natural experiences as possible. Placing children and their parents in a room with no (or few) toys, with little to no natural stimulation and expecting them to "function appropriately" is unrealistic. CPS Specialists need to become very creative about where visits occur and the opportunities parents and children have to interact naturally. Can they cook a meal together? Clean a room together? Can they play a game, go on a picnic or have fun together? Can they do a school project together? **Risk cannot be assessed accurately when children and families are placed in unnatural settings that bear no resemblance to day-to-day life.**

Don't overestimate a parent's understanding of the impact of their behavior on the child. Most visitation plans assume that birth parents understand the impact of a "no show" for visitation on the child, that parents have leisure and recreation skills independent of drugs, alcohol, sex, danger, and violence. Other common assumptions are that birth parents know how to: play with their children, talk politely with their children, enjoy their children's company, separate from the visit their frustration, shame, and humiliation over losing custody, read to children or read and understand court reports, contracts, priorities, major and minor requirements. **Yet, these assumptions do not always hold true**. By overestimating parents' abilities, CPS Specialists can unwittingly undermine family reunification.

As parents interact with their child in a more nurturing way, increase the amount of time the child and their family spend together. Plan for:

- § longer, more frequent visits;
- § supervised visits in the parent's home;
- § unsupervised visits in the parent's home;
- § extended daytime visits in the parent's home; and
- § unsupervised overnight visits in the parent's home.

While pursuing the case plan, also identify and provide services to implement the concurrent plan, when applicable**.**

DOCUMENTATION :

Document the selection of family reunification as the permanency goal in the Permanency Goals window.

Also, document the concurrent permanency goal using the Permanency Goals window.

Document services to be provided to the child's parent in the Case Plan Tasks window.

Document the concurrent case plan using the Case Plan Tasks window.

Revision History:

DES(07-2006)

Next

11-2

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 11: Section 2

Supporting and Assessing Family Progress Toward Family Reunification

Legal Basis

Policy: The CPS Specialist shall regularly evaluate parents' progress toward achieving outcomes that will enable the child to return home safely.

Implementation and Procedures Guide

When family reunification is the goal, monitor case progress at least monthly:

- to determine if the services that were identified as being helpful and necessary in the case plan are actually proving to be necessary and helpful.
- to determine whether all parties are carrying out tasks within the time frames specified in the case plan; and if not what supports can be provided to help the families complete tasks that make their home and family safe for their children; and
- to ensure that linkages between family members, service providers and other resources have been made.

BEST PRACTICE TIP:

Practicing full disclosure is a fundamental practice of family engagement. When monitoring progress, CPS Specialists must involve parents in straight forward and honest discussions about progress, worker's observations, concerns and "next steps". Families need to understand the impact of all their actions (or lack of action) throughout the flow of the case. CPS Specialists should not assume because parents were told about the child protection process during one initial visit that they fully understood the explanation or that they remember it. People do not absorb information well during times of crisis.

Mobilizing motivation is another critical aspect of the case monitoring process. Various approaches can be employed to take advantage of the motivation that family members have to becoming reconnected. If a threat of termination of parental rights exists, clarification of this possibility can help parents to become more focused and more actively involved in reunification efforts. Many parents who have been reunited with their children point to the one single aspect that made the reunification possible; a special someone who kept hope alive, forgave them for their mistakes and made them feel important for their efforts and their accomplishments.

If specified tasks have not been carried out, determine whether this is a result of:

- lack of clarity in the tasks assigned;
- unrealistic expectations of the family—this can often occur when the family has multiple systems involved in their lives and each has asked the family to carry out tasks;

BEST PRACTICE TIP:

When working with a family it is critical to know what other helping systems are involved in their life. Ask to look at the family's calendar—or ask about the number of appointments that they are expected to keep on any given week. Families cannot be expected to do more than is possible.

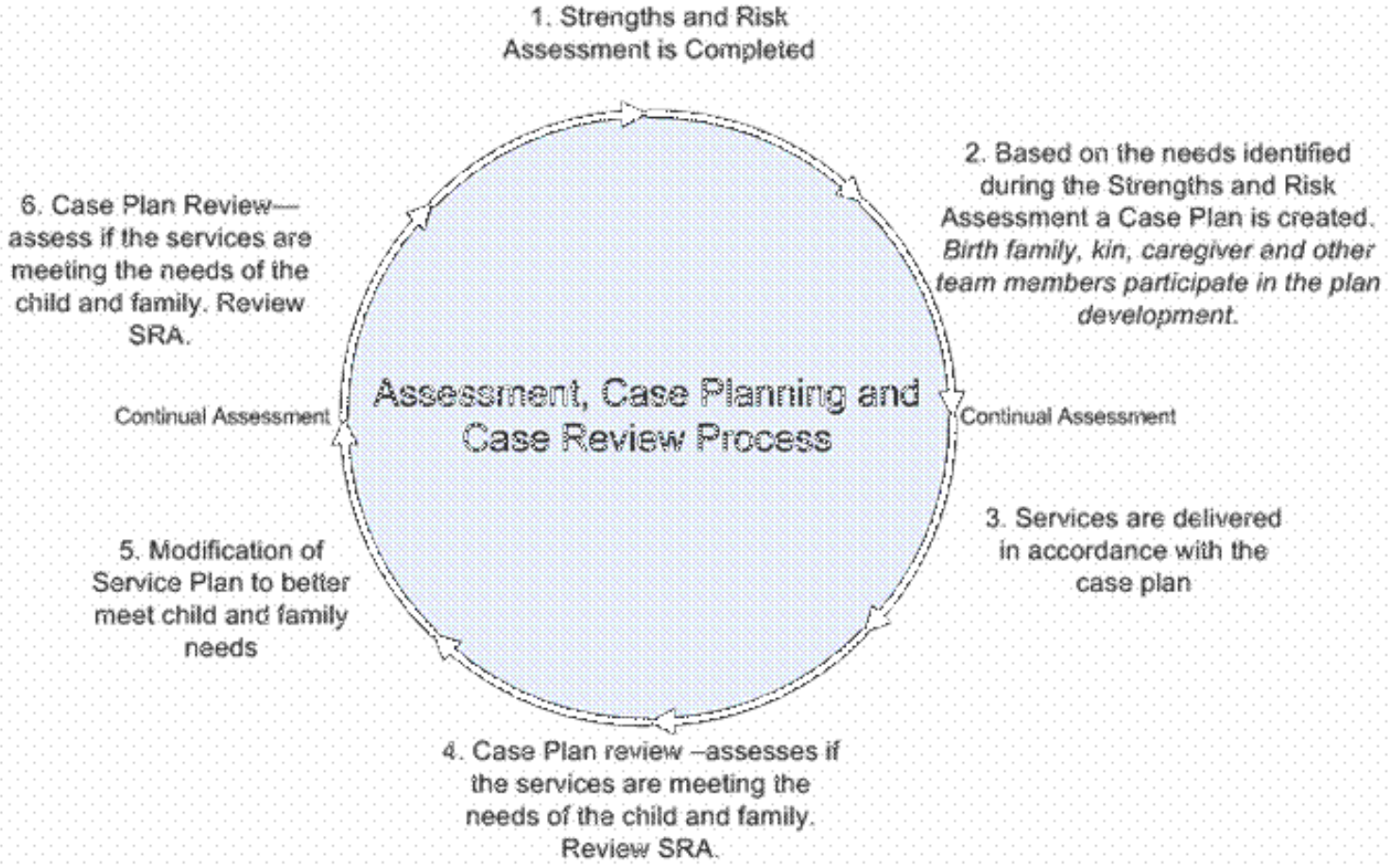
- § changes in circumstances;
- § lack of cultural sensitivity of the provider of services; and
- § failure or inability of an individual or agency to fulfill responsibilities specified in the case plan.

Take actions necessary to facilitate continued case progress, including:

- § clarifying tasks or expectations;
- § modifying tasks; or
- § arranging for the use of different resources or service providers**.**

If necessary, convene a case plan staffing to discuss case progress and initiate changes in the case plan.

See the chart on the following page for a depiction of Best Practice in Assessing Family Progress.



Reassess the case and revise the case plan at least every six months, as described in Family Centered Case Planning (Chapter 9).

DOCUMENTATION :

Document case progress or lack thereof using the Case Notes window. When tasks have not been carried out in accordance with the case plan, identify barriers to their completion.

Document the reassessment of the case and revision of the case plan using the windows associated with the Case Plan Directory. If new risk factors have been identified since the last assessment, complete an updated Family Strengths and Risks Assessment.

Document the case plan staffing using the Case Notes window designated as Staffing type.

Revision History:
DES(07-2006)

Previous / Next

11-3

Legal Basis: ARS §8-861 requires the court to reunify the family following the temporary custody if such reunification would not create a substantial risk of harm to the child's physical, mental or emotional health or safety. The court is also to consider the failure of the parent or guardian to comply with the terms of the case plan as evidence that return of the child would create a substantial risk of harm to the child.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 11: Section 3

Reunifying Families

Legal Basis

Policy: The department shall seek to reunify families when the parent has successfully addressed risk factors that prevented him or her from caring for the child safely without DES involvement.

Unless it is not in the child's best interest, the department shall require a trial placement of the child at home prior to petitioning the court to dismiss the dependency order.

The department shall comply with court orders regarding the reunification of families.

To determine whether a child can be returned home safely, consider these questions:

- Has the parent made changes in his or her behavior or environment to address each of the risk factors identified in the Family Strength and Risk Assessment?
- Has visitation (including unsupervised overnight visits) been safe and successful?
- Has the parent planned for the child's re-entry into the family and community - for example, by making child care arrangements, by considering school placement, by arranging for ongoing support and assistance?

BEST PRACTICE GUIDE

Reunification is not a simple thing for families. Parents often need to be coached and "warned" about the lack of privacy, frequency of visitors, telephone calls, and financial responsibilities that will accompany the child's return home. CPS Specialists should help family members identify perceived differences or changes in family rules, patterns and behaviors on the part of each family member. This understanding can be used to help support the child's re-entry.

In some families it will be important to "predict" problems or pressures that will accompany their child's return and explore how each family member will handle these pressures.

Implementation and Procedures Guide

Unless the court has ordered immediate reunification as a result of the Temporary Custody Hearing under ARS §8-861:

- § Convene a case plan staffing to determine when family reunification is appropriate.
- § Consider returning the child home on a trial basis for three to six months (or longer if necessary) prior to petitioning the court to dismiss the dependency petition.

With the parent, determine arrangements for the child's return home. Assist the parent in arranging for the child's re-entry into the family by ensuring that the parent has considered:

- § child care arrangements;
- § how they will manage the stress of having the child back in the home (do they have support?)**;**
- § school placement; if possible have someone assist the parent in registering the child for school, if the child will be attending a different school. Assist in the transfer of educational records;
- § health care; if possible have someone assist the parent in finding a primary care provider for the child**;**
- § physical needs (e.g., bed, formula)**;** and
- § community or recreational activities for the child and the family.

Plan the child's transition from placement to home with both the parent and the out-of-home care provider.

If a physical custody order is in effect, request that the Attorney General's Office petition the court for a change of physical custody order. See Laws, Legal Processes and Liability (Chapter 20).

Provide support and supervision during the trial placement at home. In particular, during this period:

- § Monitor the child's continued safety by visiting the child(ren) and parent(s) in the home **at least monthly.**
- § Discuss any adjustment problems with the family.
- § Assist the family in securing needed services.

§ Encourage the family to use extended family members, places of worship, neighborhood organizations, and community networks as an ongoing source of support and assistance.

DOCUMENTATION :

Document the case plan staffing using the Case Notes window designated as Staffing type.

Document visitation with the family using the Case Notes window.

Revision History:

DES(07-2006)

Previous / Next

11-4

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 11: Section 4

Closing the Case After Family Reunification

Legal Basis

Policy: The department shall petition the court to dismiss a dependency order when a child has been reunified with his or her family and it appears that DES involvement is no longer necessary to ensure the child's health and safety at home.

Prior to closing the case, the department will meet with the family to determine what services are necessary in the development of the aftercare plan.

To determine whether it is appropriate to petition the court to dismiss a dependency order following family reunification, consider these questions:

- Have the risk factors that necessitated department involvement been adequately addressed?
- Have the child and any siblings remained safe in the home during the trial placement?
- Does the parent have extended family members or community support networks that can assist him or her if difficulties arise?
- Does the parent know how and under what circumstances to seek help in the future?
- Is there an aftercare plan in place?

Implementation and Procedures Guide

Gather information during contacts with family and service team members, and through written reports and evaluations, assess whether the risk factors necessitating department involvement have been adequately addressed.

Hold a clinical supervision conference with the supervisor to determine whether case closure is appropriate.

At least 30 days, but **no more than six months** prior to case closure, meet with the child and the

child's parent, or guardian and other service team members as appropriate to determine whether aftercare services are needed. Complete an updated Strengths and Risks Assessment using the Strengths and Risks Assessment window.

Develop and document an aftercare plan following the procedures found in Accessing Services - After Care Services (Chapter 9 Section 19). Provide the family with a printed copy of the aftercare plan.

Visit the home **within one month** prior to case closure. Be sure to see all children involved in the case. Inform family members of the case closure and ensure that they have all necessary referrals to community resources.

Contact the Attorney General's Office to arrange to petition the court to dismiss the dependency.

Following the procedures found in Closing Case Records (Chapter 19) and Accessing Services - After Care Services (Chapter 9 Section 19) to ensure that the case record is complete and that all documentation is in place, including an Order of Dismissal signed by the court.

DOCUMENTATION :

Document information gathered during contacts with family and service team members to assess whether the risk factors necessitating agency involvement have been adequately addressed using the Case Notes window.

File written reports and evaluations in the hard copy case record.

Document the clinical supervision conference with the supervisor using the Case Notes window, Supervisory type.

Document the meeting with the child and the child's parent or guardian and other service team members as appropriate to determine whether aftercare services are needed, and whether the child and caregiver desire aftercare services using the Case Notes window. Include documentation of the outcome of the meetings.

Document the aftercare plan using the Case Closure window. Ensure detailed information is included identifying the child's or caregiver's aftercare needs and services or referrals provided to

address those needs.

End all service authorizations using the Provider Services Authorization window.

Revision History:
DES(07-2006)

Previous / Next

11-5

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) directs states to pursue other options for the permanent placement of a child if the goal of family reunification cannot be achieved within a time frame that meets the needs of the child.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires that reasonable efforts be made to place the child in a timely manner in accordance with the permanency plan and to complete steps necessary to finalize the permanent placement of the child.

The Act further requires states to file termination of parental rights actions under certain circumstances.

ARS §8-862 authorizes the court to determine whether a change in permanency goal is the most appropriate plan for the child at the time of the Permanency Hearing.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 11: Section 5

Changing the Permanency Goal from Family Reunification

Legal Basis

Policy: The department shall recommend that the court change a child's permanency goal from family reunification to another option if it is determined, as a result of a case plan staffing, that the child's parent(s) are unable or unwilling to address the safety and/or risk factors that prevent them from caring for the child safely at home within a period of time that meets the needs of the child.

The department shall comply with court orders regarding the change of permanency goals.

The department shall not change the permanency goal or discontinue reunification services unless ordered by the court. Pending court approval of a change in the permanency goal, the department shall increase efforts to implement the concurrent plan.

The department shall consider other permanency goals in the following order of preference:

- Adoption;
- Legal guardianship;
- Independent living as Another Planned Permanent Living Arrangement (APPLA).
- Long term foster care as Another Planned Permanent Living Arrangement (APPLA).

BEST PRACTICE TIP:

Long Term Foster Care and Independent Living are the least preferred permanency goals for children. Children should never leave the child welfare system without adults who are legally connected to them. If children are removed from their homes and cannot be returned, the department has a legal and some would say a moral obligation to ensure that they are provided with permanent families; preferably a kin or, if not, another family willing to care for the child.

To decide whether to recommend that the court change the permanency goal from family reunification to another goal, consider these questions:

§ Have the parents taken any concrete steps towards addressing the safety and/or risk factors that prevent them from caring for the child safely at home?

§ To what extent have they been willing and able to utilize recommended services to make changes in their behavior or in the home environment that will enhance the safety of the child at home?

§ Have the parents expressed ambivalence about parenting their children? Have you explored this ambivalence with them?

§ Does it appear that enough progress will be made to ensure that the child can be cared for safely at home within a period of time that meets the needs of the child?

§ Has there been further maltreatment of this child or other children in the home?

§ Have parents followed through on visitation plans? If so, has it been possible to reduce supervision of visits?

§ How long has the child been in care, relative to his or her age?

§ Does the child's need for a permanent home outweigh the likelihood that return home can be achieved within a reasonable time frame?

§ Is continuation of reunification services contrary to the best interests of the child?

§ Is there an extenuating circumstance that precludes continuation of reunification services?

§ Does any of the four federal requirements for initiating termination of parental rights actions apply?

BEST PRACTICE TIP

If it is determined that the permanency goal needs to be changed, the CPS Specialist needs to explore with the family and the child (as age appropriate) what optimal connection might look like. Can the child and the parents share holidays? Can they write letters and share pictures? Can they see one another from time to time? Termination of Parental Rights does not necessarily assume that the parent and the child have no contact with one another.

Implementation and Procedures Guide

Convene a case plan staffing to discuss recommending a change in the permanency goal. Attempt to secure the parents active involvement in this meeting. If parents are not present at the staffing, notify them immediately of any change in goal.

To determine whether another permanency goal may be appropriate, see:

Consent and Termination for Adoption (Chapter 12)

Guardianship (Chapter 15)

Long Term Foster Care as a Planned Living Arrangement (Chapter 16, Section 8).

DOCUMENTATION :

Document the family's lack of progress in achieving outcomes that will allow the child to be cared for safely at home in the case notes. If new risk factors have been identified since the last assessment, complete the Family Strength and Risk Assessment window.

Document the change of goal in the Permanency Goals window.

Revision History:
DES(07-2006)

Previous

12-1

Legal Basis: The Indian Child Welfare Act (P.L. 95-608) is the federal law that governs consent and placement of Native American children.

ARS §8-106 allows the department to accept a parent's consent to place a child for adoption.

Rules: Section R6-5-6611 and R6-5-6612 of the Arizona Administrative Code addresses consents for adoption.

Revision History:
DES(07-2006)

Chapter 12: Section 1

Accepting a Consent to Place a Child for Adoption

Legal Basis

Policy:

A consent to place a child for adoption may be accepted from any mentally competent parent of a child who is in the care, custody and control of the department.

A consent to place a child for adoption is irrevocable, unless obtained by fraud, duress or undue influence. (ARS §8-106)

A consent to place a child for adoption shall not be accepted prior to 72 hours after the child's birth and will be invalid if given before 72 hours. (ARS §8-107)

A consent to place a child for adoption is required from the father married to the child's mother at the time of conception or any time between conception and the child's birth unless his paternity is excluded or another man's paternity is established pursuant to ARS §25-801 et seq. [ARS §8-106(A)(2)(a)]

The department shall provide verbal and written information to ensure that parents understand the meaning of consent, its implications for the child and parents, and information regarding access to non-identifying information in adoption records.

A parent may choose to consent only for specific person(s) to adopt his or her child. However, if the specified individual(s) do not adopt the child, the consent may be deemed void and a new consent (or a severance procedure) may be necessary to allow for adoption of the child. Use of a direct consent shall be approved by a supervisor.

A dependency petition shall be filed on every child for whom a consent for adoption is accepted.

For Native American children, a consent to place a child for adoption is invalid if taken prior to, or within ten days after the birth of the Native American child. [25USC §1913(a)]

A consent to place a Native American child for adoption must be signed and recorded before a judge and accompanied by the presiding judge's certificate that the terms and consequences of the consent were fully explained in detail and understood by the parent or Indian custodian.

A consent to place a Native American child for adoption may be withdrawn, for any reason at any time, before entry of the final order of termination or adoption. [25USC §1913(c)]

A consent to place a Native American child for adoption may be withdrawn up to two years after entry of the final order of adoption upon a finding by court that the consent was obtained through fraud or duress. [25USC §1913(d)].

See Chapter 17 Serving Native American Children and Families

To decide whether to seek or accept a voluntary consent for adoption, consider these factors:

- the availability of the parent;
- the willingness of the parent to consent to the adoption; and
- the mental competence of the parent.

When considering mental competence, ask these questions**:**

- Does the parent appear to have or alleged to have limited intellectual or verbal capacity?
- Is the parent known to have, appear to have or alleged to have a substance abuse problem?
- Is there any indication or allegation of significant emotional, psychological or behavioral problems?
- Does the parent appear to be confused or disoriented?

If there is any question of mental competency, consult with your supervisor before accepting consent.

If the child is or may be Native American, consult with your supervisor and with an Assistant Attorney General regarding the requirements of the Indian Child Welfare Act before accepting a consent.

Implementation and Procedures Guide

If, after providing written and verbal information, a mentally competent parent wishes to consent to the adoption of the child, gather all the necessary information by using the following forms:

- Birth Parent's Interview Form, FC-091;
- Consent to Place a Child for Adoption, AN-001;
- Waiver of Notice and Appearance, AN-010;
- Birth Parent's Release of Identifying Information, FC-174; and
- Affidavit of Potential Fathers, AN-008.

Inform a mother consenting to adoption that:

- being untruthful, incomplete or inaccurate on the Affidavit of Potential Fathers, AN-008, is a class 6 felony (ARS §8-128);
- all legal and potential fathers named will be served, informed of their rights and responsibilities, and will have 30 days to initiate paternity proceedings (ARS §8-106);
- she may write a letter to the court asking that her address be omitted from the affidavit if there is concern for her safety, -
- state law permits communication among the child, birth parents and adoptive parents after finalization of the adoption. See Communication Agreements, (Chapter 13, Section 8).

For a Native American child, inform the consenting parent(s) that the consent must be signed before a judge. (25 U.S.C.§1901 et seq.)

For a parent wishing to consent to the adoption of a child who is subject to the Indian Child Welfare Act (ICWA):

- Request the Attorney General's Office file a motion for hearing on ICWA consent and order; and
- Obtain the original and a certified copy of the ICWA consent and certification order from the Attorney General's office**.**

For a parent who lives in another state or county:

Send a letter to the appropriate DES office or state social service agency requesting that they provide verbal and written information on consents to the relinquishing parent and accept the consent.

Send a packet with the following forms and instructions**:**

- § Birth Parent's Interview Form, FC-091;
- § Consent to Place a Child for Adoption, AN-001;
- § Birth Parent's Release of Identifying Information, FC-174;
- § Affidavit of Potential Fathers, AN-008; and
- § Waiver of Notice and Appearance, AN-010.

DOCUMENTATION :

DOCUMENT THE CONSENT AS FOLLOWS:

- Birth Parent's Interview Form, FC-091 - File the form in the child's record. Include any pictures, keepsakes or documents that will follow the child into his/her adoptive placement.
  - § Consent to Place a Child for Adoption, AN-001 - Have the parent sign two originals. Each must be witnessed by two people over age 18 and notarized.
    - o Use one original to accompany a severance petition to court, if needed and use one original to accompany an adoption petition to court.
    - o Make four copies of the AN-001. Keep two copies in the child's record and give one to the parent(s). If the child is in another county or state, send one copy for their record.
  - § Waiver of Notice and Appearance, AN-010 - Have the client sign two originals. As with Form AN-001, above, have each witnessed and notarized.
    - o Use one original to accompany a severance petition to court, if needed and use one original to accompany the adoption petition to court.
    - o Make four copies of the signed and notarized AN-010. Keep two in the child's record; and give one to the parent(s). If the child is in another county or state, send a copy for their record.

- ICWA consent and certification. The consent to place a Native American child for adoption must be signed and recorded before a judge. The judge must sign a certificate stating that the terms and consequences of the consent were fully explained in detail and

understood by the parent or Indian custodian.

§ Birth Parent's Release of Identifying Information, FC-174. Place the form in the child's record until the agency consents are processed or it is determined that the adoptive placement will be finalized; then forward the form to the supervising adoptions CPS Specialist or contract agency case manager to place in the child's adoptive case record.

§ Affidavit of Potential Fathers, AN-008 - For children born after July 17, 1994, the parent(s) must sign three originals and have them notarized. Make four copies and distribute the originals and copies as follows:

- Send one original to the Attorney General's Office with the letter requesting omission of the mother's address, if applicable.
- Send one original to the Putative Father's Registry (c/o Department of Health Services, Vital Records, P.O. BOX 3887, Phoenix, AZ 85030.
- Keep one original in the child's record to accompany a termination of parental rights petition or motion to court, if requested by the Assistant Attorney General.
- Keep one copy in the child's record to accompany the adoption petition to court.
- If the child is placed in another county or state, send one copy to the supervising CPS Specialist, contract agency case manager or other state's case manager.
- Keep one copy permanently in the child's case record.
- Give one copy to the birth mother.

- For children born before July 17, 1994, obtain only the original Affidavit of Potential Fathers, AN-008, and place it in the child's record.

Revision History:
DES(07-2006)

Next

12-2

Legal Basis: The Adoption and Safe Families Act of 1997 (P.L. 105-89) advances child health and safety and promotes expeditious permanency for children by requiring the filing of termination of parental rights actions in specific circumstances.

ARS §8-531 through 8-544 addresses termination of parent-child relationships.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 12: Section 2

Making the Decision to Terminate Parental Rights

Legal Basis

Policy:

Termination of parental rights either by consent or by court order is necessary for every child in the care, custody and control of the department who has a permanency goal of adoption.

In unusual cases, termination of parental rights may be necessary for a child with another permanency goal if a continued legal relationship between the child and parent would be harmful to the child.

Termination of parental rights is necessary when:

- The permanent plan for this child is adoption and the parent is not available or willing to consent to place the child for adoption.
- The permanent plan for this child is something other than adoption and a continued legal relationship between parent and child would be harmful for the child.

Best Practice Tip:

Termination of Parental Rights (TPR) is the last resort when the family has been unable to make the changes necessary to ensure that their child is safe in their home. A TPR allows the child to move toward adoption with a family. It is critical to understand that the process of terminating a parent's rights is a legal distinction—not an emotional one—not to the child or to the birth parents. Parents and their children often have a need to stay connected and know one another throughout their lives…regardless of the age of the child at adoption. When the needs of a child require that a TPR must occur in order for the child to have a permanent family, it is the responsibility of the CPS Specialist or contract agency case manager to evaluate what optimal connection between the child and their family would look like.

þ Can the child visit and develop relationships with kin who while they were unable

to adopt want a relationship with the child?

- Can the child safely maintain telephone or mail contact with their birth family?
- If the adoption did not include siblings, how are the siblings going to stay connected to the child?

These and other questions must be explored as the TPR is going through the court system.

Never assume that the legal process of Termination of Parental Rights is the end of the parent-child relationship.

Revision History:

DES(07-2006)

Previous / Next

12-3

Legal Basis: The Indian Child Welfare Act requires the state to notify the tribe of an Indian child of a proceeding to involuntarily terminate parental rights and of their right to intervene in the proceeding. [25USC §1912(a)]

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires states to file termination of parental rights actions while concurrently identifying, recruiting, processing and approving qualified families for children under the responsibility of the state and in out-of-home care when any of the following conditions exist:

§ A child has been in out-of-home care for a cumulative total period of 15 of the most recent 22 months.

§ A court has determined a child to be an abandoned infant.

§ A court has determined that the parent murdered another child of the parent or that the parent aided, abetted, attempted, conspired or solicited to commit such an act.

§ A court has determined that the parent committed voluntary manslaughter of another child of the parent or that the parent aided, abetted, attempted, conspired or solicited to commit such an act.

§ A court has determined that the parent committed a felony assault that resulted in serious bodily injury to the child or another child of the parent.

The Adoption and Safe Families Act of 1997 allows exceptions to the termination of parental rights requirement in the following circumstances:

§ The child is being cared for by a relative.

§ The state has not complied with court ordered reasonable efforts to enable the child to return home safely.

§ The case plan documents a compelling reason that termination of parental rights would not be in the child's best interest.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) permits the use of the Federal Parent Locator service to assist in locating a parent.

ARS §8-862(D) requires at the Permanency Hearing, if the court determines that termination is

in the child's best interest, that the court order the department or the child's attorney or guardian ad litem to file a motion for termination of parent-child relationship pursuant to ARS §8-533(B) within ten days after the Permanency Hearing and set a date for an initial hearing on the motion for termination of parental rights within thirty days.

ARS §8-223 requires the court to set the hearing to terminate parental rights before a jury if requested by the parent whose rights are sought to be terminated.

ARS §8-533 gives the department authority to file a petition for termination of parent-child relationships.

ARS §8-533 provides for the court, when considering the evidence to support any ground for termination of parental rights, to also consider the best interests of the child.

ARS §8-533 also defines the grounds upon which a petition for termination of parent-child relationships can be filed.

ARS §8-533(C) requires the court to consider the availability of reunification services to the parent and the parent's participation in these services when considering grounds for termination based upon the child's length of time in out-of-home care or the child's return to out-of-home care.

ARS §8-533(D) requires the court, when considering grounds for termination of the parent-child relationship based on length of time in out-of-home placement, to exclude the first sixty days of the initial out-of-home placement pursuant to a voluntary placement in calculating the child's cumulative total period of time in out-of-home placement.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 12: Section 3

Petitioning for Termination of Parental Rights

Legal Basis

Policy: The department shall initiate a petition for termination of parental rights for any child with a permanency goal of adoption, if the child's parent is unwilling to consent to adoption in a timely manner.

The department shall file a motion for termination of parental rights when ordered by the court pursuant to ARS §8-862(D) for children entering out-of-home care after July 1, 1998.

The department shall include any time beyond the first 60 days of an initial voluntary placement in out-of-home care when calculating the cumulative total time in out-of-home placement for termination of parental rights purposes.

Termination of parental rights shall not be initiated when it has been determined that such action is not in the child's best interests.

The Program Manager or designee must approve a recommendation that termination of parental rights is not in the child's best interests.

The petition for termination of parental rights must account for any parent who has not relinquished or whose death is not verified.

This includes:

- any man married to the mother at the time of conception, during the pregnancy or at birth of the child; unless his paternity has been excluded or another man's paternity is established pursuant to ARS §25-801 et seq.
- any parent named on the child's birth certificate;
- any man named by the mother or other person as the biological father;
- any man named by the mother as possibly being the biological father;
- any man claiming to be the biological father;

- anyone who has legally adopted the child;
- any man who has filed a notice of claim of paternity for this child with the Putative Father Registry; and
- "John Doe," when no father is identified on the birth certificate or by the mother, when the mother is unsure of or does not know the name of the father; and/or when multiple fathers are identified and there is the possibility of unknown potential fathers.

If a court order of paternity or adoption has been issued, only the person named in this order needs to be included in the termination petition.

If all parents have signed a valid Consent to Place Child for Adoption, AN-001, a petition to terminate parental rights need not be filed, unless any parent has attempted to revoke the consent. If a petition to terminate parental rights is to be filed on any parent, the parent who has signed a consent may also be included in the severance action.

The department shall provide written and verbal information to ensure that parents understand the meaning of severance, its implications for the child and parents, and information regarding access to non-identifying information in adoption records.

The department shall inform an incarcerated parent of the termination proceedings, the consequences of the proceeding and actions that the parent must take after being served with the petition to terminate the parental rights.

To determine that termination of parental rights is in the child's best interest, consider all of the following factors:

- the child's permanency goal;
- parent's successful interaction with the development and completion of the case plan and likelihood of imminent family reunification;
- if the parents are expressing ambivalence to parenting;
- the child's age and willingness to consent to adoption;

- child's need for a permanent parent-child relationship;
- if reunification services were ordered, but not provided;
- if the services that were provided were culturally sensitive and if the provider was successful in engaging the family in the services;
- availability of relatives or other significant persons to provide a safe, permanent home for the child;
- effects of removal from current placement on the child's long term emotional well-being and the caregiver's willingness to adopt;
- compliance with Indian Child Welfare Act requirements relating to provision of active reunification services, placement and standard of evidence; and
- applicability of the grounds for termination and supporting evidence.

If the child is or may be Native American, consult with the Attorney General's Office regarding requirements of the Indian Child Welfare Act before planning to pursue termination of parent-child relationships**.**

Implementation and Procedures Guide

Convene a case conference to determine whether termination of the parental rights is in the child's best interest, and if it appears that there may be sufficient grounds for a petition. Include Assistant Attorney General, child's attorney, CPS Specialist and supervisor and others considered necessary.

Complete the Report to Juvenile Court for Permanency Hearing.

If termination of parental rights is recommended, ensure the following has occurred:

- an extensive and documented search for relatives, consider convening a family group decision making conference to identify relatives or other significant persons who can provide a safe, permanent home for the child;
- a request for Arizona Parent Locator Service and process according to district operating procedures; and
- refer to Chapter ** on Missing Parent Locator services.

Meet with the Attorney General to discuss the case and prepare for its presentation in court.

For termination of parental rights hearings tried before a jury, the CPS Specialist or supervisor must be present at the pre-trial conference if requested by the assigned Assistant Attorney General, and throughout the trial including jury selection, jury deliberation, and return of the verdict.

Inform the incarcerated parent of the pending court proceeding to terminate the parent-child relationship; the consequences of the proceedings and actions that the parent must take including responding to the petition through the parent's attorney or requesting the court appoint an attorney; if not already appointed.

BEST PRACTICE TIP:

Termination of Parental Rights does not necessarily equate with termination of the parent-child relationship. There are parents who for a variety of reasons may not be able to parent their child at this point in their life. However, the child may be able to maintain a relationship with them. The CPS Specialist should explore with the child (age appropriate) and the parent the optimal connection that the parent and child can have that still ensures child safety—but also allows the child to maintain a connection to his roots and his culture. The nature of this relationship depends on the dynamics of the child and family relationship and may change over time as the child grows older, or as the parent becomes more able to interact with the child, in a way that ensures the child's best interests are front and center.

Additionally, although parental rights are terminated—this does not mean that the child has to lose extended family. The CPS Specialist should explore how the child can maintain connection to relatives who may not be able to adopt, but who care about the child.

DOCUMENTATION :

Document the compelling reason that termination of parental rights is not in the child's best interests using the Compelling Reason check box on the Permanency Goals window.

Document the grounds for Termination of Parental Rights in Case Notes, Case Conference type.

The type of documentation needed for Termination of Parental Rights depends on the grounds upon which termination will be sought such as the following:

Abandonment: Requires documentation of diligent efforts to locate the parent, to remain in contact with the parent, and to rehabilitate the parent. Document that the parent was informed of the child's out-of-home placement and how the parent could provide reasonable support and maintain regular contact with the child. This requires documentation by foster parents of all contacts between the parent and child and the parent and foster parents.

Abuse and neglect: Requires timely documentation of all incidents of abuse and neglect, including medical reports, police reports, and written professional opinions; availability of eyewitnesses for testimony in court.

Mental deficiency, mental illness or substance abuse: Requires reports that address the nature and severity of the condition, how it interferes with parenting, its likely duration and the possibility of effective treatment; also requires a psychological or psychiatric evaluation of the parent that is less than one year old.

Incarceration-nature of the felony: Nature of felony conviction requires documentation of conviction of murder or voluntary manslaughter of another child of the parent; conviction of a felony assault that resulted in serious bodily injury to the child or another child of the parent; and aiding, attempting, conspiring or soliciting to commit murder or involuntary manslaughter of another child of the parent are grounds for severance regardless of the length of sentence.

Incarceration- length of sentence: Length of sentence requires documentation of sentence expiration and the length and strength of parent-child relationship at the time of incarceration; the degree to which the parent-child relationship was continued and nurtured during incarceration; the age of the child and likelihood that incarceration will deprive the child of a normal home; the availability of another parent to provide a normal home life; and the effect of the deprivation of a parental presence on the child.

Length of time in care: Requires documentation of contacts with the parent as well as of services offered and provided; documentation that the parent was informed of the plan and the department's expectations; and documentation of the parent's progress or lack of progress in addressing the risk factors that prevent the parent from caring for the child safely at home.

Relinquishment: If including a parent who has relinquished in a petition to terminate the other parent's rights, requires submission of the original, signed relinquishment forms to the court.

Paternity action: If termination is sought due to a potential father's failure to file a paternity action with 30 days of notice, then proof of legal notice, is required.

Notice of Claim of Paternity: If termination is sought due to the putative father's failure to file a notice of claim of paternity, then proof from the Putative Father Registry of failure to file

notice is required.

Unknown Parent Abandonment: Requires documentation of efforts to identify and locate the unknown absent parent. Document contacts (letters, telephone calls, personal interviews) with the mother, relatives, friends, neighbors, etc. who may know the identity and whereabouts of the unknown absent parent of the child.

Prior Termination: Requires documentation of the prior termination including a certified copy of the Order of Termination, a copy of petition, and a copy of the social study or report that was filed with the petition. Copies of current medical records, police records and psychological evaluations should also be obtained. A psychological assessment that the parent is currently unable to discharge parental responsibilities due to the same cause cited in the previous determination may be necessary.

Return, Subsequent Removal: Requires documentation that the department previously made diligent efforts to provide appropriate reunification services through: contacts with the parent; services offered and provided; evidence that the parent was informed of the plan and the department's expectations; and documentation of the parent's progress toward addressing the risk factors that caused the previous removal. A copy of previous and current dependency petitions; a copy of the court order that previously returned the child to the parent's legal custody; and the current order removing the child are also required. Copies of current medical records, police records and psychological evaluations should be obtained. A psychological assessment that the parent is currently unable to discharge parental responsibilities should also be provided.

Revision History:
DES(07-2006)

Previous / Next

12-4

Legal Basis: ARS §8-121(E) states that an adoptee who is 18 years of age or older or a birth parent whose rights have been terminated may file with the court, an adoption agency, DES or an attorney who participated in an adoption, a notarized statement granting consent, withholding consent or withdrawing consent to the release of confidential information.

ARS §8-121(F) permits notification to a birth parent of the death of a child that the birth parent has placed for adoption.

ARS §8-106(E) requires that parents consenting to place a child for adoption must sign and notarize a statement at the time of consent that either allows or withholds permission for the adopted child to obtain identifying and non-identifying information about the consenting parent and child upon the child reaching age 18. Parents may change their decision regarding permission at any time by filing a notarized statement with the court.

ARS §8-534(B) directs the court, whenever possible, to obtain from a birth parent whose parental rights have been terminated, a statement that grants or withholds consent for the child who is subject of the action to review adoption records when the child reaches the age of 21 or older.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 12: Section 4

Working with Birth Parents About Sharing Identifying Information

Legal Basis

Policy: Prior to accepting a consent or completing a termination action, the department shall provide the birth parents with accurate information regarding the release of identifying information.

The department whenever possible will obtain from a birth parent whose parental rights have been terminated, a statement that grants or withholds consent for the child who is subject of the action to review adoption records when the child reaches the age of 21 or older.

Birth parents shall be informed that the department cannot assure that the adoptive parents will agree to share specific identifying information.

Implementation and Procedures Guide

Obtain from a birth parent who has signed Consents to Adopt or whose parental rights have been terminated, a statement that grants or withholds consent for the child who is subject of the action to review adoption records when the child reaches the age of 21 or older.

BEST PRACTICE TIP:

There will be times when the birth parents for a variety of reasons may indicate that they do not want any contact with their child following a Termination of Parental Rights. Whatever the reason, the CPS Specialist should help the family see that in time, their child may want to know who they are and where they come from and that the family may want to know about their child.

For More Information: About the sharing of confidential information, see Laws, Legal Processes and Liability (Chapter 19).

Revision History:
DES(07-2006)

Previous / Next

12-5

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 12: Section 5

Establishing a New Case Record Following Termination of Parental Rights

Legal Basis

Policy: When termination of parental rights is completed, and the case plan goal for a child is adoption, the department shall establish a new case record that includes all information pertaining to the adoptive child.

No confidential information relating to the adoption will remain in the parent's case record.

Implementation and Procedures Guide

Create a new Adoption case record for each child whose parental rights have been terminated and the case plan goal for the child is adoption even if the order terminating parental rights is on appeal. The parent's case record may be maintained for ongoing services to other family members or, if no services are planned, the case record is closed.

DOCUMENTATION :

Create the new CHILDS electronic Adoption case record by following the CHILDS Users Guide for Field users, Creating an adoption case in DCYF Public Folders.

Create the new hard copy Adoption case record and include the following documents from the Child Protective Services case record:

- certified copy of the child’s birth certificate;
- severance social study, if applicable;
- termination of parental rights order;
- certified copy of the parent’s death certificate, if applicable;
- agency consents;
- parent's consent to place child for adoption;
- waivers of notice of appearance;
- affidavit of potential father;
- birth parent release of information;

- non-identifying information;
- most recent court report and attachments;
- most recent FCRB report;
- any standing court orders;
- psychological and medical information on the child and parent, if applicable;
- provider reports about the child; and
- case notes pertaining to the child.

Revision History:
DES(07-2006)

Previous

13-1

Legal Basis: The Indian Child Welfare Act, 25 U.S.C.§1901 et seq., is the federal law that governs placement of Native American children.

Interethnic Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188) prohibits denial or delay in the foster or adoptive placement of children on the basis of race, color or national origin of the foster or adoptive parent or child involved.

Adoption and Safe Families Act of 1997 (P.L. 105-89) requires that the child's health and safety be the paramount concern when making placement and permanency planning decisions and providing services.

ARS §8-845(B) states that the court, in reviewing the status of the child and in determining its order of disposition, shall consider the health and safety of the child as a paramount concern.

Rules: Section R6-5-6613 of the Arizona Administrative Code addresses the assessment and placement processes.

Revision History:
DES(07-2006)

Chapter 13: Section 1

Adoptive Placement: Assessing Placement Needs

Legal Basis

Policy: The department shall ensure that a child's placement needs are fully assessed prior to selecting a family and placing the child for adoption.

The race, color or national origin of the child may be considered in the placement decision only when the individualized assessment of the child's needs requires such consideration.

When assessing the placement needs of a child, consider the following factors:

- characteristics of the child: age, gender, religion, primary language, physical, emotional, social and educational needs,
- child's history: past placements, ties to current or past caregivers, experience with bonding and attachment,
- child's relationships: relatives, siblings, foster parents or other significant adults,
- parent's preferences regarding placement (The parent's placement preference regarding race, color or national origin shall not be considered); and
- child's preference regarding placement.

Implementation and Procedure Guide

To assess the child's placement needs, gather information by:

- § completing, if not already completed, and reviewing the AN-036, Family History (Non-Identifying Information);
- § reviewing the Birth Parent's Interview Form, FC-091, in the child's case record;
- § reviewing the recommendations of other professionals who have worked with the

child;

- § interviewing the child and his/her caretakers; and
- § determine the child's need for adoption subsidy (see Chapter 14 Adoption Subsidy).

If the child has or is at risk of the following conditions, obtain an evaluation from one or more professionals regarding the impact of the condition on the child's placement needs:

- § developmental disability;
- § emotional disturbance;
- § physical disease or disability; and
- § mental disease or disability.

If the child is or may be Native American, follow the special requirements of the Indian Child Welfare Act [see Selecting an Adoptive Family (Chapter 13, Section 3) and Native American Child Placements and Placement Preferences (Chapter 18 Section 6)]. Consult your supervisor and, if necessary, an Assistant Attorney General if there is any question about child's status as Native American or about the requirements of the Act.

DOCUMENTATION :

Document the child's assessed placement needs by completing /UPDATING the following windows:

- þ Child Assessment and Special Rate Evaluation
- þ Special Needs Detail
- þ Medical/Dental Condition Detail
- þ Medication Detail, Psych/Behavioral Condition Detail
- þ Practitioner Detail, Examination Detail
- þ Participant Education Condition
- þ Hospitalization Detail.

Revision History:
DES(07-2006)

Next

13-2

Legal Basis: ARS §8-105 directs the department to establish and maintain a Central Adoption Registry that includes the names of individuals who are certified to adopt and any children who are available for adoption.

Rules: Section R6-5-6502 of the Arizona Administrative Code provides Rules governing the Central Adoption Registry.

Revision History:
DES(07-2006)

Chapter 13: Section 2

Preparing for Adoptive Placement: *Central Adoption Registry*

Legal Basis

Policy: Children shall be prepared for adoptive placement in a manner that is age appropriate and sensitive to their individual needs.

The CHILDS Adoption Registry shall identify children whose permanency goal indicates they will be available for adoption.

Implementation and Procedure Guide

For a child to be identified in the CHILDS Adoption Registry, ensure that the child's active case plan goal is adoption.

see Selecting an Adoptive Family (Chapter 13, Section 3)

DOCUMENTATION :

Update CHILDS within five days of a change in the child's legal status, placement, adoption finalization, or when there is the death of a child.

The DCYF Central Office Adoption Specialist or designee is responsible for entering children in the custody of the Division of Developmental Disabilities into the CHILDS Adoption Registry and updating the status of these children in the Registry.

To prepare for adoptive placement, be sure the child's record includes the following updated windows:

- Child Assessment and Special Rate Evaluation;
- Special Needs Detail;
- Medical/Dental Condition Detail;
- Medication Detail;
- Psych/Behavioral Condition Detail;
- Practitioner Detail;
- Examination Detail; and

- Participant Education Condition Detail and Hospitalization Detail.

Be sure the hard copy record includes:

- AN-036, Family History (Non-Identifying Information);
- one of the following for each parent:
  - death certificate; or
  - documents verifying relinquishment: Consent to Place Child for Adoption or ICWA consents and certification; and AN-001; Waiver of Notice and Appearance, AN-010; Affidavit of Potential Fathers, AN-008 (if applicable); or
  - termination of parental rights order
- certified copy of the child's birth certificate;
- current medical and psychological information on the child and birth parent, if applicable; and
- current picture of the child

For More information on casework practice related to preparing children for adoptive placement, see Guidelines for Preparing a Child for Adoptive Placement. (Exhibit 37).

Revision History:
DES(07-2006)

Previous / Next

13-3

Legal Basis: The Indian Child Welfare Act, 25 U.S.C. §1901 et seq., defines the placement preference for Native American children.

The Interethnic Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188) prohibits denial or delay in the foster or adoptive placement of children on the basis of race, color or national origin of the adoptive or foster parent or the child involved.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) requires the department to consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant state child protection standards.

The Adoption and Safe Families Act of 1997 (P.L. 105-89):

§ Requires the department to concurrently identify, recruit, process and approve a qualified family for an adoption when a petition to terminate parental rights is initiated in specific circumstances.
§ Requires that, in the case of a child whose permanency plan is adoption, there is documentation in the case plan of the steps taken to find an adoptive home, to place the child with an adoptive family and to finalize the adoption, and any child specific recruitment efforts.
§ Prohibits the denial or delay in the placement of the child for adoption when an approved out-of-state adoptive family is available and requires the department to grant an opportunity for a fair hearing to an individual who alleges such denial or delay.

ARS §8-105.01 prohibits the department, an agency or the court from denying or delaying a placement or an adoption certification based on the race, color or national origin of the adoptive parents or child.

ARS §8-105.02 prohibits the removal of a child from the child's foster parents for the sole reason that the foster parents have applied to adopt the child.

ARS §8-105 requires prospective adoptive parent applicants to have a valid fingerprint clearance card.

ARS §8-105(D) specifies that the division shall not present for certification a prospective adoptive parent unless that person has a valid fingerprint clearance card pursuant to title 41,

chapter 12, article 3.1 or provides to the division documentation of the person's application for a fingerprint clearance card. The prospective adoptive parent must certify on forms that are provided by the division and that are notarized whether the prospective adoptive parent is awaiting trial on or has ever been convicted of any of the criminal offenses listed in section 41-1758.03, subsection B and C in this state or similar offenses in another state or jurisdiction

ARS§8-112 requires a state and criminal records check of the prospective adoptive parent and each adult who resides with the adoptive parent.

ARS §8-514 requires the department to place a child in the least restrictive placement available, consistent with the needs of the child. The order of placement preference is: with a parent; grandparent; in kinship care with another member of the child's extended family, including a person who has a significant relationship with the child; in licensed foster care; in licensed therapeutic foster case; in a group home; or in a residential treatment facility. The placement preference for an Indian child is in accordance with the Indian Child Welfare Act.

Rules: Sections R6-5-6613 and R6-5-6614 of the Arizona Administrative Code addresses selection of adoptive families.

Chapter 13: Section 3
Selecting an Adoptive Family

Legal Basis

Policy: The ability of the family to meet the child's needs shall govern the selection of an adoptive family. No single factor shall be the sole determining factor in the selection of a family.

The department's order of placement preference for children who are not Native American is:

- grandparent;
- kinship care with another member of the child's extended family, including a person who has a significant relationship with the child;
- non-relatives without a prior relationship to the child.

For children who are Native American, the order of placement preference shall be determined in accordance with the requirements of the Indian Child Welfare Act as follows:

- a member of the child's extended family;
- other members of the child's tribe;
- other Native American families. (25 U.S.C.§1901 et seq.)

For Native American children, the order of placement preference must be followed, except under the following circumstances:

- The child's parents have relinquished their parental rights and have requested anonymity. In this case, preference shall be given to placement with other Native American families
- The child's tribe sets a different order of preference.
- The tribe chooses not to intervene in the case and the state court finds that there is good cause to change the order of placement preference. (25 U.S.C.§1901 et seq.)

The department shall place siblings in the same adoptive home whenever possible.

The department shall make efforts to identify and approve an adoptive family for a child upon filing a petition or motion to terminate parental rights or when a concurrent permanency goal of

adoption has been identified.

The department shall not deny or delay a placement based on the race, color or national origin of the adoptive parent or the child (ARS §8-105.01)

The department shall not remove the child from the child's foster parents for the sole reason that the foster parents have applied to adopt the child.(ARS §8-105.02).

The department shall not deny or delay the placement of a child for adoption when an approved out-of-state adoptive family is available for placement.

The department shall grant an opportunity for a fair hearing to an approved out-of-state adoptive family who alleges that the department denied or delayed the placement of a child solely because the family resides out-of-state.

The department shall place a child in an identified adoptive home within 90 days of the completion of the Family and Home Evaluation (home study) Case Conference resulting in identification of the placement.

A child is eligible for foster-adoptive placement if his or her concurrent goal is adoption, or his or her permanent plan is adoption, and no relatives or significant persons can meet his/her needs for an adoptive placement, because they are unwilling or unavailable to do so, or they have been denied certification, or they have been assessed as unable to meet the needs of the child.

Reasonable efforts shall be made to place the child for adoption without adoption subsidy unless such efforts are contrary to the welfare of the child due to significant emotional ties to the prospective adoptive parents while in their care as foster parents or relatives.

An individual residing in Arizona, who wishes to adopt shall be certified to adopt by the juvenile court (ARS §8-105), except the spouse of the natural or legal parent of a child or an adult sibling, aunt, uncle, grandparent or great-grandparent of a child by the whole or half blood or by marriage or adoption.

An out-of-state family wishing to adopt shall be approved for adoption by an entity authorized by the state in which the family resides to approve families for adoption.

In choosing an adoptive family, See Guidelines for Selecting An Adoptive Family (Exhibit 38) and *consider the following questions*:

For grandparents and other kinship caregivers (extended family members including persons who have a significant relationship with the child which may include the child's foster parent):

- Will the family offer the child a positive connection to his/her heritage and to extended family members?
- What kind of relationship does the family have with the child's biological parent(s) and how will this relationship impact the placement?
- To what extent can this family meet the child's physical, social and emotional needs?
- Is there any background information which would adversely affect the person's ability to provide a safe, nurturing environment for the child?
- How long has the child had a relationship with the family?
- What is the nature of the attachment between the child and family?
- To what extent might removing the child from this family cause emotional harm? (See Childhood Loss and Behavioral Problems (Exhibit 46)
- Does the family have the capacity to claim the child and view the relationship as permanent?
- If applicable, to what extent will the family cooperate with future sibling and/or relative contact?
- If applicable, is the family going to continue with foster parenting after the adoption is final, and what is the potential impact for the adopted child?

If a grandparent or kinship caregiver cannot meet the child's needs as an adoptive placement, consider placement with a family that has no relationship with the child. Consider the following questions:

Foster-Adoptive Families:

§ What are their expectations of the placement?

§ Can they accept the consequences of placement of a child whose parental rights have not been terminated or may not be?

§ To what extent can this family meet the child's physical, social and emotional needs**?**

Certified Adoptive Families:

§ What are the expectations of this family for an adopted child, and are these

expectations reasonable for the child they are considering adopting?

§ What impact will an adoptive placement have on other children in the family?

§ To what extent can this family meet the child's physical, social and emotional needs?

§ Is this family willing to be licensed as a foster family in order to accept placement of a child whose case plan goal is adoption and who is not legally free for adoption?

Implementation and Procedures Guide

Use the following procedures when considering placement with a grandparent or extended family member including a person who has a significant relationship with the child:

§ Complete an extensive and documented search for grandparents or extended family members including a person who has a significant relationship with the child. Re-contact any grandparent or extended family members including a person who has a significant relationship with the child whose circumstances may have changed; consider convening a family group decision making conference to determine/identify grandparents or extended family members including a person who has a significant relationship with the child with current interest in and ability to adopt the child.

§ Ensure interested grandparents or extended family members including a person who has a significant relationship with the child and all adults permanently living in the household are fingerprinted and have a state and federal criminal history records clearance within the last year and a current Child Protective Services records clearance of child abuse and neglect reports and history.

§ Provide information to the grandparents or extended family members including a person who has a significant relationship with the child on arranging for fingerprint and criminal history records check, if not current within the last year. Have the grandparents or extended family members including a person who has a significant relationship with the child and all adults permanently living in the household complete:

- Request for licensing/employment information, J-709
- FBI Fingerprint Card, FD-258
- AN-048, Adoptive Families Child Protective Services Records Clearance

Schedule a case conference if the fingerprinting has not been initiated within 30 days. The conference should include the child's case manager, his/her supervisor, and the grandparent or extended family member including a person who has a significant relationship with the child. It

should focus on resolving any barriers to completion of the fingerprinting and certification process or, if necessary, on planning for selection of another family.

If the grandparent or extended family member including a person who has a significant relationship with the child and all adults permanently living in the household have a criminal history records and Child Protective Service records clearance of child abuse and neglect reports and history, assess his/her ability to parent the child by reviewing the child's assessed placement needs. If the grandparent or extended family member including a person who has a significant relationship with the child is approved and selected as an appropriate adoptive parent for the child, enter the approved relative or significant other adoptive family into the CHILDS Provider (Adoption) Registry according to the procedures found in **Central Adoption Registry** (Chapter 13, Section 2). Document the reasons for selection of the family in the Adoptive Family Evaluations window.

If there are questions concerning the ability of the grandparent or extended family member including a person who has a significant relationship with the child to meet the needs of the child, conduct a case conference including the CPS Specialist and his/her supervisor, the child's attorney and other professionals as appropriate. A supervisor must approve a decision not to place a child with a grandparent or extended family member including a person who has a significant relationship with the child.

BEST PRACTICE TIPS:
It is critical for the CPS Specialist to carefully evaluate the relationship and bonding that has developed between the child and the existing caregiver. If the child has bonded with the foster parent—and if they do not know or have a minimal relationship with the relative—the CPS Specialist must consider the overall long term best interest of the child to be placed with the foster parent versus the relative including significant others.. These are very difficult decisions and there is no "one size fits all" answer for these circumstances. CPS Specialists, supervisors and relatives including significant others need to have honest and forthright conversations about the impact of moving a child out of a home where they have bonded with the caregivers.

Use the following procedures when considering placement with foster parents:

§ Verify with OLCR that the foster home meets all licensing requirements and is currently licensed as a foster home.

§ Verify that a Significant Person Placement checklist has been completed on all

household members and is current within the last year.

§ Review case files to evaluate the providers success in meeting the child's safety, health and other identified special needs.

§ Determine the foster parents' willingness to proceed with certification and adoption.

§ If there are questions concerning the foster parent's ability to meet the needs of the child, conduct a case conference including the licensing case manager, OLCR case manager, adoption supervisor, psychologist and/or therapists, medical doctor, teacher and other appropriate professionals such as the child's attorney and GAL. A supervisor must approve a decision not to place a child with a foster parent.

Use the following procedures to select a family with no prior relationship to the child:

§ Use the Find Provider In Registry window to initiate a search of the CHILDS Provider (Adoption) Registry **within five days** of filing a petition or motion to terminate parental rights by selecting the desired search criteria such as service group, service type, district served, age, gender, special capabilities, religion, and ethnicity restrictions.

§ Consider foster-adoptive and adoptive homes for placement.

§ If no homes are available on the CHILDS Provider (Adoption) Registry, begin child specific recruitment efforts **within five days** (see Child Specific Recruitment, Chapter 13, Section 6).

§ If homes are available on the CHILDS Provider (Adoption) Registry, review the profiles in CHILDS of those families that appear to be appropriate for placement.

§ If the child has a developmental disability, request Family and Home Evaluations (home studies) of adoptive families that are able to meet the needs of a child with developmental disabilities from the DCYF Central Office Adoption Specialist or designee.

§ Request case files on those families that appear to be appropriate for placement from the families' CPS Specialists or if a District VII family then make the request to Central Office Adoption at 940A.

§ Evaluate the families by reviewing the Family and Home Evaluation (home study) and the Foster Care/Adoption Assessment Guide, LCR-1031, **within 30 days** of filing the

petition or motion to terminate parental rights.

§ If an approved out-of-state adoptive family is to be considered at a Family and Home Evaluation (home study) case conference, complete and send the ADS-1000A, Placement Consideration Application, to the family.

§ Keep the file on selected families for a case conference; and confirm and/or ensure families are entered into the CHILDS Provider (Adoption) Registry; return the unused files **within ten working days**.

§ Convene a case conference to make the final selection **within 30 days** of reviewing the family evaluations (home studies) for appropriateness. Include the CPS Specialist, his/her supervisor, certification specialists for the homes to be considered, foster parents (if appropriate), child's attorney, GAL and other professionals who know the child and/or are familiar with adoption issues.

§ Ensure that the child is placed with the identified adoptive family **within 90 days** of the case conference resulting in identification of the placement.

When An Adoptive Family Is Not Selected

§ Return the files of families that were not selected within ten working days. Enter the denial reason on the Adoptive Family Evaluation window **within five working days**.

§ If no home is selected at the Family and Home Evaluations (home study) case conference, begin special recruitment efforts **within five days.** See **Special Recruitment**, (Chapter 13, Section 6).

§ If an approved out-of-state adoptive family was considered at the Family and Home Evaluation (home study) case conference and the child was not placed or a placement was not identified, use the ADS-1001A, Notification Letter, to notify the family of:

- the review of their home study at the case conference;
- the fact that no placement was identified or made; and
- the right to a fair hearing if they feel the department denied placement of the child with them solely because they reside out-of-state.

If an approved out-of-state adoptive family was considered at the home study case conference

and the child was placed with another family or another placement was identified, use the ADS-1002A, Placement Notification Letter, to notify the family of the review of their home and that another placement was selected.

Adoption Subsidy

Determine whether the child has one or more special needs that may impede his or her adoption. Consult with your supervisor and/or other members of the service team, as necessary.

To assess whether adoption subsidy may be necessary to facilitate the adoption of a child, review all legal, social, medical, educational and psychological records on the child for relevant information.

Make reasonable efforts to find an adoptive placement for the child without subsidy. At a minimum:

- § Discuss the child's special needs with prospective (relative, foster parent or significant other) adoptive parents.
- § Explain that subsidy is based on the child's assessed needs at the time of adoptive placement and the circumstances of the family.
- § Provide prospective parents with the Adoption Subsidy - A Program for Children with Special Needs, PAP-194.
- § Ask prospective parents whether they would consider adopting without subsidy.

Select the family that can best meet the child's needs, without consideration of subsidy, unless placement without subsidy is contrary to the child's best interest due to significant emotional ties to the prospective adoptive parents while in their care as foster parents or relatives.

When determining that placement without subsidy is contrary to the child's best interests, consider the following information:

- § age of the child;
- § child's ability to transition and form healthy attachments to another family;
- § length of placement in the home;
- § number of previous placements and disruptions;
- § any history of bonding and attachment problems; and

§ any regression in developmental or medical condition which would likely occur if the child is removed from the home.

DOCUMENTATION :

If there is no current Child Protective Services records check, complete a search of the Child Protective Services CHILDS Central Registry and CHILDS Case Management Information System for all adults permanently living in the home.

If the grandparent or extended family member including a person who has a significant relationship with the child and all adults permanently living in the household have a criminal history records and Child Protective Services records clearance of child abuse and neglect reports and history, assess his/her ability to parent the child by reviewing the child's assessed placement needs. If the grandparent or extended family member including a person who has a significant relationship with the child is approved and selected as an appropriate adoptive home for the child, enter the approved adoptive family into the CHILDS Provider (Adoption) Registry according to the procedures found in **Central Adoption Registry** (Chapter 13, Section 2). Document the reasons for selection of the family on the Adoptive Family Evaluation window.

Document steps taken, including child specific efforts, to identify and place the child into a permanent adoptive home and to finalize the adoption using the Case Plan Tasks window.

§ Document when a placement for the child has been identified by entering the Identified date in the Adoption Characteristics window.

§ Document all families that were considered for placement on the Adoptive Family Evaluation window.

§ Document the selection of a family and the denial reasons on the Adoptive Family Evaluation window.

§ Document the number of homes reviewed for placement, names of the homes selected for the placement staffing, who was selected for placement and why the other homes were not selected for placement in the Case Notes window.

§ Document efforts to contact grandparents and extended family members including a person who has a significant relationship with the child as well as the assessment of

grandparents and extended family members including a person who has a significant relationship with the child, foster parents, and families with no prior relationship to the child using the Case Notes window.

§ Document the willingness of each family to be considered to adopt without subsidy (or, if applicable, document why efforts were not made to find a family to adopt without subsidy) using the Case Notes window.

§ Document that placement without adoption subsidy was contrary to the best interest of the child using the Case Notes window.

Revision History:
DES(09-2006)

Previous / Next

13-4

Legal Basis: Not applicable

Rules: Section R6-5-6510 of the Arizona Administrative Code addresses international adoptions.

Revision History:
DES(07-2006)

Chapter 13: Section 4

Special Circumstances: *Out-of-County, Out-of-State Adoptions and Private Adoptions*

Legal Basis

Policy: When a child is placed for adoption out of his or her home county, the department office in the county in which the adoptive parents reside shall designate a courtesy supervision CPS Specialist or contract agency case manager. The child's CPS Specialist or contract agency case manager and the courtesy supervision case manager shall work cooperatively to ensure that the child and family receive the services they need to facilitate the adoption.

When a child is to be placed out-of-state, the department shall facilitate the adoption, following procedures outlined in Interstate Compact for the Placement of Children (Chapter 10).

When ordered to do so by the court, the department shall perform functions for independent adoptions. The department shall notify the Attorney General's Office of such court orders.

For children in the custody of private agencies, the Adoption Subsidy Supervisor shall provide information and forms necessary to enable the agency to assist families in applying for subisdy on behalf of children in custody.

Implementation and Procedures Guide

For out-of-county adoptions:

Child's CPS Specialist or contract agency case manager:

Conduct staffings, and write reports to the court and Foster Care Review Board.

Complete and sign the Adoptive Placement Agreement, AN-012, or the Foster Adoption Agreement, FC-074.

Provide the courtesy supervision CPS Specialist or contract agency case manager with background information, from the hard copy record including: documents for filing the adoption petition, and medical coverage information, and documentation needed to apply for

adoption subsidy, if applicable.

Request dismissal of the dependency petition when the adoption is finalized.

File the certified copy of the adoption order and other documents in the child's hard copy record.

Courtesy supervision CPS Specialist or contract agency case manager:

Make home visits to ensure that the child is safe and that the placement is going well.

Help the family complete and sign the Adoptive Family Application for Subsidy, AN-018-A, if applicable.

Help the family to petition to adopt and complete the final adoption report if required.

Send the child's CPS Specialist or contract agency case manager a certified copy of the final adoption order.

For out-of-state placements the child's CPS Specialist or contract agency case manager shall:

Follow the procedures on Interstate Compact for the Placement of Children. In addition:

- Ensure that the child's active case plan goal is adoption.
- Request court approval of out-of-state placement.
- Obtain reports from the supervising agency and/or court regarding the progress toward adoption.
- Supply documentation required by the state in which the adoption will take place.
- If adoption subsidy is applicable, ensure that the family completes the Adoption Subsidy application and submits it to Arizona Adoption Subsidy Program with the necessary documentation.

DOCUMENTATION :

The CPS Specialist must ensure that the supervisor designates the courtesy supervision case manager as the support case manager using the Case Assignment window.

The out of county courtesy supervising CPS Specialist or the contract agency case manager must document progress using the Case Notes window and report crises to the child's case manager as they occur.

Revision History:
DES(07-2006)

Previous / Next

13-5

Legal Basis: The Adoption and Safe families Act of 1997 (P.L. 105-89) prohibits the denial or delay in the placement of a child for adoption when an approved out-of-state adoptive family is available and requires the department to grant an opportunity for a fair hearing to an individual who alleges such denial or delay in placement.

Rules: Sections R6-5-2401 through R6-5-2405 of the Arizona Administrative Code addresses appeals.

Revision History:
DES(07-2006)

Chapter 13: Section 5

Appeal Of Decision Regarding Out-Of-State Adoptive Placement

Legal Basis

Policy: The department shall notify an approved out-of-state adoptive family when a placement is not made or identified as a result of a home study case conference.

The department shall grant an opportunity for a fair hearing to an approved out-of-state adoptive family who alleges that the department denied or delayed the placement of a child solely because the family resides out-of-state.

The fair hearing shall be conducted according to Arizona Administrative Code, Sections R6-5-2401 through R6-5-2405 .

The DCYF Adoption Specialist shall coordinate appeals in accordance with the requirements of DES 5-24, Appeals and Hearings.

To decide whether a family shall be notified of the denial of placement and be granted an opportunity for a fair hearing, consider these questions:

- Is the family an approved out-of-state adoptive family who was considered for placement at a home study case conference?
- Was the child, for whom placement was considered at the home study case conference, not placed with any adoptive family or a placement was not identified?
- Was placement with an approved out-of-state adoptive family delayed beyond 90 days after the home study case conference?

Implementation and Procedures Guide

Send a notification letter to the family, ADS-1001A, Notification Letter, advising them of the child's placement status and their right to a fair hearing.

Forward a copy of the notification letter to the DCYF Adoption Specialist at 940A.

The DCYF Adoption Specialist shall coordinate appeals in accordance with the requirements of DES 5-24, Appeals and Hearings.

Revision History:
DES(07-2006)

Previous / Next

13-6

Legal Basis:

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires:

§ The effective use of cross-jurisdictional resources to facilitate timely adoptive placements for waiting children,

§ Prohibits the denial or delay in the placement of a child for adoption when an approved out-of-state adoptive family is available; and

§ The department to grant an opportunity for a fair hearing for an individual who alleges such denial or delay.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that reasonable efforts be made to place children without adoption assistance.

45 CFR 1356.40(f) requires the department to actively seek ways to promote the adoption assistance program to encourage the adoption of children with special needs

Rules: Section R6-5-6507 of the Arizona Administrative Code addresses procedures for recruiting families for children with special needs.

Revision History:
DES(07-2006)

Chapter 13: Section 6
Child Specific Recruitment

Legal Basis

Policy: All appropriate recruitment resources shall be explored and/or utilized within three months of the referral for child specific recruitment.

Child specific recruitment shall be conducted to find adoptive families for legally and non-legally free children for whom no homes are found on the CHILDS Provider (Adoption) Registry, including children with special needs.

For children who are legally free with no identified adoptive placement, child specific recruitment shall be initiated by sending a completed AN-042, Specific Recruitment Plan for Adoptive Placement, to the DCYF Foster/Adoptive Home Recruitment Coordinator at 940A.

- Within five days of conducting a CHILDS Provider (Adoption) Registry search resulting in no available homes; or
- Within five days of concluding an adoptive Family and Home Evaluation (home study) case conference that resulted in no identified placement.

For children who are not legally free, child specific recruitment shall be initiated on a selective basis, determined by the child's particular circumstances.

Child specific recruitment includes registering the child with the Arizona Adoption Exchange Book, the **ADOPTUSKIDS,** Wednesday's Child and other cross-jurisdictional resources, such as regional exchanges, to facilitate timely and permanent placement for children awaiting adoption.

Media presentations personally identifying a child require a court order.

If more than one appropriate family who can meet the needs of the child responds to a child specific recruitment effort, priority shall be given to families who are already certified or approved to adopt.

Implementation and Procedures Guide

To conduct child specific recruitment/family identification:

- Forward a referral packet for special recruitment to the DCYF Foster/Adoptive Home Recruitment Coordinator at 940A within 45 days of no placement being identified through the CHILDS Provider (Adoption) Registry search or Family and Home Evaluation (home study) case conference.
    - ***Include in the referral packet:***
        - § a copy of the previously completed Specific Recruitment Plan for Adoptive Placement, AN-042,
        - § court order for recruitment through all media sources; if a court order for recruitment through all media sources is not available, contact the Assistant Attorney General about obtaining a court order,
        - § three photos of the child, and
        - § narrative about the child which may include:
            - an attention-getting phrase as an opening statement;
            - colorful details on the child's unique character (hobbies, interests, strengths);
            - highlights of the child's progress and ways to manage challenges;
            - identification of clinical diagnoses;
            - description of how the child relates to adults and other children;
            - quotation from the child or adults important to the child; and
            - suggestions of what the child needs from a family.

The Foster/Adoptive Home Recruitment Coordinator will route child specific information to recruitment resources and/or search for prospective families listed with various adoption exchanges.

Evaluate all Family and Home Evaluation (home studies) resulting from a search of adoption exchanges within ten days of receipt.

Complete the ADS-100A, Placement Consideration Application, and forward to all approved out-of-state adoptive families to be considered for placement at the Family and Home Evaluation (home study) case conference.

Respond to all inquires within ten days of receipt. Contact appropriate families personally;

send all responses (whether or not they are appropriate for the particular child) to the office that serves the area in which the family lives.

Conduct an individual or group meeting with interested, appropriate families.

Refer all interested, appropriate families for Family and Home Evaluation (home studies).

Make and document your selection through the Family and Home Evaluation (home study) case conference as previously described in **Selecting an Adoptive Family**, (Chapter 13, Section 3).

If an approved out-of-state adoptive family was considered at the Family and Home Evaluation (home study) case conference and the child was not placed or a placement was not identified, use the ADS-1001A, Notification Letter, to notify the family of:

- the review of their home study at the case conference,
- the fact that no placement was identified or made, and
- their right to a fair hearing if they feel the department denied placement of the child with them solely because they resides out-of-state.

If an approved out-of-state adoptive family was considered at the Family and Home Evaluation (home study) case conference and the child was placed with another family or a another placement was identified, use the ADS-1002A, Placement Notification Letter, to notify the family of the review of their home and that another placement was selected.

Revision History:
DES(07-2006)

Previous / Next

13-7

Legal Basis: ARS §8-129 addresses compiling and presenting to the prospective adoptive or foster-adoptive family detailed non-identifying information.

Rules: Section R6-5-6616 of the Arizona Administrative Code addresses provision of information on the child to be placed.

Revision History:
DES(07-2006)

Chapter 13: Section 7

Presenting the Child's Information to the Prospective Adoptive Family

Legal Basis

Policy: The department shall ensure that a meeting to share non-identifying information is held with the perspective adoptive family prior to the first visit with the child.

The department shall ensure that all non-identifying information including health and genetic history on the child and non-identifying information on the birth parents and members of the birth family is presented to the prospective adoptive parent in a written format.

Families who are considering adopting a child with whom they have no prior relationship shall receive non-identifying information before deciding whether they want to meet the child. This information shall include: the child's history, his or her physical, emotional, social and educational needs, and the birth parents' wishes regarding sharing of identifying information.

The department shall assist the prospective adoptive family in consulting with other professionals who have worked with the child. The department shall also assist the family in identifying community resources to provide support for the child and family.

Preparation by the CPS Specialist or contract agency case manager

Review information to be provided to the perspective adoptive family and ensure all identifying information is removed from the documents that will be shared. In particular compile the following items**:**

- § CHILDS medical summary report (includes Medical/Dental Condition Detail, Medication Detail, Psych/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Participant Education Condition Detail and Hospitalization Detail);
- § pictures of the child and when possible video tapes;
- § AN-036, Family History;
- § psychiatric and psychological evaluations on the child and birth parents;
- § child's birth and medical records;

§ birth parent's and other family member's medical records and/or history;

§ child's school records, evaluations, report cards and IEP; and

§ any other documents related to the child or birth parents social, behavioral or mental health history.

Implementation and Procedure Guide

Follow these steps when presenting information on the child to the identified perspective adoptive or foster-adoptive family:

§ Help the family see the child as a whole person, discuss the child's likes and dislikes, hobbies and ways that the child passes his/her time, the verbal skills of the child, if the child expresses emotions easily, the child's fears and hopes. The child is more than their "special needs" and they need to be introduced to the prospective adoptive parents accordingly.

§ Using the AN-036, Family History (Non-identifying Information), as a basis for the initial discussion of the child with the family, discuss the child's special needs with prospective adoptive parents.

§ Identify professionals who have a history of the child's identified conditions and who would be available for consultation or to answer questions.

§ Facilitate consultations with professionals and/or obtain from professionals in writing answers to questions related to reports, evaluations etc.

§ Provide the family with pictures of the child and when possible video tapes.

§ Advise the family that an initial meeting with the child in the foster home will be arranged and that any move toward placement will only occur upon completion of a series of transition visits.

§ Provide prospective parents with the Adoption Subsidy pamphlet - A Program for Children with Special Needs, PAP-194, and ask if they will be able to adopt without subsidy.

DOCUMENTATION :

Document discussion regarding placement without adoption subsidy in the Case Notes window.

Document names of documents and type of non-identifying information shared with the prospective adoptive family in the Case Notes window.

Revision History:
DES(07-2006)

Previous / Next

13-8

Legal basis: Not applicable

Rules: Section R6-5-6618 of the Arizona Administrative Code addresses availability of counseling, educational and supportive resources to the adoptive family to facilitate the child's acceptance into the family.

Revision History:
DES(07-2006)

CHAPTER 13: Section 8

Development of an Adoptive Placement Transition Plan

Legal basis

Policy: The department shall ensure that each child whose placement in an adoptive home is planned shall have a transition plan developed.

The transition plan shall be developed in consultation with the prospective adoptive parents, foster parents, child (if appropriate) CPS Specialist or contract agency case manager, therapists and other interested parties as appropriate.

The transition plan shall be developed after the initial visit with the prospective adoptive parents and child and prior to any subsequent visits.

Visits shall be planned to allow the child and family ample time to get to know each other. Timing and number of visits shall be determined with consideration of the child's and family's needs as well as consideration of factors such as distance and expense.

Consider the following when developing a transition plan:

- § the age and identified special needs of the child;
- § the physical location of the child to the prospective adoptive parents home;
- § the expressed concerns of the child if the child is of an age/ability to appropriately express his desires;
- § any therapeutic recommendations/ suggestions regarding visitation; and
- § the child's developmental level, schedule, likes and interests, fears and anxieties.

Implementation and Procedures Guide

Discuss the following during the formulation of the transition plan:

§ The goal of pre-placement planning is to decrease anxiety and limit the child's perception of loss.

§ The value of a cooperative relationship between the prospective adoptive parents and the foster parents and how this relationship can facilitate the attachment process.

§ Allowing the child to keep familiar belongings, maintaining the child's schedule and familiar child care practices and maintaining cultural continuity.

§ Identify when and where visits will occur, activities during visits and when overnight and weekend visits will begin and the projected date of placement.

§ Provide the child a copy of the plan for the transition including a written schedule of the visits and activities described above.

§ Provide written copies of transition plan to the adoptive family and foster family or current caregiver.

DOCUMENTATION :

Document in the Case Notes window the transition plan meeting and the steps to be included in the transition plan. Indicate if the child received a copy of the transition plan**.**

Revision History:
DES(07-2006)

Previous / Next

13-9

Legal Basis: Not applicable

Rules: Sections R6-5-6618 through R6-5-6620 of the Arizona Administrative Code address making and supervising adoptive placements.

Revision History:
DES(07-2006)

Chapter 13: Section 9

Making and Supervising Adoptive Placements

Legal Basis

Policy: The department shall explore and exhaust all efforts to place legally free children whose case plan goal is adoption in an adoptive placement.

After the child is legally free and the family is certified or approved as acceptable to adopt, the date of the adoptive placement is the date the family signs the AN-012, Adoptive Placement Agreement**.**

The department shall place a legally free child in the identified adoptive home of a relative or foster parent **within 90 days** of identification of the placement.

The department shall place a child in an identified adoptive home or foster-adoptive home **within 90 days** of the family and home evaluation (home study) case conference resulting in the identification of the placement.

The department may place a child whose case plan goal is adoption and who is not legally free for adoption in an identified foster-adoptive placement when the family is certified to adopt and licensed by the department as a foster home.

The department shall not guarantee to the foster-adoptive family that the child placed in a foster-adoptive placement will be freed for adoption.

The department shall ensure that the foster-adoptive family understands the legal consequences of accepting placement of a child whose parental rights have not been terminated.

The department shall ensure that an adoptive family understands the legal consequences of accepting placement of a child where the order terminating parental rights is or may be appealed.

At the time of placement the adoptive family shall become responsible for any expenses for the child beyond the payments currently provided by the department.

Implementation and Procedures Guide

Follow these steps when making an adoptive placement:

§ Follow the previously prepared transition plan visitation schedule.

§ Work with out-of-home placement providers to ensure that the child is prepared emotionally and physically for the move prior to his or her placement date. (See **Guidelines for Preparing a Child for Adoptive Placement** (Exhibit 37).

At the time of adoptive placement, give the adoptive parents any information or documents they need to assume responsibility for the child including:

þ AN-036, Family History (Non-Identifying Information); have them sign and copy the medical form; file the copy of the form in the child's record;

þ medical information, documents, a list of scheduled appointments and names and addresses of practitioners who have worked with the child;

þ school information and documents;

þ PAP-194, Adoption Subsidy, A Program for Children with Special Needs; and the completed AN012, Adoptive Placement Agreement; and

þ the application for Adoption Subsidy, AN-018, Adoptive Family Application, if applicable.

BEST PRACTICE TIPS:

The more information the adoptive parents have prior to placement about the child, the better equipped they will be to meet the needs of the child. Many adoptive parents state they were not provided with all of the information about the child at the time of the adoption. CPS Specialist or contract agency case managers need to provide the adoptive family with as much information as they have about the child and non-identifying information about the child's family. The child may, in time, want to know about his/her birth family. They will want to have information to "fill in the gaps" of their understanding of themselves and their background, their roots, their birth family. We need to equip adoptive families with as much information as possible, so that they can fully meet the needs of their adoptive children.

Ensure that a family, who is adopting a child where the order terminating parental rights is or may be appealed, has read and understands the legal consequences of the appeal being granted and the adoption decree overturned as described in the AN-012, Adoptive Placement Agreement. Have the adoptive parent(s) sign the completed AN-012. Ensure the adoptive parent (s) initial Items F-J on the AN-012. Give the original to the family; give one copy to the certification specialist, if applicable, and file a copy in the family's record.

During the supervision period:

§ Make the initial supervisory visit within five days of the child's placement. Make additional visits at least once a month until finalization.

§ Assist the family in determining their desires around sharing identifying information with the birth parents.

§ Complete the ADS-1005AFORNA, Affidavit of Information Disclosure for Adoption, review it with the adoptive parents and have the adoptive parents sign the completed ADS-1005AFORNA. Give the original ADS-1005AFORNA to the adoptive parents and place a copy in the child's case record.

§ If applicable, determine which type of subsidy is most appropriate to meet the child's needs: medical coverage, special services subsidy, maintenance payments, and/or non-recurring adoption expenses. Assist the family in applying for Adoption Subsidy within 30 days of placement. Subsidy is based upon the child's assessed needs at the time of application.

§ Inform the adoptive parents that they should apply for a new social security number upon finalization for the child and that use of the old number could result in a loss of confidentiality.

§ Inform the adoptive parents that state law permits communication among the child, birth parents and adoptive parents after finalization of the adoption.

When placing a child in a foster-adoptive home:

§ Follow the procedures for placing children in family foster homes as outlined in Placing Children in Out-of-Home Care (Chapter 6 Section 7) .

§ Ensure that the family has read and understands the legal consequences of accepting a child who is not legally free for adoption as described in the FW-074, Foster-Adoption Agreement.

§ Have the foster-adoptive parents sign the FW-074, Foster-Adoption Agreement. Give the original to the family; give one copy to the licensing and certification specialists, and file one copy in the family's record.

When changing a child from foster-adoptive status to adoptive placement status:

§ Ensure the child is legally free. A placement is permissible even when the order terminating parent-child relationship is on appeal.

§ Have the adoptive parent(s) sign the completed AN-012, Adoptive Placement Agreement. Ensure the adoptive parent(s) initial items F-J on the AN-012. Give the original to the family; give one copy to the certification specialist, if applicable, and file a copy in the family's record.

§ If not previously done provide to the adoptive parents the completed AN-036, Family History (non-identifying information) and ADS-1005AFORNA, Affidavit of Information Disclosure for Adoption; have them sign and copy the forms; provide the original to the adoptive parents and file a copy in the child's case record.

§ If applicable give the adoptive parents PAP -194 Adoption Subsidy, A Program for Children with Special Needs and the application for adoption subsidy, AN-018, Adoptive Family Application**.**

DOCUMENTATION :

File a copy of the signed AN-012 or FC-074 in the family's record.

Document the placement in CHILDS following the CHILDS users guide for field users in DCYF public folders under Adoption Characteristics.

Document the date of the pre-adoptive or foster-adoptive placement by entering the Placement date in the Adoption characteristics window. For foster-adoptive placements this is the date the FW-074, Foster-Adoption Agreement is signed. For other types of placements it is the date the child was placed in the home after the family decided to adopt. In some cases the Identified and Placement date will be the same date such as when a relative or foster parent who already has the child in the home decides to adopt.

To complete the documentation of the adoptive placement, follow these steps:

- Enter the Adoptive Agreement Signed date on the Adoption Characteristics window.
- Add the adoptive parents to the family relationship by updating the Family Relationships window and complete the Service Authorization Request, Service Authorization Approval and Service Authorization Provider Match windows within five days of placement.
- Update the legal status, goal, case plan, CPS Specialist or contract agency case manager, and other changes as necessary in CHILDS within five days of the change.

During the supervision period:

- Complete the Adoptive Parent(s) Release of Identifying Information, FC-173, with the family.
    - Document discussion of the provision of the Foster-Adoption Agreement, FC-074; with the foster-adoptive parents using the Case Notes window designated as Out of Home Care Provider Contact type.
    - Document discussion of the provisions of the Adoptive Placement Agreement, AN-012, with the adoptive parents using the Case Notes window designated as Out of Home Care Provider Contact type.
    - If another CPS Specialist or contract agency case manager will be supervising the placement, provide the new CPS Specialist or contract agency case manager with:
        - copy of AN-036, Family History (Non-Identifying Information), and
        - other documents relevant to the placement.

- If the adoptive parents want to continue CMDP coverage for the child until the adoption is final, notify CMDP of the placement. (Adoption subsidy medical coverage and special services do not begin until the adoption is final.)

For More Information: On supervising the adoptive placement see **Supervising an Adoptive Placement** (Exhibit 45).

Revision History:
DES(07-2006)

Previous

13-10

Legal Basis: ARS §8-113 addresses placement disruption.

Rules: Section R6-5-6623 of the Arizona Administrative Code addresses placement disruption.

Revision History:
DES(07-2006)

Chapter 13: Section 10
Unsuccessful Placements

Legal Basis

Policy: A family may withdraw from consideration for placement of a specific child at any time prior to placement by notifying their certification specialist or the child's CPS Specialist or contract agency case manager. A family that withdraws may remain on the CHILDS Provider (Adoption) Registry as a placement resource for other children.

During the supervision period, a family may request removal of a child placed in their home by submitting the request in writing to the child's CPS Specialist or contract agency case manager.

If a request for removal of the child is made *after* the filing of the Petition to Adopt, the family must withdraw the petition from court.

If at any time the CPS Specialist or contract agency case manager and his or her supervisor believe that a placement is not suitable for a particular child, the department shall submit a report to the court requesting a hearing on removal of the child if the family does not withdraw the petition.

If removal of the child is necessary, the department will provide counseling for both the child and the family.

Implementation and Procedures Guide

Provide counseling for families who wish to withdraw from consideration for a particular child or who have requested that a child be removed from their home. Help the family to determine whether they want:

- to remain on the CHILDS Provider (Adoption) Registry with their current listing;
- to change their "child desired" specifications;
- to be placed "on hold" for a period of time; or
- to withdraw from the Registry.

If removal of the child is necessary after the petition has been filed:

- Notify the family and the Attorney General's Office, county attorney or the family's

attorney of the need to withdraw the petition.

- Instruct the family that they may remain on the CHILDS Provider (Adoption) Registry as long as their certification to adopt remains in effect.

BEST PRACTICE TIP:
Individuals involved in an unsuccessful adoptive placement often feel pain, confusion, disappointment and guilt. The parents may have many conflicting emotions and need a place to process these emotions. The CPS Specialist or contract agency case manager should encourage the family to seek therapy as a good therapist can assist the family in accepting their decision to have the child removed from their home and can help them decide what they will do next.

Children's experiences will most likely be very complicated. They may not be willing to allow themselves to feel their sadness and disappointment, much less express their emotions. When an adoption placement fails, children often blame themselves; the experience may validate their sense that they are unworthy to have a family or be loved. These are serious and life impacting emotions. If children do not have a therapist prior to an unsuccessful adoptive placement, they need to be encouraged to see a therapist following the placement.

DOCUMENTATION :

To reflect any change in a family's child preferences and special capabilities, update the Provider Maintenance Special Capabilities and Provider Maintenance Preference Detail windows.

If removal of a child is necessary prior to filing the Petition to Adopt, update the CHILDS Adoption Registry within five days of the child's removal by completing the Service Authorization Request and Provider Service Authorization windows.

If removal is necessary after the petition is filed:

- Document the removal and the reasons for it in the child's and family's case record by completing the Legal Status, Service Authorization Request, Provider Service Authorization, and Case Notes windows.
- If applicable, close the family's adoption certification record by updating the Provider Maintenance Status List Detail and Provider Maintenance Service Detail window.

Document disruption of the pre-adoptive/foster-adoptive placement or an adoptive placement by entering the Disruption date and Disruption Reason in the Adoption Characteristics window.

Revision History:
DES(07-2006)

Previous / Next

13-11

Legal Basis: ARS §8-102 requires that for children born in the United States, a Petition to Adopt must be filed before a child's 18th birthday. A foreign-born child, who is not an illegal alien, may be adopted until his or her 21st birthday. The child must be present in Arizona at the time the Petition to Adopt is filed.

ARS §8-103 specifies that the adoptive parent must be a resident of this state in order to file a Petition to Adopt in Arizona.

ARS §8-104 permits the petitioner to initiate adoption proceedings in the county where the adoptive family resides or in the county where the child is a ward.

ARS §8-109 requires that the division's consent to adoption be filed with the Petition to Adopt and specifies that the potential adoptive parent or parents, an agency or the division may file a Petition to Adopt.

ARS §8-112 requires the division, an agency or an officer of the court to conduct and submit a social study to the court ten days before the hearing on the Petition to Adopt.

ARS §8-113(C) specifies that pending the final adoption hearing, the child is subject to further investigation by the division, an officer of the court or an agency.

ARS § 8-113(D) requires the court to hold the hearing on the Petition to Adopt as follows:

§ **Within 60 days** if the child has resided in the home of the prospective adoptive parent(s) for at least one year immediately preceding the filing of the petition for adoption. If the prospective adoptive parent is the step-parent of the child, this requirement only applies if the step-parent has been married to the birth or legal parent of the child for at least one year.

§ **Within 90 days** if the child is under six months of age or has resided in the home of the prospective adoptive parent(s) for at least six months preceding the filing of the petition for adoption. If the prospective adoptive parent is the step-parent of the child, this requirement only applies if the step-parent has been married to the birth or legal parent of the child for at least one year.

§ In all other cases, within six months after the filing of the petition to adopt.

ARS §8-113(F) requires the court to postpone a hearing on the Petition to Adopt pursuant to

ARS §8-113(D) if the court has not received the results of the state and federal criminal records check at least 48 hours before the final hearing. The court shall reschedule the hearing within 21 days after receiving the results.

ARS §8-113(H) requires the court to hold an expedited hearing on a motion that is supported by a sworn affidavit that an expedited hearing is in the child's best interest and any of the following is true:

- The child is diagnosed as suffering from a chronically debilitating, progressive or fatal disease.
- The prospective adoptive parent, natural or legal parent is diagnosed as terminally ill.
- The court finds other compelling reasons relating to the special need and welfare of the child.

Rules: Section R6-5-6622 of the Arizona Administrative Code contains Rules pertaining to the finalization of adoptive placements.

Revision History:
DES(07-2006)

Chapter 13: Section 11
Petitioning and Finalization

Legal Basis

Policy:

The Petition to Adopt shall be filed within six months of adoptive placement unless there are extenuating circumstances,

The department shall ensure that an adoptive family understands the legal consequences of proceeding to file the Petition to Adopt a child where the order terminating parental rights is or may be appealed.

The prospective adoptive parent may file the Petition to Adopt, through the Office of the Attorney General, the County Attorney or a private attorney and the department shall provide all necessary documentation to the attorney.

The family, in consultation with the attorney and CPS Specialist or contract agency case manager, will decide whether the Petition to Adopt for a child being adopted in Arizona is filed in the county where the adoptive family resides or in the county where the child is a ward.

A certified adoptive family may file more than one Petition to Adopt during a certification period.

Adoptions may be finalized six months after the petition is filed or sooner if the child meets the timeframe criteria or reasons to expedite.

Expedited adoption may be requested under any of the following circumstances:

- The child is diagnosed as having a chronically debilitating, progressive or fatal disease.
- The prospective adoptive parent or the natural parent or legal parent is diagnosed as being terminally ill.
- The court determines that other compelling reasons exist, based on the special needs and welfare of the child.

The adoptive family shall make the final decision on whether to file for an expedited adoption

proceeding. The department may either support or oppose this decision, based on consideration of the needs of the child.

When the prospective adoptive parent is the child's step-parent who has been legally married to the child's natural or legal parent for *at least one year* and the child has resided with the step-parent and parent for *at least one year*; or, is the adult sibling by whole or half-blood, aunt, uncle, grandparent or great-grandparent and the child has resided with the prospective adoptive parent *for at least one year*, the social study will consist of the results of the

- § state and federal criminal history records check; and
- § Child Protective Services records check, on all adults permanently living in the household. [ARS §8-112(D)]:

When the prospective adoptive parent has adopted a child in this state, or was appointed permanent guardian of the child in the proceeding three years or is a foster parent licensed by this state, and the child has resided with the prospective adoptive parent for at least six months, the social study will consist of:

- § the results of the Child Protective Services records check on all adults permanently living in the household; and
- § a review of any material changes in circumstances since the previous adoption, permanent guardianship or license renewal that affect the parent's ability to adopt. [ARS §8-112(E)]

For all other prospective adoptive parents, the department shall complete a social study. [ARS §8-112(B)]

To decide when to recommend petitioning for adoption, consider these questions:

- þ Is the child working through normal issues of adjustment to adoptive placement, including separation and loss, power and control, attachment and bonding?
- þ Does the family appear able to cope with the child's mechanisms for working out these issues? Does the family appear committed to addressing and resolving these issues with the child?
- þ Does the family have a support system to help them with future challenges related to the adoption?
- þ Does the child or the adoptive family's circumstances require expediting the

adoption?

Implementation and Procedures Guide

In some districts the CPS Specialist or contract agency case manager is responsible for all of these procedures; in others they are divided between the CPS Specialist or contract agency case manager and the courtesy supervision case manager. **Consult your supervisor to determine district procedures and responsibility for completion of the activities listed below.**

To obtain the agency's consent for adoption, request in writing a signed, witnessed and notarized Consent of Division to Adoption, AN-002, from the Program Manager or designee. Send the original and one copy to the courtesy supervision case manager, if applicable.

To prepare for the filing of the Petition to Adopt complete or have the adoptive parents complete the documents required by the attorney filing the petition which may include but not be limited to:

- The Affidavit of Expedited Adoption Procedures, AN-004, if requested to do so by the family and if the department concurs with the decision. Give one copy to the family; keep one to send to the attorney.
- The FC16400, Application for Adoption and check list attached to the application found in Forms Registry, or Adoption Certification Application window.
- The FC16500, Adoption Memorandum of Understanding, found in the Forms Registry.
- The Accounting of Adoption Fees, Expenses and Costs, FC-139-A.
- The Department of Health Services form, VS-5, Certificate of Adoption, parts I and II.
- The original Consent of Division to Adoption, AN-002.

Ensure that the family, who is adopting a child where the order terminating the parent-child relationship is or may be appealed, has read and understands the legal consequences should the appeal, be granted and the adoption decree overturned as described in the AN-012, Adoptive Placement Agreement. If not previously signed have the adoptive parent(s) sign the completed AN-012. Ensure the adoptive parent(s) initials Items F-J on the AN-012.

Compile and forward to the attorney representing the prospective adoptive parents other documentation as required by the attorney or the court.

To prepare for the finalization of the adoption petition:

For step-parent and specified relatives, ensure that the state and federal criminal history records and Child Protective Services records clearance of child abuse and neglect reports and history on all adults permanently living in the household are current within the last year. Do not complete a state and federal criminal records check on a natural or legal parent who has custody of the child to be adopted.

For former Arizona adoptive parents, Arizona licensed foster parents and permanent guardians complete a review of any material changes in circumstances that affect the prospective adoptive parent's ability to adopt since the parent's adoption certification or foster parent license renewal or permanent guardianship, using the Social Study - Part 2, CT 05200 found in the Court Document Detail. Also ensure that a current Child Protective Services records check of child abuse and neglect reports and history has been completed on all adults permanently living in the household.

For all other prospective adoptive parents, complete the social study using the Social Study, CT04500 found in the Court Document Detail.

Unless directed by the court to complete a comprehensive social study report submit the following documents to the court and the Office of the Attorney General, ten days prior to the hearing on the Petition to Adopt.

When the prospective adoptive parent is the *child's step-parent* who has been married to the child's natural or legal parent for at least one year and the child has resided with the step-parent and parent for at least one year; or is the *adult sibling* by the whole or half-blood, *aunt, uncle, grandparent or great-grandparent* and the child has resided with the prospective adoptive parent for at least one year submit:

- Social Study-Part 2, CT05200;
- copy of the Assessment for Kinship Foster Care or Significant Person Placement report, CT01100;
- results of the state and federal criminal history records check (within the last year);
- results of the current Child Protective Services records check;
- Arizona State Department of Health Services form VS-5, Certificate of Adoption;
- communication agreement, if applicable; and
- Addendum Report to Juvenile Court, CT00200, if applicable.

When the prospective adoptive parent has adopted a child in this state, or was appointed *permanent guardian* of the child in the proceeding three years or is a *foster parent* licensed by this state, and the child has resided with the prospective adoptive parent for at least six months, submit:

- Social Study-Part 2, CT05200;

- results of the current Child Protective Services records check;
- Arizona State Department of Health Services form VS-5, Certificate of Adoption;
- communication agreement, if applicable; and
- Addendum Report to Juvenile Court, CT00200, if applicable.

For all other prospective adoptive parents, submit the following:

- the Social Study report, CT04500;
- communication Agreement, if applicable;
- Arizona State Department of Health Services form VS-5, Certificate of Adoption; and
- Addendum Report to Juvenile Court, CT00200, if applicable

If the prospective adoptive parent retained an attorney to file the Petition to Adopt, send the above documents as applicable, excluding the results of the state and federal criminal history records check and the Child Protective Services records check, to the attorney.

After the Petition to Adopt has been filed, provide written notification of the date, time and location of the hearing on the petition to the adoptive parents.

If the adoptive family has applied for Adoption Subsidy ensure that the application has been reviewed by the Adoption Subsidy Review Committee. If Adoption Subsidy has been approved ensure that there is a signed Adoption Subsidy agreement prior to finalization of the adoption.

Attend the final hearing and testify, as required.

If necessary, facilitate the sharing of identifying information between the adoptive and birth parents. See **Releasing Identifying Information**, (Chapter 13, Section 13).

If a child has been in adoptive placement for six months and a Petition to Adopt has not been filed, convene a case conference to discuss reasons for the delay. Participants should include the supervisor, Program Manager or designee and others who are involved with the case.

Submit a report on findings and recommendations of the case conference to the DCYF Adoption Specialist at 940A **within 30 days**. If no consensus was reached, the report will be referred to the Program Administrator for disposition.

After finalization:

Terminate CMDP coverage and other CPS services such as day care.

Ensure that the dependency is dismissed.

Notify the AG and FCRB that the adoption is final.

If applicable, send a copy of the Order of Adoption showing the finalization date to the Adoption Subsidy Unit and DCYF Eligibility Unit.

For Native American children subject to the Indian Child Welfare Act, send a copy of the final adoption decree to Chief Division of Social Services, Department of Interior, Bureau of Indian Affairs, 1849 C Street NW. MS4660-MIB, Washington, DC 20240. Also include the following information:

- the name and tribal affiliation of the child;
- the names and addresses of the biological parents;
- the names and addresses of the adoptive parents; and
- the identity of any agency having files or information relating to the adoption.

DOCUMENTATION :

Document sending the packet to the Office of the Attorney General, the county attorney or the attorney representing the prospective adoptive parent using Case Notes window. Keep a copy of the packet documents in the child's hard copy record.

Document sending of the notification of the hearing date, time and location using the Case Notes window. File a copy of the notification letter in the child’s hard copy case record.

After the final Order of Adoption and the dismissal of dependency is received, close the child's record by updating the child's legal status on the Legal Status window, end dating open service authorizations, and completing the Case Closure window **within five days**. Route the hard copy records to closed records.

If the adoptive parent elects to remain on the CHILDS Provider (Adoption) Registry, add the adopted child to the Provider Maintenance Household window.

If the adoptive parent elects not to remain on the CHILDS Provider (Adoption) Registry, update the Provider Maintenance Status List Detail and Provider Maintenance Service Detail windows to close the adoption certification record and services. Send a letter to the family notifying them that their case record has been closed.

Revision History:

DES(07-2006)

Previous / Next

13-12

Legal Basis: ARS §8-129 requires the department to compile and provide to adoptive parents non-identifying information on their adopted child. The statute also requires the department to receive and compile supplemental information from any member of the adoptive family, an adult adoptee, or a family member of an adult adoptee for any adoption record held by the department.

Rules: Section R6-5-6615 of the Arizona Administrative Code addresses the sharing of non-identifying information.

Chapter 13: Section 12
Sharing Non-identifying Information

Legal Basis

Policy: The following individuals may request non-identifying information at any time:

- Adoptive parents or, if the adoptive parents have died, the adoptee's guardian;
- The adoptee, if he or she is 18 years of age or older; If the adoptee has died, the adoptee's spouse, if he or she is the legal parent or guardian of the adoptee's child;
- If the adoptee has died, any child of the adoptee who is 18 years of age or older;
- The birth parent of the adoptee or other biological children of the birth parent. [ARS §8-129(B)(3)]

Non-identifying information includes, but is not limited to, health and genetic history, social history and developmental history. It does not include information that specifies an individual, such as names or addresses.

The DCYF district responsible for the adoption of the child will be responsible for providing the non-identifying information to the requesting individuals.

Implementation and Procedures Guide

To request non-identifying information, any of the individuals identified above must submit a signed, notarized Affidavit, AN-037 to the DCYF district office in the county in which the adoption was finalized.

When non-identifying information is requested, the assigned district representative (according to district operating procedures) will:

- Complete the AN-036, Family History (Non-Identifying Information), if it is not already in the record.

- Supplement the form with a narrative addendum, if information is incomplete.

DOCUMENTATION :

Note in the case record the person who requested information, his or her relationship to the adoptee, and the date the information was provided.

Revision History:
DES(07-2006)

Previous / Next

13-13

Legal Basis: Sharing of identifying information among birth parents, adoptive parents and adoptees is controlled by several Arizona statutes, including ARS §§8-106, 8-120(D), 8-121(D), 8-121(E) and 8-534(B). These statutes ensure that:

- The birth parent may grant or withhold permission for the child to obtain identifying information about the consenting parent and the child upon the child reaching age 18.

- An adoptee who is 18 years of age may grant or withhold permission for release of confidential information to the birth parent.

- Birth and adoptive parents may share partial or complete identifying information when mutually agreed upon.

ARS §8-121(A) requires the court to transfer all files, records, reports and other documents in possession of the court relating to the adoption to the Arizona State Library, Archives and Public Record 100 years after the date of the final order of adoption. These records are then available for public inspection.

ARS §8-134 establishes the Confidential Intermediary Program within the Administrative Offices of the Courts. The program facilitates post-adoption searches for members of the adoption triad - adoptees, adoptive parents, and birth parents, and biological siblings of the adoptee if the sibling is 18 years of age. A confidential intermediary may contact an adoptee who is at least eighteen years of age under the circumstances identified above or when there is an identified health condition that may seriously affect the health of the adoptee or a direct descendant.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 13: Section 13

Releasing Identifying Information

Legal Basis

Policy: The department shall facilitate the release of identifying information to birth parents, adoptive parents and/or adoptees to the extent allowable by law.

The department shall allow certified Confidential Intermediaries to review the following documents:

- Report to the Court on Placement of Child;
- AN-036, Family History (Non-Identifying Information);
- Pre-placement Summary;
- Family and Home Evaluation and/or Family and Home Reevaluation;
- Adoptive Home Study;
- Court Reports on Petition to Adopt;
- Consent to Place Child for Adoption, AN-001, or ICWA Consent and Certification;
- Waiver of Notice and Appearance, AN-010;
- Religious Waivers;
- Termination of Parental Rights Order;
- Adoptee's Birth Certificate;
- Parent's Death Certificate; and
- Communication Agreements.

A Confidential Intermediary may not remove or photocopy any documents inspected.

The department shall not allow certified Confidential Intermediaries to inspect documents related to:

- child protective services;
- foster care;
- dependency;
- termination of parent-child relationships;
- case notes;
- face sheets; and

- other documents not specified by law.

Implementation and Procedures Guide

To manage identifying information about the adoptive parent, request that adoptive parents complete and sign an Adoptive Parent Release of Identifying Information, FC-173, specifying what information, if any, they agree to share with the birth parents.

If adoptive parents do not wish to share any identifying information about themselves, keep the signed Adoptive Parent Release of Identifying Information, FC-173, in the child's adoption record.

If the adoptive parent agrees to share information about themselves and the birth parents wish to receive it, mail the birth parent the Adoptive Parent Release of Identifying Information, FC-173. It should be mailed, certified mail restricted delivery, to the birth parent's address as recorded on the Birth Parent's Release of Identifying Information, FC-174, after the finalization of the adoption.

If the adoptive parents wish to receive information that the birth parents have agreed to share:

- After finalization, provide the adoptive parents with the Birth Parent's Release of Identifying Information, FC-174.
- Have the adoptive parents sign the form, acknowledging receipt. Keep a copy of the form in the family's record.

Refer requests from a Confidential Intermediary to the district's Confidential Intermediary contact person.

Best Practice Tip:
Often adoptive parents may be reluctant to allow the exchange of information with the birth families. While they are allowed to decide what they want to share –or if they want to share—CPS Specialists or contract agency case managers should explore with the adoptive family the benefit for the child when there is some kind of interaction and information sharing between the child and their family. Children being adopted, especially children who had a relationship with their birth families may need to know that their family is going to be okay, before they are able to adjust to their new setting. Additionally, if adoptive families are willing to keep the birth parents involved in the life of their adopted child, it has the potential to enrich both the life of the child and the adoptive family.

DOCUMENTATION :

Document the sharing of identifying information about the birth parent with the adoptive parent by maintaining a copy of the signed Birth Parent's Release of Identifying Information, FC-174, in the family's hard copy record.

Document the sharing of identifying information about the adoptive parent with the birth parent by maintaining the certified mail receipt in the family's hard copy record.

Document the provision of information to Confidential Intermediaries in the case record. Identify the information that was provided, and date and sign the entry.

Revision History:
DES(07-2006)

Previous / Next

13-14

Legal Basis: ARS §8-116.01(A) permits the parties to an adoption proceeding to enter into an agreement regarding communication with a child adoptee, the adoptive parents and a birth parent.

ARS §8-116.01(B) specifies that a communication agreement is not enforceable unless the agreement is in writing and approved by the court. The department must approve an agreement involving a child who is a ward of the court placed in the custody of the department.

ARS §8-116.01(C) states that the adoptive parent may terminate contact between the child and birth parent at any time if the adoptive parent believes that the contact is not in the child's best interest.

ARS §8-116.01(D) states that the court shall not approve a communication agreement unless the court finds the agreement is in the child's best interests. The court may consider the wishes of a child who is at least age 12 or older.

Revision History:
DES(07-2006)

Chapter 13: Section 14
Communication Agreements

Legal Basis

Policy: The department shall support communication among the child, the birth parent and adoptive parents when communication is in the child's best interest.

The department shall inform birth parents and adoptive parents that state law permits communication among the child, birth parent and adoptive parent after finalization of an adoption.

The department shall provide to the birth parent and the adoptive parent information about communication agreements.

Prior to the finalization of the adoption, if requested, the department may participate in the development of a communication agreement. The department will not participate in negotiating communication agreements between birth parents and adoptive parents or facilitating communication after finalization of an adoption.

The department must approve an agreement involving a child who is a ward of the court placed in the custody of the department.

To determine whether a communication agreement is in the best interest of the child consider these question:

- Has the child adjusted to the adoptive placement?
- Has the child worked through issues of separation and loss?
- Has the child indicated a desire to maintain contact with the birth parent?
- What type of future contact is appropriate given the history of the parent-child relationship?
- Is communication between the birth parent and child likely to cause harm to the child's health, safety and welfare?

BEST PRACTICE ISSUES:

One of the challenging issues workers face when constructing a Communication Agreement is that adoptive parents may not desire this contact. They may wish that the child coming into their home would "let go" of the life they had before being adopted. However most children have memories of their family, may be worried about their birth parent and may need to communicate with them as part of their process of moving on. Closing off this opportunity for communication may leave a child without the necessary opportunity to process their emotions. CPS Specialists or contract agency case managers should help adoptive families understand and explore the many kinds of communications children can have with their birth family and how these interactions may help the child adjust to his/her new family.

Adoptive parents, especially adoptive parents of older children have to accept that the child had a life before coming into their homes and may need and want to stay connected to that life, to some extent.

Implementation and Procedures Guide

Discuss with the birth parent, adoptive parent and child, if age 12 or older the following characteristics of a communication agreement**:**

- Communication agreement is not enforceable unless it is in writing and approved by the court.
- A communication agreement must contain a statement that the adoptive parent may terminate contact between the birth parent and child at any time that the adoptive parent believes that the communication is not in the child's best interest.
- A communication agreement is enforceable even if it does not disclose the identity of the parties to the agreement.
- A communication agreement must be approved by the adoptive parent, the birth parent with whom the agreement is being made and the department if the agreement involves a child who is a ward of the court, placed in the custody of the department.
- The court cannot approve a communication agreement unless the court finds that the agreement is in the child's best interest. The court may consider the wishes of a child age 12 and older.
- Failure to comply with an agreement is not grounds for setting aside an adoption decree, revocation of written consents to an adoption decree or relinquishment of parental rights.
- The court retains jurisdiction to hear motions to enforce or modify a communications agreement.
- The court will not enforce or modify a communication agreement unless the person filing the motion makes a good faith attempt to mediate the dispute. The court may consider the wishes of a child age 12 and older in determining whether to modify a communication

agreement.

Provide birth parents and adoptive parents who express a desire to enter into a communication agreement a list of Arizona licensed adoption agencies and Confidential Intermediaries who may be willing to assist the parties in negotiating a communication agreement. There may be a fee for this service.

Request the assigned Assistant Attorney General review the agreement prior to approving a communication agreement involving children who are wards of the court, placed in the custody of the department.

Before the department representative declines to approve a communication agreement, efforts must be made to resolve areas of disagreement.

Obtain supervisory approval when declining to approve a communication agreement that the birth parent and adoptive parents have approved.

DOCUMENTATION :

Document discussion with the birth parent and adoptive parents of the characteristics of a communication agreement using the Case Notes window.

Document supervisory approval of a decision not to approve a communication agreement using the Case Notes window designated as supervisory contact type.

Document the reason a communication agreement is not in the child's best interest using the Case Notes window.

Revision History:
DES(07-2006)

Previous

14-1

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) is the federal law that makes available federal funds to assist in the adoption of children with special needs.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (P.L. 99-272) allows states to extend Title XIX Medicaid eligibility to children under state adoption subsidy agreements and requires Medicaid to be provided in the child's state of residence.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) substantially modified requirements to receive federal funds to assist adoptions.

ARS §§8-141 through 8-145 address the adoption subsidy program in the State of Arizona.

ARS §§8-161 through 8-166 address nonrecurring adoption expenses.

ARS §§8-171 through 8-173 specify interstate adoption subsidy requirements.

Rules: Sections R6-5-6701 through R6-5-6711 of the Arizona Administrative Code provides Rules governing adoption subsidy.

Revision History:
DES(07-2006)

Chapter 14: Section 1

Overview of Adoption Subsidy

Legal Basis

Policy: The adoption subsidy program supports the department's efforts to provide permanent adoptive placements for children who cannot be cared for by their birth parents to ensure that no foster child is considered unadoptable solely because of his or her specials needs.

A child is eligible for adoption subsidy if he or she:

- is in the custody of the department or of a licensed private child placing agency in Arizona;
- the child cannot or should not be returned to the care of the birth parents, as evidenced by an order of termination of parental rights, parental consent for adoption and/or birth parent death certificate;
- a reasonable, but unsuccessful, effort has been made to place the child with appropriate parents without providing adoption assistance unless it would not be in the best interest of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while their care as a foster child or relative;
- the State has determined that one of the following special needs exists because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance:

    - physical, mental or developmental disability;
    - emotional disturbance;
    - high risk of physical or mental disease that may result in a debilitating condition;
    - high risk of developmental disability that may result in a debilitating condition;
    - age six or older at the time of application for adoption subsidy;
    - sibling relationship when such factor impedes the child's adoptive placement;
    - racial or ethnic factors when such factor(s) impede the child's adoptive placement; and
    - high risk of severe emotional disturbance if removed from the care of the child's foster parent or relative.

The department may provide the following types of adoption subsidy, as determined by the needs of the child:

- medical coverage through eligibility for Title XIX;
- special services subsidy;
- maintenance payments; and
- reimbursement of nonrecurring adoption expenses.

Adoption subsidy maintenance cannot exceed the amount the child is receiving or would be eligible to receive in family foster care and is based upon the assessed needs of the child and the circumstances of the family.

No adoption subsidy payment shall be made until the adoptive parents and the Adoption Subsidy Supervisor or designee have signed an Arizona Adoption Assistance Agreement, AN-054.

The adoption subsidy agreement remains in effect regardless of the state of residence of the adoptive parents.

The adoption subsidy may be terminated if the State determines that the adoptive parents are no longer legally responsible for the support of the child or the adoptive parents are no longer providing any support to the child.

The Adoption Subsidy Program is managed by DCYF Central Office, with offices in Phoenix and Tucson. Overall responsibility for providing services for adoption cases are shared as follows:

- The child's local office CPS Specialist or contract agency case manager assists families with the process of adopting children in the department's custody including informing the adoptive parents about the Adoption Subsidy program. The local office case manager may be an adoption CPS Specialist, a CPS Specialist, a DDD Support Coordinator, or a private agency case manager.

- The child’s local office case manager is responsible for assisting the adoptive family in applying for adoption subsidy including obtaining the necessary documentation.

- Adoption Subsidy Specialist is responsible for the case after finalization of the adoption, when the local office case manager closes his or her case.

For children in the custody of private agencies, the department's Adoption Subsidy Supervisor shall provide information and forms necessary to enable the agency to assist families in applying for subsidy on behalf of children in their custody.

The Adoption Subsidy Specialist will be responsible for private agency cases after finalization of

the adoption.

The adoption subsidy will continue until the child's 18th birthday if the adoptive parents remain legally and financially responsible for the child. The adoption subsidy may continue through the age of 21 if the child is enrolled in and regularly attending school, unless the child has received a high school diploma or certificate of equivalency (GED).

Revision History:
DES(09-2006)

Next

14-2

Legal Basis: ARS §§8-143 through 8-144 address the application process.

Rules: Section R6-5-6705 and Sections R6-5-6707 through R6-5-6709 of the Arizona Administrative Code provides Rules for application for adoption subsidy.

Revision History:
DES(07-2006)

Chapter 14: Section 2

Applying for Adoption Subsidy

Legal Basis

Policy: An application for adoption subsidy may be filed on behalf of any Arizona child under the care of the department or of a licensed private child placing agency at any time prior to the finalization of the adoption.

An application for adoption subsidy can be processed after the primary case plan goal is changed to adoption and the child is placed for adoption, as evidenced by an adoptive placement agreement. If the application is approved, the adoption subsidy agreement can be signed after the child is legally free and the Petition to Adopt has been filed.

The adoption subsidy agreement must be signed by the adoptive parents and the Adoption Subsidy Supervisor or designee prior to finalization of the adoption. [ARS §8-144(A)]

Adoption subsidy will terminate if an adoption is not finalized within one year after the filing of the Petition to Adopt. Should the family later receive a final hearing date, they may apply for adoption subsidy at that time.

An application for a new or increased subsidy may be filed after finalization only upon submission of documentation of an undiagnosed pre-existing condition. [ARS §8-144(D)].

Implementation and Procedures Guide

Child's CPS Specialist, private or contract agency adoption case manager, and DDD Support Coordinator

Assures the adoptive family reads and signs page 1 of the Adoptive Family Subsidy Application, AN-018-A

Assist the adoptive family in completing the Adoptive Family Subsidy Application, AN-018-A, pages 2 and 3.

Assist the family in obtaining documentation that demonstrates the child meets the criteria of a special needs child.

Assist the family in obtaining documentation of each of the conditions to be covered by subsidy. Include reports and evaluations that identify diagnosis and prognosis. If treatment is in progress or imminent, include a treatment plan specifying number of sessions and participants. All documentation must be current within one year of the application.

Follow these requirements for documenting the child's diagnosed conditions or high risk of developing specific condition(s):

- § Medical conditions must be diagnosed by one or more health service professionals approved by the department.

- § Dental conditions must be diagnosed by a dentist or an orthodontist.

- § Mental/behavioral health conditions must be diagnosed by one or more psychiatrists or psychologists or certified mental health professional approved by the department.

If a request for maintenance is applicable, assist the family in identifying and listing on the application (AN-018-A) the child's conditions, behaviors, services and family circumstances that support the maintenance payment request.

Have the family complete the AN-020, Rate Evaluation.

If a request for non-recurring adoption expenses is applicable, assist the family in identifying and specifying the expenses subject to reimbursement. Actual or estimated costs must be specified in the application. Documentation of the exact costs incurred including receipts and bills must be submitted before reimbursement can be made and must be received **within nine months** of the final adoption.

Assist the family in identifying community and other available resources and child benefits.

Have the family read page 4 of the application, statements of understanding, answer any questions raised and ensure the family signs this page.

Read and complete the following:

- þ Page 5 instruction of the Adoption Subsidy and Title IV-E section of the AN-018-A, Adoptive Family Subsidy Application, and
- þ Adoption Subsidy and Title IV-E Application section of the AN-018-A, Adoptive Family Subsidy Application, pages 6 and 7 (Adoption Subsidy Checklist).

Based on documentation from professionals or the child's circumstances (sibling relationship, racial or ethnic factors, etc.), determine the child's special needs that qualify him/her for Adoption Subsidy.

If the child's special needs criteria is only met because of "high risk of severe emotional disturbance if removed from the care of the foster parents or relatives", documentation must include a diagnosis by a psychiatrist or psychologist and documentation by the CPS Specialist, private or contract agency adoption case manager, and DDD Support Coordinator which must include the following information:

- § child's identification as a member of the family of the foster parent or relative;
- § the foster parent or relative identification of the child as a member of the family; and
- § child's inability to establish significant emotional ties to another family if permanent placement with the foster parent or relative is denied.

Determine what efforts were made to place the child without subsidy.

If *reasonable efforts* to place the child without subsidy *were not made* due to significant emotional ties between the child and the foster parents or relatives (prospective adoptive parent), check the appropriate box, fill in the appropriate relationship to the child on the Adoption Subsidy and Title IV-E Application section of the AN-018-A, Adoptive Family Subsidy Application and prepare an assessment of significant emotional ties to include the following information in the case notes, form or letter:

- þ age of the child;
- þ length of placement in the home;
- þ number of previous placements and disruptions;
- þ any history of bonding and attachment problems;
- þ any regression in development or medical condition which would likely occur if the child is removed from the home; and
- þ a statement that the adoptive parents are unable to adopt without adoption subsidy

If a reasonable but unsuccessful attempt was made to place the child without subsidy, check the appropriate box on the Adoption Subsidy and Title IV-E Application section of the AN-018-A, Adoptive Family Subsidy Application and indicate the number of homes reviewed. For department adoptions, provide a copy of the case notes or form documenting

efforts to place without adoption subsidy.

For private agency adoptions provide a copy of the Assessment Service Plan documentation required per Arizona Administrative Code R6-5-6613 and Placement Decision documentation required per Arizona Administrative Code R6-5-6614.

Enter current daily foster care rate on the adoption subsidy application, AN-018A and the date established.

Obtain your supervisor's signature on the Adoption Subsidy and Title IV-E application section of the AN-018-A, Adoptive Family Subsidy Application.

Route the forms, along with all supporting documentation, to the Adoption Subsidy Unit having jurisdiction for the area in which the family resides.

If the Adoption Subsidy Unit sends notice that the application is incomplete, provide the missing information or documentation within 30 days of the date of the notice.

Adoption Subsidy Specialist

Review documentation and establish an adoption subsidy record.

If the application is incomplete, call **or** send notice to the local office case manager specifying what information or documentation is missing. If the missing information or documentation has not been provided within 30 days of the date of the notice, close the record. An applicant whose record has been closed may later apply.

Forward the eligibility documentation to the Eligibility Unit, Site Code 101C, for determination of the child's Title IV-E and Title XIX eligibility status.

If the ASRC approves subsidy (by signing the Review Committee Checklist, AN-019), prepare the Arizona Adoption Assistance Agreement, AN-054**.**

Route the agreement to the child's local office case manager to obtain the family's signatures. Forward the signed agreement to the Adoption Subsidy supervisor for his/her signature.

If subsidy is denied, send a denial letter to the adoptive parent(s), including:

-

the reason for denial;

- their right to appeal;
- the time frames for appeal; and
- appeal initiation procedures.

DOCUMENTATION :

Adoption Subsidy Specialist

Ensure that the primary adoptive parent is entered on the CHILDS Provider Registry.

Enter the case in CHILDS. Create a new identity for the adoptive child by using the adoptive surname, pseudo social security number and new HLCI number.

If subsidy was approved, enter the date the agreement was signed by the Adoption Subsidy Supervisor as the agreement date on the Adoption Subsidy Application window. Complete the Maintenance Detail and Pre-Existing Conditions Detail windows.

If subsidy was denied, keep a copy of the denial letter in the file.

File the original Arizona Adoption Assistance Agreement, AN-054, in the adoption subsidy case record . Send copies to:

- § the DCYF Eligibility Unit, Site Code 101C;
- § the child's CPS Specialist; and
- § the child's adoptive parent(s), along with a letter of introduction.

Revision History:
DES(07-2006)

Previous / Next

14-3

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and ARS §8-144(c) require adoption subsidy cases to be reviewed at least annually.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 14: Section 3

Managing Adoption Subsidy Cases

Legal Basis

Policy: To ensure continuity of care, the child's local office case manager shall remain the primary case manager until the adoption is final. The Adoption Subsidy Specialist shall become the primary case manager after the adoption is final.

Case management services are aimed at supporting the integration of the child within the adoptive family.

The department shall ensure that the case of every child receiving adoption subsidy is reviewed annually.

Implementation and Procedures Guide

Adoption Subsidy Specialist

Prior to finalization of the adoption:

- Refer all requests for services to the child's local office case manager.
- If necessary, conduct a joint staffing of the case for any child who appears to be experiencing serious medical, emotional or behavioral problems in the home.

After finalization of the adoption:

- Assist families locate and utilize supportive and preventive services in their communities. Visit the child and family upon request of the family.
- Assure families are aware of Title XIX benefits and assist in accessing services for which they are eligible.
- Attend staffings as part of the treatment team when requested by the family.
- Refer requests for special services to the Adoption Subsidy Supervisor and/or Adoption Subsidy Review Committee (ASRC) for prior authorization.
- When residential treatment or other out-of-home placement is requested refer the family to public, private and/or community resources and explore and advocate for alternative services that will maintain the child in the home. Inform the family that if out-of-

home placement is authorized, the maintenance payment may be re-negotiated.

When applicable, encourage parents to make a written request to the child's school for an evaluation to determine if the child is eligible for special education and/or related services. Encourage parents of children receiving special education or related services, who believe the child's needs are not being met, to request a review of the child's Individual Educational Plan (IEP).

Conduct an annual review of all children in cooperation with the adoptive parents. To conduct the review:

- Send the adoptive parents the Adoption Subsidy Annual Review, AN-028, and the Rate Evaluation, AN-020.
- Use the returned forms to determine the appropriateness of continued adoption assistance and the appropriateness of the assigned rates.
- Contact the family if questions or concerns arise.
- Request a review of the case by the ASRC if needed.

When notified that a child is not living in the home, ask the family for documentation that they remain legally responsible for the child, that the family is providing support and the plans for the child to return to the family. Send the case to the ASRC for determination of whether the Adoption Subsidy will be renegotiated or terminated.

If notified by CPS that an adoption subsidy child has been removed from the home, after verifying that contact will not interfere in the CPS investigation, contact the adoptive family and inform them that the subsidy may be renegotiated when the child is in the care, custody and control of a state agency.

If the State determines that the adoptive parents are no longer legally responsible for the support of the child or the adoptive parents are no longer providing any support to the child the Adoption Subsidy may be terminated. Send the case to the ASRC for determination of whether the Adoption Subsidy will be terminated.

DOCUMENTATION :

For children with an open Adoption Subsidy case who are in the custody of CPS:

Update CHILDS to reflect any changes in maintenance and special services authorizations. Do *not* end-date the agreement on the Adoption Subsidy Application window.

Instruct CPS to open a separate case, and to use that case number when authorizing services, to prevent funding errors.

When the child returns to the adoptive home, send an Annual Review, AN-028 and Rate evaluation, AN-020 and re-negotiate the Adoption subsidy to begin when foster care payments terminate.

Revision History:
DES(09-2006)

Previous / Next

14-4

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) makes Title IV-E adoption subsidy children categorically eligible for Title XIX Medicaid (if U.S. citizens).

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (P.L. 99-272) allows states to extend Title XIX Medicaid eligibility to children under state adoption subsidy agreements and requires Medicaid to be provided in the child's state of residence (if U.S. citizens).

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires states to provide health insurance coverage for adoption subsidy children who could not be placed for adoption without medical assistance because the children have special needs for medical, mental health, or rehabilitative care.

ARS §36-2901 defines children under a state adoption subsidy agreement as optionally eligible for medical coverage pursuant to Title XIX of the Social Security Act.

Rules: Not Applicable

Revision History:
DES(07-2006)

Chapter 14: Section 4

Providing Medical Coverage

Legal Basis

Policy: The department shall enroll children (U.S. citizens) in the Title XIX Medicaid program in their resident state upon finalization of adoption. The parents may select a health plan or one will be assigned by the Arizona Health Care Cost Containment System (AHCCCS).

For Arizona adoption subsidy children residing in another state:

If the child has a Title IV-E agreement or resides in a state that adheres to the Interstate Compact on Adoption and Medical Assistance (ICAMA), the department shall submit eligibility information and initiate enrollment in the Title XIX Medicaid program in the child's state of residence.

The department shall provide the same level of Title XIX services for a child receiving Title XIX services residing in another state as the child would have received if he or she resided in Arizona.

The department will continue to be responsible for agreed-upon special services related to the pre-existing conditions on the Adoption Subsidy agreement that are not covered under the resident state's Title XIX Medicaid program if the services are prior authorized by the Arizona Subsidy program.

Implementation and Procedures Guide

Adoption Subsidy Specialist

When a final Order of Adoption is received, ensure that the Eligibility Unit has recorded the eligibility determination in CHILDS and transmitted the medical eligibility to AHCCCS.

Contact the family and encourage them to obtain a new social security number for the adopted child. When the new number is received, do **not** update CHILDS. Record the Social Security Number in the hard copy case record.

When notified that an adoption subsidy child is moving out of Arizona, or moving from one state to another, notify the ICAMA Administrator and the Eligibility Supervisor of the anticipated move and complete the necessary ICAMA forms**.**

Revision History:
DES(07-2006)

Previous / Next

14-5

Legal Basis: ARS §8-144 provides for adoption subsidy maintenance payments.

Rules: Sections R6-5-6705 and R6-5-6706 of the Arizona Administrative Code address adoption subsidy maintenance payments.

Revision History:
DES(07-2006)

Chapter 14: Section 5

Providing Maintenance Payments

Legal Basis

Policy: Monthly maintenance payments are appropriate only when they facilitate the goal of adoption. The adoptive family is responsible for payment of all expenses incurred on behalf of the child; the maintenance payment can assist the family, but it is not intended to cover all expenses involved in the care of the child.

Maintenance payments shall not exceed the rate of family foster home care for which the child is eligible.

The maximum maintenance payment rate shall not exceed the Special III rate of foster care or the professional/therapeutic rate if applicable.

Maintenance payments may be increased proportionately to increases in the daily rate for foster home care.

If the State determines that the adoptive parents are no longer legally responsible for the support of the child or the adoptive parents are no longer providing any support to the child, no maintenance payments shall be made to the parents.

If a child is placed in a hospital, residential treatment facility or other out-of-home placement, the monthly maintenance payment may be renegotiated.

All direct benefits available to the child shall be subtracted from the subsidy. Such benefits include but are not limited to Social Security (SSA) and Veteran's (VA) benefits. It is not considered a direct benefit to the child if the compensation is part of an award to the adoptive parent that replaces wages such as retirement or disability payments for the adoptive parent.

Implementation and Procedures Guide

When a child is or may be eligible for direct benefits, such as SSI, SSA, or VA benefits:

Before the adoption is final:

- The department continues to be the representative payee.

§ When the adoptive parent is not the foster parent, the department may pay the adoptive parents the amount of the maintenance payment for which the child has been determined eligible.
§ When a private agency or an adopting parent is payee, the amount of the benefit must be deducted from the adoption subsidy maintenance payment. In no case shall a combination of adoption subsidy and direct benefits exceed the amount of the maintenance payment for which the child was approved.

After the adoption is final:

§ The adoptive parent(s) must apply as representative payee for the benefits being received.
§ If the adoptive parent(s) become representative payee, the amount of all benefits received other than SSI shall be deducted from the maintenance payment.
§ The adoptive parent is responsible for notifying the Social Security Administration of the dollar amount of the adoption subsidy maintenance payment when the child is eligible for SSI benefits**.**

DOCUMENTATION :

Adoption Subsidy Specialist

Initiate monthly maintenance payments by entering the Adoption Subsidy Agreement date on the Service Authorization and Service Authorization Provider Match windows as the begin date

If an adoptive parent becomes or is payee for a child receiving benefits other than SSI, all benefits are deducted from the maintenance payment using the Co-Pay window.

If adoptive parents report that they have not received a maintenance payment:

§ Determine whether the check was issued and whether the address was correct.
§ Inform the parents that there is a ten day waiting period to determine if the check is returned to DES.
§ If the check is not returned in ten days, a bond of indemnity may be issued to the parents, along with instructions on completing it and obtaining a new check.
§ Contact the payment processing unit.

Revision History:
DES(07-2006)

Previous / Next

14-6

Legal Basis: ARS §8-142 and ARS §8-144 address special services subsidy.

Rules: Section R6-5-6706 of the Arizona Administrative Code addresses special services subsidy.

Revision History:
DES(07-2006)

Chapter 14: Section 6

Providing Special Services Subsidy

Legal Basis

Policy: Special services subsidy is provided for extraordinary, infrequent or uncommon needs related to the pre-existing special needs conditions of the child on the Adoption Subsidy agreement.

The Adoption Subsidy Program is the payer of last resort. The adoptive family must exhaust all other resources, including private insurance, Arizona Health Care Cost Containment System (AHCCCS)/Medicaid, Regional Behavioral Health Authorities, Arizona Long Term Care System (ALTCS) and the public school district services before applying to the Adoption Subsidy Program for special services payment. [ARS § 8-144(A)]

Special services must be:

- § recommended by an appropriate professional approved by the department as necessary to maintain or enhance physical functioning, emotional well-being of the child or family integration;
- § related to a condition listed on the Adoption Subsidy agreement;
- § provided by an appropriate professional approved by the department;
- § provided in the least restrictive environment;
- § in close proximity to the family residence;
- § documented as effective at least annually; and
- § be an accepted “Standard of Treatment” as defined by AHCCCS.

All special services must be authorized by the Adoption Subsidy program prior to receipt of the service.

The family is expected to participate to the extent possible in providing special services.

Special services payments do not cover child care, summer camp, personal and clothing allowances, or social or recreational activities. However, all children who are eligible for Title

IV-E are also eligible for Title XX social services in their community (P.L. 96-272), except Title XX child care services. Applicants must meet standard child care eligibility criteria.

Payment for services that are prior authorized will be made according to the AHCCCS, DES or Adoption Subsidy fee schedules or rates as applicable for the service rendered. Payment will be made directly to the parent who will pay the provider except in the case of a high cost service when payment may be made directly to the provider at the request of the adoptive parent.

The Adoption Subsidy Specialist may approve requests for respite up to 288 hours (12 days) per year. The need for respite must be related to the child's special needs. If additional respite is necessary, the request must include documentation of the special circumstances or conditions that make it necessary. Assessment of need should be provided by a professional who has a relationship with the family or by the Adoption Subsidy Specialist. Additional respite requires authorization by the Adoption Subsidy Review Committee (ASRC). Respite will be paid according to the Adoption Subsidy fee schedule and may not substitute for day care or other services.

Claims for special service payments must be submitted no later than nine months after a service has been rendered or the claim shall not be paid.

An amount up to $5,000 may be negotiated with the family for funeral expenses.

Modifications or repairs to structures, vehicles or equipment are limited to modifications or repairs related to the special needs conditions of the child as listed on the Adoption Subsidy agreement. Requests must include documentation of necessity by a professional, indication of attempts to finance the modification or repairs using other resources, and three estimates from qualified vendors as to cost of the proposed modification or repair. Adoption Subsidy does not cover additions to structures.

Implementation and Procedures Guide

Adoption Subsidy Specialist

To initiate requests for special services, have the family submit a written request for the service with the required documentation. Review requests with the Adoption Subsidy Supervisor and refer requests as necessary to the ASRC for prior authorization.

Requests for special services must include:

- § documentation by the primary care professional that the service is necessary;
- § documentation that the service is related to a condition listed on the Adoption Subsidy agreement; and
- § documentation that all public and private resources have been exhausted.

If the request is approved, advise the family of the specifics of the approval and the rate and advise the family to submit a claim after the service has been performed, but no later than **nine months** from the date of service.

If the request is denied, notify the family of the denial reason, their right to appeal the denial **within 15 calendar days** of the postmark of the decision letter, and the procedures to initiate an appeal.

The Adoption Subsidy Claims Specialist will:

- § Check payment requests for completeness and necessary prior authorizations.
- § Coordinate with third party payers to ensure that primary payments have occurred.
- § Review previous claims forms to avoid duplicate payments.
- § Make payment according to AHCCCS, DES or Adoption Subsidy fee schedule and procedures.

Revision History:
DES(07-2006)

Previous / Next

14-7

Legal Basis: The Federal Tax Reform Act of 1986 amended the Social Security Act [Title 42, Chapter 7, Subchapter IV, Part E §673(a)(6)(A and B)] to allow for reimbursement of nonrecurring adoption expenses.

ARS §§8-161 through 8-166 address nonrecurring adoption expenses.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 14: Section 7

Nonrecurring Adoption Expenses

Legal Basis

Policy: A one-time payment, up to $2,000, is available to reimburse parents for reasonable and necessary nonrecurring adoption expenses incurred in the process of adopting a child with special needs.

To be eligible for reimbursement of nonrecurring adoption expenses:

- The child must be unable to return to the home of his or her birth parents (as evidenced by voluntary consents, death certification or court orders terminating parental rights).
- The child must have special needs (as defined in Section 1) that make financial assistance necessary in order to achieve adoption.
- A reasonable, but unsuccessful, effort has been made to place the child with appropriate parents without providing adoption assistance unless it would not be in the best interest of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while their care as a foster child or relative

Reimbursable nonrecurring adoption expenses may include:

- adoption fees, court costs, and attorney fees;
- other expenses directly related to the legal process of adoption (such as fingerprint costs, home study costs, psychological and physical examination expenses, and costs for supervision of the placement before finalization); and
- transportation costs and reasonable cost of food and lodging for the child or adoptive parents incurred to complete the adoption process. (ARS §8-161)

Reimbursement is limited to the actual costs incurred for reasonable and necessary expenses. Any single expense is subject to review by the department. If the expense is found to be over the prevailing rate for such services, the department may reimburse at a lesser rate.

The nonrecurring expense agreement must be signed by the adoptive parents and the Adoption Subsidy Supervisor prior to the final decree of adoption. [ARS §8-161(B)]

Reimbursable expenses shall not include:

- § family counseling prior to the decree of adoption;
- § costs of remodeling or renovating the adoptive parents' home; and
- § other costs not directly related to the legal process of adoption. [ARS §8-164(C)]

When the adoption of the child involves interstate placement, the state that enters into an Adoption Subsidy agreement shall be responsible for paying the nonrecurring adoption expenses of the child.

In cases where there is interstate placement but no adoption subsidy agreement, the state in which the final adoption decree is issued shall be responsible for reimbursement of eligible nonrecurring expenses.

Implementation and Procedures Guide

Child's Local Office CPS Specialist, private or contract agency case manager and DDD Support Coordinator

Before finalization of the adoption, discuss the nonrecurring expense program with the adoptive parents.

If the adoptive parents wish to apply, assist them in completing the Nonrecurring Adoption Expense section of the Adoption Subsidy Application AN-018 and documenting the costs incurred or estimated, if actual costs have not yet been determined.

Submit this to the Adoption Subsidy Unit for review and approval or denial by the Adoption Subsidy Supervisor or Adoption Subsidy Review Committee.

Instruct the family to submit a copy of the final Order of Adoption, within nine months of finalization, along with documentation of expenses if not previously submitted.

Adoption Subsidy Supervisor

If the application is approved, have the Adoption Subsidy Specialist complete the Nonrecurring Expenses section of the Arizona Adoption Subsidy Agreement AN-054 or Non-recurring Adoption Subsidy Agreement.

If the application is denied, complete and sign the Decision Letter, and send it to the adoptive parents advising them of their right to appeal **within 15 calendar days** of the postmark of the decision letter.

When the final Order of Adoption and documentation of expenses is received, determine which expenses are to be paid and for what amount and authorize the payment.

Revision History:
DES(07-2006)

Previous / Next

14-8

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 14: Section 8

Reviewing Requests for Adoption Subsidy

Legal Basis

Policy: The Adoption Subsidy Review Committee (ASRC) is responsible for ensuring compliance with federal and state statutes, rules and regulations for adoption subsidy and for reviewing requests for prior authorization of special services.

The ASRC consists of at least three employees of the State of Arizona who have expertise in adoption subsidy policy and procedures. Whenever possible, at least one member represents the Department's Division of Developmental Disabilities.

The ASRC or the Adoption Subsidy Supervisor may request that an objective professional review any case to determine the appropriateness of treatment plans, the necessity for testing or evaluation, or the appropriateness of placement.

If the ASRC cannot reach consensus, the DCYF Adoption Manager shall make the final decision.

Adoption Subsidy Specialist

Refer all initial adoption subsidy applications to the ASRC with a Review Committee Checklist, AN-019.

Refer Supplemental Adoption Subsidy Applications, AN-018-E, to the ASRC for review and approval.

Refer special services requests to the ASRC with an Adoption Subsidy Review Committee Service Authorization, AN-049.

Revision History:
DES(07-2006)

Previous / Next

14-9

Legal Basis: ARS §8-145 addresses appeals of adoption subsidy decisions.

Rules: Sections R6-5-2401 through R6-5-2405 of the Arizona Administrative Code addresses appeals.

Revision History:
DES(07-2006)

Chapter 14: Section 9

Appeal of Decisions Regarding Adoption Subsidy

Legal Basis

Policy: An applicant may appeal the department's decision to deny, reduce or terminate adoption subsidy.

A request for an appeal must be made in writing no later than **15 calendar days** from the postmark of the decision letter. The request for appeal shall specify the action being appealed, the reasons for the appeal, and a brief summary of why the department's action was erroneous, unlawful or improper.

The DCYF Adoption Subsidy Program Specialist or Adoption Subsidy Supervisor shall coordinate appeals in accordance with the requirements of DES 5-24, Appeals and Hearings.

Revision History:
DES(07-2006)

Previous

14-10

Legal Basis: The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 addresses medical coverage for adoption subsidy children who move across state boundaries.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that adoption subsidy agreements remain in effect regardless of the state of residence and provides protection of the interests of the child when the adoptive parents and child move to another state while an adoption subsidy agreement is in effect.

ARS §§8-171 through 8-173 address interstate adoption subsidy activity.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 14: Section 10

Accessing Medical Coverage for Adoption Subsidy Children Moving to or from Another State

Legal Basis

Policy: To protect the interests of adoption subsidy children who move across state lines, the department will follow all rules and procedures required by the Interstate Compact on Adoption and Medical Assistance (ICAMA).

To receive medical coverage families of adoption subsidy children who move to another state must enroll those children in Medicaid in the family's state of residence. If that state's Medicaid does not cover any service that is normally covered by Arizona Health Care Cost Containment System (AHCCCS), Arizona's Adoption Subsidy Program will cover the service related to conditions on the Adoption Subsidy agreement, AN-0517.

The ICAMA Administrator is responsible for initiating and maintaining coverage under the AHCCCS for adoption subsidy children who move to Arizona from another state.

The ICAMA Administrator is responsible for providing information necessary to initiate Medicaid coverage for adoption subsidy children who move to another state, using information provided by the Adoption Subsidy Specialist, as well as for notifying the receiving state if the child becomes ineligible for adoption subsidy.

Revision History:
DES(07-2006)

Previous

15-1

Legal Basis: ARS §8-871 provides for the appointment of a guardian for a child through the juvenile court. Any party to a dependency proceeding may file a motion for permanent guardianship.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 1

Selecting Guardianship as a Permanency Goal

Legal Basis

Policy: The department shall establish a permanency plan of guardianship when guardianship is in the child's best interest, family reunification is not possible, and:

- § the potential for adoption is not optimistic at this time; or
- § termination of parental rights is not in the child's best interests

The department shall give priority to guardianship by relatives, rather than non-relatives, unless this is contrary to the best interest of the child.

To decide whether a permanency plan of guardianship is appropriate, consider these questions:

- Did the court order reunification services not be provided or a permanency plan other than family reunification?
- If reunification services were ordered, have reasonable efforts been made to reunite the family?
- Would further efforts be counterproductive?
- Is a guardianship the best permanency plan for a younger child?
- Is the guardianship likely to remain intact as the child gets older, particularly in adolescence?
- Is the potential for adoption not optimistic at this time?
- Is termination of parental rights not in the child's best interests?
- Has a family or individual who wants to provide for the child's needs been identified?
- Can the child be maintained without the support services currently provided through the department?
- Is supervision of the placement by DES or juvenile court unnecessary?

BEST PRACTICE TIP:

Guardianship may be a strong permanency option in that it offers a legal relationship between the child and the guardian. If a family is close to a child, has developed a relationship but cannot adopt, legal guardianship offers a way to function as the legal caregiver for the child.

Careful consideration should be given when pursuing a permanent plan of guardianship for a younger child.

Implementation and Procedures Guide

Before pursuing permanent guardianship, be aware of the following characteristics of guardianship and ensure that the prospective guardian knows them as well:

The court makes the appointment of a guardian in the best interests of the child.

The guardian has the power and responsibilities of a parent to:

- § Authorize medical or other professional care, treatment or advice.
- § Enroll the child in school.
- § Determine where the child will reside.
- § Consent to marriage or adoption (in some instances, parental consent may also be necessary).
- § Consent to social or recreational activities.

A guardian is not:

- § legally obligated to be financially responsible for the child if the child has an estate or is due funds; or
- § liable to third persons for acts of the minor child solely by reason of guardianship.

The appointment of a guardian does not terminate the parents' rights or affect the child's inheritance rights or affect the parent's obligation to contribute to the support of the child.

The court will appoint a person nominated by the child if the child is 14 years of age or older,

unless the court finds that the appointment is not in the child's best interests.

A guardian may petition the court for permission to resign.

Any person interested in the welfare of the child may petition the court for removal of a guardian on the grounds that removal would be in the child's best interests.

Any party, including the child, parent of the child or any party to the dependency petition, may request that guardianship be rescinded if there is a significant change of circumstances including:

- the child's parent is able and willing to properly care for the child; or
- the child's guardian is not able to properly care for the child.

DOCUMENTATION :

Document the selection of Guardianship as a permanency goal in the Permanency Goal window.

Revision History:
DES(07-2006)

Next

15-2

Legal Basis: ARS §8-871 discusses procedures for establishing guardianship through the juvenile court.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 2

Implementing a Permanency Plan of Guardianship

Legal Basis

Policy: The department shall consider recommending a permanency plan of guardianship when:

- The child is adjudicated dependent.
- The child has been in the custody of the prospective permanent guardian for a least nine months as a dependent child. The court may waive this provision for good cause.
- Reasonable efforts have been made to reunite the parent and child and further efforts would be unproductive. The court may waive this provision if the court finds that reunification efforts are not required by law.
- Reunification of the parent and child is not in the child's best interests because the parent is unwilling or unable to care for the child.
- The likelihood that the child would be adopted is remote or termination of parental rights would not be in the child's best interests.
- The prospective permanent guardian has made a commitment to provide care and support to the child.
- Guardianship is in the child's best interests. (ARS §8-871)

The Attorney General's Office is responsible for assisting the CPS Specialist in determining whether requirements for permanent guardianship have been met.

Implementation and Procedures Guide

Obtain supervisory approval of a case plan of guardianship and request that the supervisor sign the Referral for Guardianship, FC-116, found in the Forms Registry.

Discuss the characteristics of guardianship with the prospective permanent guardian, ensuring that the guardian understands the legal, and parental responsibilities being undertaken.

If a parent's whereabouts are unknown, conduct an extensive and documented search using the Parent Locator Service. Complete the request for Parent Locator Service and process according to district operating procedures.

Refer children and prospective permanent guardians to the Attorney General's Office for legal services using the FC-116.

Inform prospective permanent guardians of the requirements to complete a home study including fingerprinting and a Child Protective Services (CPS) records search.

If not already completed, ensure that the prospective permanent guardian and all persons 18 and older permanently living in the household:

- § are fingerprinted;
- § have a state and federal criminal history records clearance within the past year; and
- § have a current CPS records check.

Conduct a home study of the prospective permanent guardians to ascertain the appropriateness of the home using the Report to Juvenile Court for Permanent Guardianship, CT04900, found in the Court Document Detail. Submit the report of the home study to the juvenile court and all parties prior to the hearing.

If the prospective permanent guardian lives out-of-state, take these additional steps:

- § Inform prospective permanent guardians that the motion for guardianship may be filed where the child resides or in the county where the child is a ward. The laws of the state in which the guardianship is granted apply to the child and the family.
- § Inform the prospective permanent guardian, who resides out-of-state, that guardianship subsidy is available only for permanent guardians appointed through juvenile court in Arizona.
- § Make referrals for guardianship for children who are Arizona court wards placed in another state through the Interstate Compact on the Placement of Children (ICPC).
- § Receive ICPC approval of the prospective permanent guardian's home, prior to submitting the FC-116, .state and federal criminal history records clearance
- § Assure that fingerprints and the home study requirements are completed prior to a referral for legal services to the Attorney General's Office.

Provide the following information to the Attorney General's Office for incorporation into the petition:

- the name, sex, residence, date and place of birth of the child;
- the facts and circumstances supporting the grounds for permanent guardianship;
- the name and address of the prospective permanent guardian;
- date of placement with the prospective permanent guardian;
- a statement that the prospective permanent guardian agrees to accept the duties and responsibilities of guardianship;
- the relationship of the child to the prospective permanent guardian;
- the basis for juvenile court's jurisdiction;
- the names, addresses, marital status and dates of birth of the birth parents, if known; and
- whether the child is subject to the Indian Child Welfare Act (ICWA) of 1978 [ARS §8-872].

If the child is an Indian child as defined by the ICWA, provide the following additional information:

- the tribal affiliation of the child's parents;
- the actions taken to notify the parents' tribe(s) of the plan of permanent guardianship and the result of those contacts (including names, addresses, titles, telephone numbers of persons contacted and copies of any correspondence with the tribe); and
- the efforts made to comply with the placement preferences under ICWA. [ARS §8-872]

The department will provide the Attorney General's Office with sufficient information to enable them to notify the following individuals of the filing of the guardianship petition:

- the parents of the child (excluding a parent who relinquished parental rights or whose parental rights are terminated);
- the foster parents with whom the child is currently residing;
- the child's current physical custodian;
- any foster parents with whom the child has resided within six months before the date of the hearing;

- the prospective permanent guardian if the guardian is not the current physical custodian;
- any person appointed to represent a party (including the child's attorney and guardian ad litem);
- any parent, Indian custodian and tribe of an Indian child as defined by the Indian Child Welfare Act of 1978; and
- any other person that the juvenile court orders. [ARS §8-872]

Forward the completed FC-116 to the Attorney General's Office with the following:

- Report to Juvenile Court for permanent guardianship including Attachment;
- Acceptance of the Duties and Responsibilities of Guardianship;
- Results of criminal history records check, state and federal;
- child's Birth Certificate;
- parent's death certificate, if applicable; and
- written correspondences to and from the tribes regarding the plan of permanent guardianship

If the guardianship involves a child placed out-of-state, forward a copy of the home study with the cover memo.

Keep one copy in the child's record.

Revision History:
DES(07-2006)

Previous / Next

15-3

Legal Basis: ARS § 8-872 (1) addresses requirements for follow-up when a guardianship has been granted.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 3

Involvement Following the Awarding of Guardianship

Legal Basis

Policy: The department shall petition the court to dismiss its dependency order following the granting of a guardianship by the court.

Implementation and Procedures Guide

Assist the permanent guardian in applying for representative payee for children receiving SSI, SSA, VA or child support.

Recommend that the dependency petition be dismissed after the guardianship has been granted.

Refer any cases that are not dismissed to the Attorney General's Office for appeal.

If the juvenile court does not dismiss the dependency petition, continued supervision of the placement should include:

- § services to the child;
- § visits with the child and caregiver together in the caregiver's home at least once every three months;
- § monthly telephone contact with the child and the caregiver; and
- § compliance with orders of the juvenile court.

If ordered by the court, complete an investigation of the facts and circumstances surrounding the welfare and best interests of the child using the Addendum Report **to** Juvenile Court format found in the Court Document Detail, CT00200. Submit the report to the court prior to the Report and Review Hearing.

Participate in the report and review of the guardianship.

DOCUMENTATION :

When the juvenile court *dismisses* the dependency petition, or the court *does not order* the department to provide continued case management services, document case closure in the Case Closure window. See Closing Case Records in CHILDS (Chapter 19, Section 5).

Update the Legal Status window to reflect the change in the child's legal status, then terminate all ACYF-funded services.

Revision History:

DES(07-2006)

Previous / Next

15-4

Legal Basis: ARS §8-814 creates a permanent guardianship subsidy program.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 4

Guardianship Subsidy: *Eligibility*

Legal Basis

Policy: The guardianship subsidy program shall support permanent placements for children who cannot return home and for whom adoption is not an option. Guardianship subsidy is intended to be only a partial reimbursement for expenses involved in the care of the child.

A permanent guardian is eligible for guardianship subsidy if he or she:

- has a permanent guardianship granted pursuant to ARS §8-871, on or after August 6, 1999; and
- has applied for other state and federal benefits on behalf of the child.

Guardianship subsidy maintenance payment shall not exceed the current adoption subsidy maintenance payment as established by the department.

Guardianship subsidy maintenance payments shall be offset by monthly amounts received from state and federal program benefits, child support, trust funds, and any other financial assets available for the child's care.

The Guardianship Subsidy Program is managed by ACYF Central Office. Overall responsibility for assisting families with the guardianship subsidy process is shared by:

- the *child's local office CPS Specialist* who assists the family with completing the application for guardianship subsidy and state and federal benefits; and
- the *guardianship subsidy program specialist* who assists those families after the guardianship is finalized and who reviews applications for program eligibility.

A permanent guardian receiving a guardianship subsidy maintenance payment shall:

§ Notify the department in writing within two weeks of the following:

- termination of the guardianship;
- death of the child;
- child no longer resides with the permanent guardian;
- change in state and federal program benefits to which the child is entitled and other financial assets available to the child; and
- change in address.

§ Cooperate with the department in the annual review process.

Revision History:
DES(07-2006)

Previous / Next

15-5

Legal Basis: ARS §8-814(B) permits the department to provide guardianship subsidy to an applicant on behalf of a child.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 5

Applying for Guardianship Subsidy

Legal Basis

Policy: An application for guardianship subsidy may be filed by a person appointed permanent guardian of a child in the care, custody, and control of the department pursuant to ARS §8-871.

An application is complete when a copy of the signed Letter of Appointment or a copy of the order appointing the permanent guardian is received by the department.

The start date for payment shall be the date the guardianship was finalized.

For permanent guardians appointed by the court who apply after appointment, the start date for payment shall be the date of approval of the application.

An application for guardianship subsidy will be closed if the Letter of Appointing or order appointing the permanent guardian is not received by the department **within 90 days** after the appointment. The permanent guardian may reapply for guardianship subsidy.

Implementation and Procedures Guide

Child's Local Office CPS Specialist

Assist the family in completing the Guardianship Subsidy Application found in the Forms Registry.

Ensure the prospective permanent guardian signs the Guardianship Subsidy Application.

Inform the prospective permanent guardian that the Guardianship Subsidy Application may be submitted on or after the motion for permanent guardianship has been filed with the court. Include a copy of the stamped motion for permanent guardianship with the application.

Inform the prospective permanent guardian, who resides out-of-state, that guardianship subsidy is available only for permanent guardians appointed through juvenile court in Arizona.

Inform the prospective permanent guardian that, even though he/she may be eligible for guardianship subsidy, funds may not be available to the department for all eligible applicants.

Provide the application for guardianship subsidy to the prospective permanent guardian who resides out-of-state and who wishes to pursue guardianship in Arizona.

Notify the Guardianship Subsidy Specialist when the new guardianship subsidy case is created and subsidy authorization completed.

Close the CPS case when the dependency petition is dismissed if the child is the only child in the case. End date the child's case role in the CPS case if the case is not closed.

Guardianship Subsidy Program Specialist

Review all applications for guardianship subsidy within ten working days of receipt.

If the application is missing the stamped copy of the filed motion for guardianship, send notice to the CPS Specialist advising that the stamped copy must be received within 30 days from the date of the notice.

Send a Notice Letter to the prospective permanent guardian indicating the receipt of the application.

Upon receipt of the Letter of Appointment or court order and verification that the guardian has applied for Financial Assistance Administration (FAA) assistance an Approval Letter will be sent to the guardian indicating the amount of subsidy and effective start date.

If the Guardianship Subsidy Application is approved but funds are not available, send a Waiting Notice to the prospective permanent guardian indicating that his/her name will be placed on a waiting list. File the original application and supporting documentation in the guardianship subsidy hard copy file.

When funds become available, send a Confirmation Notice to the permanent guardian.

If the Guardianship Subsidy Application is denied, send a Letter of Denial to the permanent guardian to include:

- § the reason for denial;
- § the right to appeal;

- § the timeframes for appeal; and
- § appeal initiation procedures.

DOCUMENTATION :

The local office CPS Specialist should ensure the primary permanent guardian is entered in the CHILDS Provider Registry, according to district procedures, through completion of the following windows:

- Provider Maintenance Detail
- Provider Maintenance Facility Detail
- Facility Contacts
- Provider Maintenance Household
- Provider Maintenance Service Detail

When notified by the Guardianship Subsidy Program Specialist that the application for guardianship subsidy has been approved, create a guardianship subsidy case in the name of the permanent guardian.

When notified of the guardianship subsidy amount, complete the service authorization and provider match process by completing the following windows: Service Authorization Request, Service Authorization Approval and Service Authorization Provider Match.

File copies of all written correspondences to the prospective permanent guardian in the hard copy guardianship subsidy case record.

File the Guardianship Subsidy Application in the hard copy guardianship subsidy case record.

Revision History:
DES(07-2006)

Previous / Next

15-6

Legal Basis: ARS §8-814 requires that guardianship subsidy cases be reviewed annually to determine continued eligibility and appropriateness of the guardianship subsidy amount.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 6

Managing Guardianship Subsidy Cases

Legal Basis

Policy: The department shall review each guardianship subsidy case annually.

A permanent guardian, who receives guardianship subsidy and relocates to another state, must provide verification of application for state program benefits in the new state of residence within 90 days of relocation in order to maintain eligibility for guardianship subsidy.

Implementation and Procedures Guide

Guardianship Subsidy Program Specialist

Send the permanent guardian the Guardianship Subsidy Annual Review within 30 days of the anniversary date.

Review the returned Guardianship Subsidy Annual Review, (page 2) to determine continued eligibility for guardianship subsidy and appropriateness of the subsidy amount within ten days of receipt.

Send the Annual Review Notification to the permanent guardian within 30 days of the annual review.

If the permanent guardian fails to return the Guardianship Subsidy Annual Review, (page 2), within 30 days, suspend the guardianship subsidy.

Notify the permanent guardian of suspension of subsidy by completing and mailing the Suspension Notice.

If the permanent guardian relocates to another state, inform the guardian that he/she must apply for and provide verification of application for state program benefits in the new state of residence within 90 days of relocation.

Local Office CPS Specialist:

When notified of continued eligibility and subsidy amount, update and extend the service authorization.

Upon notification from the Guardianship Subsidy Program Specialist, suspension of guardianship subsidy payments will be entered by the Program Specialist.

DOCUMENTATION :

If necessary, update the Provider Maintenance Service Detail window.

File copies of all written correspondences with the permanent guardian in the guardianship subsidy hard copy case record.

Revision History:

DES(07-2006)

Previous / Next

15-7

Legal Basis: ARS §8-814 addresses the appeal of guardianship subsidy decisions.

Rules: Sections R6-5-2401 through R6-5-2405 of the Arizona Administrative Code addresses appeal of department actions.

Revision History:
DES(07-2006)

Chapter 15: Section 7

Appeal of Decisions

Legal Basis

Policy: An applicant may appeal the department's decision to deny, reduce, suspend or terminate guardianship subsidy.

The department shall notify the permanent guardian when a decision has been made to deny, reduce, suspend or terminate guardianship subsidy.

The department shall grant an opportunity for a fair hearing to a permanent guardian who has applied for guardianship subsidy and alleges that the department unfairly denied, reduced, suspended, or terminated guardianship subsidy.

The Guardianship Subsidy Program Specialist shall coordinate appeals in accordance with the requirements of DES 5-24, Appeals and Hearings.

Revision History:

DES(07-2006)

Previous / Next

15-8

Legal Basis: ARS §8-814 (G) directs the department to terminate guardianship subsidy under specific circumstances.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 15: Section 8

Termination of Guardianship Subsidy

Legal Basis

Policy: The department shall terminate guardianship subsidy when any one of the following occurs:

The permanent guardianship terminates.

- The child dies or does not reside with the permanent guardian.
- Child reaches 18 years of age except that the department may continue the subsidy until the child's twenty-second birthday if the child is enrolled in and regularly attending school and has not received a high school diploma or certificate of equivalency.
- The applicant fails to comply with requirements for guardianship subsidy.

Implementation and Procedures Guide

Guardianship Subsidy Program Specialist

§ Terminate guardianship subsidy when any of the above circumstances occur.

§ Send the Termination Notice to the permanent guardian notifying them of the decision to terminate guardianship subsidy and the reasons for this action.

If a child receiving guardianship subsidy is placed in out-of-home care by CPS:

§ Suspend guardianship subsidy maintenance payment.

§ Instruct the CPS Specialist to create a separate CPS case in the name of the permanent guardian.

§ Coordinate with CPS to resume guardianship subsidy maintenance payment when the child returns home and foster care payments terminate.

DOCUMENTATION :

Close the Guardianship Subsidy case.

Upon notification from the Guardianship Subsidy Program Specialist, suspend or terminate guardianship subsidy payments by end-dating the Provider Service Authorization window.

File copies of written correspondences with the guardian in the guardianship subsidy hard copy case record.

Revision History:
DES(07-2006)

Previous

16-1

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 1

Identifying the Need for Independent Living Services and Supports

Legal Basis

Policy: All youth in out of home care who are age 16 and older shall have an independent living plan which supports their individual transition to adulthood including the development of daily living skills, and complements other services being provided towards attainment of the assigned permanency goal.

The department shall provide services and opportunities to support all young people to make sound life decisions and develop a sense of competence, usefulness, belonging and empowerment.

If the team to include the youth, CPS Specialist, tribe if applicable, and others involved in assisting the youth, determine that the youth could benefit from the services and supports offered through the Arizona Young Adult Program the CPS Specialist should refer the youth for these services including:

- participation in the Arizona Young Adult Program specialized case management (where available);
- independent living skills training;
- educational and employment training opportunities (including the Education and Training Voucher (ETV) Program);
- independent Living Subsidy;
- voluntary continued out-of-home care for young adults 18 through 20; and
- other activities such as local youth advisory boards, youth conferences, etc.

All youth who are working toward emancipation shall be referred for Independent Living Services and Supports. For the purpose of this policy, “emancipation” refers to the acquisition of adequate skills and resources which will enable the youth to live independently, (outside of the state foster care system) at age 18 or older.

BEST PRACTICE TIP:
Shortly after the passage of ASFA, the National Resource Center for Youth Services (NRCYS) looked at what "permanency planning" means for adolescents. The result of this year-long effort is the publication, *Permanency Planning: Creating Life Long Connections: What Does it Mean for Adolescents?*
This publication, available on the NRCYS website **http://www.nrcys.ou.edu**, offers three compelling conclusions:

- § Adolescents need connections to adults and peers throughout their lifetime.
- § Adolescents need to be taught skills that will prepare them to live independently.
- § All youth, but particularly adolescents, must be seen as central actors in their own futures.

These findings underscore that young people need permanency planning services concurrent with independent living services. The study recommends that "concurrent planning be incorporated into any effective strategy to prepare adolescents for permanency…" and that states "engage in concurrent planning, continue to discuss adoption while putting independent living programs into place, and continue to provide training in life skills while adoption is pending. It is not an either/or choice."
Significant research underscores the fact that consistent, secure, permanent relationships with adults are a strong indicator of "resilience" in children, a factor which helps determine the extent to which they are able to overcome obstacles and avoid negative outcomes. Young people themselves repeatedly indicate their desire for these permanent family connections.

Implementation and Procedures Guide

Provide the youth with the PAC-533, Questions and Answers About Youth Rights in Foster Care, and with any additional program material available.

Describe aftercare support and services available including:

- transitional living and support services (through the Transitional Independent Living Program-TILP);
- education and employment training opportunities (including the Education and Training Voucher (ETV) which is available to age 23);
- re-entry into DCYF supervised services after exiting care at age 18 or older; and
- health insurance (for eligible youth through AHCCCS).

DOCUMENTATION :

Document tasks related to the delivery of Independent Living Services and Supports in the Case Plan Tasks window, Independent Living type.

Revision History:

DES(07-2006)

Next

16-2

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 2

Implementing Independent Living Services and Supports

Legal Basis

Policy: The department shall employ the principles of Positive Youth Development to develop case plans which are youth centered and youth driven.

The department shall make every effort to ensure parenting teens are provided with appropriate services which support healthy parent-child bonds and may include parenting skills training, peer support or other services.

The department shall make every effort to ensure a diverse array of services and resources are identified to assist teens to address their needs, including any special needs, or concerns related to their sexual orientation and/or gender identity

The department shall ensure youth in care are aware of their rights including the right to utilize established complaint/grievance processes to assist in conflict resolution.

The department shall assist undocumented youth to initiate and complete all processes necessary to establish legal residency.

The department shall provide services and support to assist all youth in out-of-home care to develop the life skills necessary to prepare for a successful transition to adulthood.

These services may include:

- independent living skills training;
- planning and support of educational and employment goals;
- counseling and other therapeutic services;
- supporting community and family connections;
- Independent Living Subsidy;
- voluntary continued care for young adults 18 through 20 years of age;

- discharge planning; and
    - other transitional support services including re-entering DCYF case management and services.

The department will make every effort to coordinate services available through the Independent Living Program with other federal and state programs for youth including abstinence education programs, local housing programs, programs for disabled youth, and school-to-work programs offered by high schools or local workforce agencies.

The department shall assist youth to plan and establish a safe, stable, long term living arrangement and set of relationships with persons committed to long term support and nurturance of the youth.

The department shall ensure every youth develops an appropriate discharge plan which addresses how their basic needs will be met and includes a safe, stable living arrangement, supportive/nurturing relationships and available resources in their community.

The department shall ensure that basic resources are in place for youth transitioning to adulthood including:

- a living arrangement;
- a source of income;
- affordable health care;
- transportation;
- access to at least one adult committed to helping with the transition;
- access to peer support; and
- provision of essential documents including an original birth certificate, state identification card and social security card.

The department shall maintain contact with the child’s parents or extended family, whenever possible, to:

- inform and involve the family in decisions about their child where feasible;
- stay informed of changes in the family situation that might indicate a need to re-evaluate the permanency goal of independent living, unless such contact would compromise the safety of the child; and
- support and strengthen healthy connections with parents and extended family.

The department shall make every effort to assist the youth to maintain contact with parents, siblings, extended family, friends and community through phone contact, written communication and visitation, as appropriate to the safety and well-being of the youth.

BEST PRACTICE TIP:

Research suggests that a significantly high percentage of youth who "age out" of the child welfare system go back to their families. Given this reality, CPS Specialists should explore the feasibility of this option with youth who do not have a permanent family. They should assist in preparing the youth for what they might experience when and if they go back to their family. Specifically, CPS Specialists should consider facilitating a meeting between the child and his/her birth family. Sometimes youth who have had little to no contact with their birth family due to Termination of Parental Rights have unrealistic expectations for what this "reunification" will be like. Having a CPS Specialist beside the youth during this process provides the youth with support and someone with whom they can process the experience.

To determine if contact/communication between the youth and family, friends or home community (where the youth resided prior to coming into care) is appropriate, consider the following questions:

- Does the youth desire contact? If so, what type of contact is desired (i.e., in person, via phone, mail or other method.)?
- Does the youth desire contact but has concerns about their own safety or well-being? What supports or assistance might alleviate these concerns (i.e., therapeutic intervention, supervised contact)?
- Does the service team have concerns for the youth's safety or well-being? If so, what supports or assistance might alleviate these concerns (i.e., therapeutic intervention, supervised contact)?
- Has the youth or other service team members identified any other barriers to contact with family, friends or involvement with the home community (i.e. transportation, scheduling conflicts)? If so, what support or assistance might be available to address these issues?

To determine if a youth has been or may be the subject to harm, discrimination, or any adverse act because of their perceived gender identity, gender expression, ethnicity, religious beliefs and/or sexual orientation considers the following questions:

§ Is the youth actually or perceived to be a member of a minority group?
§ Has the youth expressed concern for their safety or well-being?
§ Has the caregiver or other person reported concerns for the youth's safety and well-being?
§ Has the youth been a target of any adverse act with reference to their perceived gender identity, gender expression, ethnicity, religious beliefs and/or sexual orientation?

- If so, what support or assistance is available to address these safety concerns?

BEST PRACTICE TIP:

Statistics for children who leave the child welfare system are not encouraging**.** A significant number of children end up homeless, without medical insurance, without employment, and on public assistance. Young girls are often pregnant multiple times before the age of 23. Independent Living Services and Supports can be an effective deterrent from these outcomes when combined with an adult who cares about the youth. While planning for services and supports which teach the youth about decision making and planning for living as an adult, the CPS Specialist should also work diligently to identify an adult with whom the youth has a relationship and can rely on when facing very predictable trials and struggles. Very few 18 year olds have the maturity or the resources to be completely independent.

Implementation and Procedures Guide

Provide case planning and case management services, as described in Family Centered Case Planning (Chapter 9) with the following additions:

- Identify outcomes that will help the youth to build, strengthen or maintain positive, healthy relationships.
- Identify relative and non-relative persons with whom the youth desires to establish a long-term connection and provide assistance and services to support the relationships.
- Identify outcomes that will help the youth develop independent living skills (daily living, interpersonal, education planning, employment and community living skills) and provide services that will facilitate achievement of these outcomes
- Identify and address any special needs or concerns the youth may have including concerns related to the quality of services including out-of-home placement.

- Using a valid assessment tool (such as the Daniel Memorial or Ansell-Casey Life Skills Assessment), complete or arrange for an assessment of the youth's preparedness for adulthood in such areas as:
    - daily living skills (i.e., personal hygiene, health, housekeeping and food management, emergency and safety skills);
    - interpersonal skills;
    - educational planning;
    - employment skills (i.e. job seeking, job maintenance); and
    - community living skills (i.e. legal, transportation, resource and housing skills).

§ Complete the YAP/ILS Program Enrollment window with the following information:

- program start date;
- assessment date; and
- other applicable fields.

§ Encourage the youth to actively participate in his or her case planning by:

- communicating their life vision, post foster care (after discharge);
- identifying personal goals related to education, employment, self-esteem, relationship skills and other areas;
- identifying adults (including relatives, friends, teachers, clergy, etc.) who may provide assistance and support during the transition to adulthood;
- attending and participating in the case plan staffing;
- reviewing and discussing service needs;
- identifying resources to meet needs; and
- accepting personal responsibility for their participation in services and signing the case plan agreement.

§ Provide or arrange for services and activities to help the youth prepare for discharge from foster care, or to enhance his or her:

- emotional preparation for adulthood;
- interpersonal relationships and life long connections;
- success in education, job and career;
- daily living skills;
- health and family planning, recreational and vocational activities;
- understanding of his or her legal rights and responsibilities;
- use of community systems and services; and
- use of a community advisor or mentor.

§ Advise the youth of the following financial incentives and support for youth leaving

the child welfare system without a legal permanent family:

- graduation incentive: $100 with a GED or high school graduation certificate;
- training incentive: $50 with a certificate of completion of Independent Living Skills Training;
- independent Living Savings Match: Two dollars for every one dollar accumulated in an approved savings account (up to a maximum match of $400), payable at the time the youth exits care and the DCYF case is closed (payment may be initiated up to 45 days prior to the youth's last day of care);
- Education and Training Voucher (ETV) and other funding for post-secondary educational/vocational pursuits; and
- after care services available through the Transitional Independent Living Program (TILP).

§ Whenever possible, maintain contact with the child's parents or extended family to:

- inform and involve the family in decisions about their child;
- stay informed of changes in the family situation that might indicate a need to reevaluate the permanency goal of independent living, unless such contact would compromise the safety of the child; and
- support and strengthen healthy connections with parents and extended family.

• Whenever it is determined that a youth has been or may be subject to harm, discrimination or any adverse act because of their perceived gender identity, gender expression, ethnicity, religious beliefs and/or sexual orientation, meet with the youth and caregiver (if appropriate) to discuss the concern, assisting the youth to:

— Identify any service, support (including community based advocates or organizations) or strategy which will ensure their safety or decrease their risk of harm.

— Contact local law enforcement and file a report in any instance where criminal wrong-doing is suspected or known.

— Provide an immediate change in the living arrangement if such poses a threat to the youth's physical, mental and/or emotional safety and well-being.

At minimum, maintain quarterly telephone contact or written correspondence with all parents whose whereabouts are known and whose rights have not been terminated.

Family Centered Case Planning (Chapter 9).

Ensure all youth are assisted to maintain contact with parents, sibling, extended family, friends and community, as appropriate to the safety and well-being of the youth.

Provide or make arrangements for youth to receive a certified copy of their birth certificate,

social security card and state identification card (unless ineligible to receive).

Assist youth who are not documented citizens to establish legal residency by initiating and completing requirements of the local office of immigration and naturalization.

Assist youth to apply for post-secondary education and training funds through the ETV application or other financial resource application process (i.e., Free Application for Student Financial Aid-FASFA).

Assist all youth in out-of-home care to pre-enroll in an AHCCCS plan by completing and submitting the Young Adult Transitional Insurance (YATI) Referral and Turnaround Document (FAA-1097) during the month in which the youth turns 18 years of age.

DOCUMENTATION :

Document the youth's life vision in the Permanency Goal window Explain box.

Document independent living anticipated outcomes and tasks in Case Plan Tasks window Independent Living plan type. Ensure the youth's preparation for foster care discharge is reflected in the Independent Living plan.

Document the assistance to be provided to the youth to maintain contact with parents, siblings, extended family and friends.

Document all efforts made to determine if a youth has been or may be subject to harm, discrimination or any adverse act because of their gender identity, gender expression, ethnicity, religious beliefs and/or sexual orientation, and those strategies, supports or services provided to ensure the youth's physical, mental and/or emotional safety and well-being. (Documentation including related case notes shall be noted as confidential and not for dissemination unless necessary to the safety and well-being of the youth. The youth should be made aware of the dissemination of these case notes.)

Document the tasks and activities which will support the youth's connectedness to their community.

Document any factors which may adversely affect the youth's safety or well-being, as well as

strategies to assure the youth's safety and well-being while engaged in family contact and/or community activities.

Document the youth's eligibility for financial incentives by maintaining a copy of the youth's GED certificate, high school diploma, certificate verifying completion of Independent Living Skills training, or verification of savings account balance, as applicable, in the hard copy files.

Document the need for financial incentives in the Case Notes window designated as Child Contact type indicating:

- high school graduation and authorized incentive amount (if applicable)
- completion of Independent Living Skills training and authorized incentive amount (if applicable), and/or
- savings account balance and authorized match amount (if applicable)

Document the savings incentive match on the Independent Living Program Savings Match Agreement, FC-169, located in the Forms Registry.

For more information: On support and services for lesbian, gay, bisexual, transgender and questioning youth, go to www.lambdalegal.org (youth and schools) or www.cwla.org (culture/ diversity)

Revision History:
DES(07-2006)

Previous / Next

16-3

Legal Basis: ARS §8-521 provides guidelines for the Independent Living Subsidy Program, an experiential living arrangement for youth in out-of -home care.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 3

Offering Services Through the Independent Living Subsidy Program

Legal Basis

Policy: The department may provide a youth the opportunity to participate in the Independent Living Subsidy Program if they meet the minimum requirements which are:

- adjudicated dependent, the subject of a dependency petition, or age 18 or older and in extended care through a Voluntary Foster Care Agreement for Young Adults 18 Through 20;
- in out-of-home care and in the custody of the department;
- at least 17 years of age; and
- employed, a full-time student, or engaged full-time in a combination of education, employment and/or therapeutic services.

The Independent Living Subsidy Program provides youth with the experience of community living while receiving support and services from the department. This program is an out-of-home care placement option, with the monthly stipend provided to the youth in lieu of any other foster care payment. This program permits youth to reside in unlicensed settings, including apartment living (alone or with roommates), dormitories and boarding with family, friends or others. All proposed living arrangements and roommates must be approved by the CPS Specialist. Youth may not cohabit with boyfriends/girlfriends while in this program.

Youth age 17 must have court approval to participate in this program; however, court approval is not required for youth age 18 and older.

The Independent Living Subsidy Program is not a requirement, but encouraged as an option for youth preparing for the transition to adulthood.

The Independent Living Subsidy is available to eligible youth in foster care and to young adults who have signed a voluntary agreement for continued care after age 18, but may not extend past

the youth's 21st birthday.

To determine the youth's readiness to participate in the Independent Living Subsidy Program, consider the following:

- Does the youth meet the minimum qualifications for the Independent Living Subsidy Program?
- Has the youth identified a potential living arrangement which will provide supervision and support appropriate to his or her level of readiness?
- Does the youth demonstrate the ability to assume responsibility and work toward self-sufficiency, as reflected in mastery of the following areas:
  - task completion;
  - goal setting;
  - decision making;
  - job readiness;
  - knowledge of basic living skills;
  - money management (including establishment of a savings account);
  - willingness to follow program requirements; and
  - willingness to complete Independent Living Skills training, if not previously accomplished.

Implementation and Procedures Guide

Assist youth who are potential candidates for the program to develop an initial monthly budget of living expenses and start-up costs, including a savings plan, utilizing current subsidy allowances.

Assist the youth in identifying a proposed living arrangement that:

- is close to schools, places of employment, training and services;
- complies with applicable state and local zoning, fire, sanitary and safety regulations; and
- is supportive of their current level of readiness.

Arrange for youth to be supervised by a community advisor who is at least 21 years of age. Encourage the youth to identify potential community advisors. The community advisor provides supervision at least three times per week for the first four weeks and at least once a week thereafter. (The community advisor may be reimbursed for his or her services (i.e., transportation costs) if approved by the Program Manager.)

For youth under 18, assist the community advisor (if non-relative) to complete finger printing and enroll in an approved DES Volunteer Program (where available).

Complete the Independent Living Program Agreement, FW-011, located in the Forms Registry, between the youth, CPS Specialist and community advisor including the following information:

- projected beginning and end date of the agreement;
- description and address of where the youth will live;
- specific responsibilities of the youth;
- supervisory responsibilities of CPS Specialist, and community advisor;
- future career goal/plan;
- identification of the youth's place of employment and type of work, and/or where the youth is attending school or training and current grade level (if applicable);
- identification of potential problems and solutions related to the youth's readiness to participate in the independent living subsidy program;
- statement of financial arrangements, including youth's monthly budget (including savings plan) and amount of subsidy stipend; and
- timeline for reviewing progress.

Review the action that will be taken if the youth does not meet the terms of the agreement. (See Section D of the Agreement).

Assist youth who do not already have a savings account to open a savings account and complete the Savings Match Agreement, FC 169, located in the Forms Registry.

The above information shall be available in the case record for review with a copy provided to the youth and community advisor.

Complete the Independent Living Subsidy Program Approval, FW-012 including the youth's date of birth, ethnicity (for statistical purposes only), custody removal date, a brief statement of the youth's level of readiness, and confirmation of life skills or daily living skills training provided to the youth. After receiving approval by the unit supervisor**,** forward the FW-012 and the completed FW-011 to the Assistant Program Manager for review and approval**.**

For youth under age 18, request a court order placing the youth in the physical custody of the Arizona Independent Living Program.

Continue to provide case planning and case management services, as described in Family Centered Case Planning (Chapter 9) with the following additions:

- meet with youth at least twice a month for the first three months, and monthly thereafter;
- have at least one of the meetings in the youth's residence; and
- for youth under age 18, provide quarterly reports to the court and to the Foster Care Review Board (ARS §8-521).

Youth may continue participation in the Independent Living Subsidy Program past the age of 18 until the age of 21 while pursuing secondary or post-secondary education, vocation or employment training programs both in-state and out-of-state, unless the youth:

- has violated the terms of the Independent Living Subsidy Program Agreement and the violation (s) cannot be remedied in a time frame that will ensure the youth's safety and well-being; or
- has made a voluntary decision to withdraw from the Independent Living Subsidy Program.

If the youth is under the age of 18, arrange for a return to a supervised out-of-home placement and obtain juvenile court approval for the change in placement status. Assist the youth to identify barriers/issues which impacted their ability to comply with the Independent Living Subsidy Program and provide services to remedy issues.

If the youth is age 18 or older and willing to participate in services to remediate concerns, assist the youth to arrange to return to an age-appropriate placement. Assist the youth to identify barriers/issues which impacted their ability to comply with the Independent Living Subsidy

Program and provide services to remedy issues.

If the youth is age 18 or older and does not wish to return to a supervised out-of-home placement, the CPS Specialist will proceed with case closure including implementation of the discharge plan. See Conclusion of Participation in the Voluntary Program, (Chapter 16, Section 5).

DOCUMENTATION :

Upon approval of the FW-012 by the Assistant Program Manager**,** complete the request for Independent Living Subsidy using the Service Authorization Request window. The Assistant Program Manager or designee will complete the Service Authorization Approval window. Complete the Service Authorization Provider Match window.

Document the independent living plan on the Independent Living Subsidy Agreement, FW-011, located in the Forms Registry.

Document the case plan staffing using the Case Notes window designated as Staffing type.

Keep a copy of all memos and reports in the youth's case record.

Update CHILDS to reflect the youth's change in status or living arrangement and to end any purchased services.

Revision History:
DES(07-2006)

Previous / Next

16-4

Legal Basis: ARS §46-134 describes guidelines for young adults remaining in foster care or in the Independent Living Subsidy Program beyond their 18th birthday.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 4

Voluntary Continued Out-of-Home Care and Services for Young Adults Age 18 Through 20.

Legal Basis

Policy: Young adults may remain in foster care after their 18th birthday only if they have signed an agreement which complements their own efforts to achieve self-sufficiency and which assures acceptance of personal responsibility for preparing for and transitioning from adolescence to adulthood.

All young adults who are in the custody of the department, in an approved out-of- home placement (i.e., ILSP, group care, foster home, relative placement, unlicensed relative or non-relative placement) when they turn 18 are eligible to remain in continued out-of-home care under the supervision of the department during the period of the agreement.

Requirements

The young adult must sign an agreement with the department which complements their own efforts to achieve self-sufficiency and which assures acceptance of personal responsibility for preparing for and transitioning from adolescence to adulthood.

The department via the assigned CPS Specialist will assist the young adult in the development of the agreement by providing information on available resources which will support their transition to adulthood. The information provided will include options/opportunities to support the desired living arrangement, education, training, employment, and counseling, as well as other support resources such as mentorship.

Young Adult's Rights and Responsibilities:

The young adult will demonstrate personal responsibility for preparing for and transitioning from adolescence to adulthood by working cooperatively with the CPS Specialist and:

- maintaining enrollment in, or enrolling in an educational, vocational training or employment program of their choice;
- participating in the educational or employment training program of their choice by

attending classes and earning credits;

- preparing for financial self-sufficiency by participating in employment or employment readiness activities of their choice, which may include paid employment, volunteer work or other activities defined in the case plan that will assist the youth to strengthen their employability;
- identifying their physical and mental health needs and participating in health services, including mental health services of their choice (Youth who choose to not participate in health services recommended by a physician, psychiatrist, psychologist or other qualified physical or behavioral health professional, must identify other strategies they will implement to address their behavioral and/or physical health needs.);
- identifying and maintaining a safe living arrangement of their choice which will allow for continuous daily living skill development and practice;
- participating in activities or services to assist in the development of permanent connections with supportive adults; and
- maintaining contact with the assigned CPS Specialist, immediately reporting any actual or anticipated changes to their living arrangement, education, training or employment or health status.

CPS Specialist Responsibilities

The CPS Specialist is responsible for working cooperatively with the young adult and providing the young adult and caregiver with information on any services, support and other opportunities which will support the young adult's desired living arrangement, education, training, employment and counseling needs.

The CPS Specialist will facilitate the development of an agreement for continued care which reflects the young adult's personal goals and clearly documents those services and supports necessary to assist the young adult to achieve positive outcomes including permanent connections with supportive adults.

The CPS Specialist will ensure all authorizations for payment of the cost of care and other services are in place prior to the young adults 18th birthday.

The CPS Specialist will ensure the young adult has an original birth certificate, social security card, and state identification card.

The CPS Specialist will provide the young adult with adequate family history, including

medical history information, including any photos, letters or other family history available in the case record. If the CPS Specialist believes a portion of the information may be harmful to the young adult, therapeutic intervention/assistance will be requested, as appropriate to meet each young adult's needs.

To determine if a young adult will continue in foster care beyond his/her 18th birthday, consider whether he/she desires to remain in care, under the supervision of the department.

Implementation and Procedures Guide

For youth who desire to continue in foster care beyond his/her 18th birthday, discuss with the youth their responsibility to demonstrate acceptance of personal responsibility for preparing for and transitioning from adolescence to adulthood through consistent participation in their case plan, which shall include his/her personally identified goals related to:

- education;
- vocation/training;
- employment;
- developing a plan to establish a long term living arrangement;
- permanent connections with supportive adults;
- physical and/or behavioral health services; or
- other personal goals (i.e., socialization, use of community resources, etc

If the youth does not desire to continue foster care services, proceed with the established discharge plan and provide information on aftercare services available through the Transitional Independent Living Program, including the opportunity to return to DCYF supervised services until the age of 21. Youth who desire to return to DCYF services may pursue such through the Transitional Independent Living Program.

If the youth desires to continue foster care services, develop the agreement for voluntary continued out of home care within 30 days prior to the youth's 18th birthday.

Prior to the youth's 18th birthday:

- Assist the youth to pre-enroll in an AHCCCS program through completion of the DCYF/

FAA YATI Referral and Turn Around Document (TAD) FAA-1097, and submit to FAA Internal Operations at Site Code 759C for processing.

§ Involve the youth and out-of-home care provider in a discussion about the possibility of continued care. Identify any issues or concerns (related to program compliance) which must be remedied in order for the youth to continue in care past 18, including any contract, licensing, certification or other issues related to the current or proposed living arrangement.

- For youth continuing in care past 18, submit a memo to CMDP to continue health insurance coverage beyond the youth's 18th birthday if the youth is residing out-of-state, does not meet the basic eligibility requirements under Medicaid (including legal resident status) or there is some extenuating circumstance why CMDP services continue to be necessary (i.e., orthodontia treatment is incomplete).

If the youth desires to remain in care under the supervision of the department, hold a case plan staffing **within 30 days prior to the youth's 18th birthday** to revise the current plan to reflect the youth's goals in relation to housing, education, employment, health and wellness (including physical, emotional, mental health or other therapeutic needs).

Assist the youth to identify outcomes, tasks and services to support successful completion of the stated goals including:

- outcomes that will help the youth maintain, strengthen or establish a long term, safe and stable living arrangement;
- outcomes that will help the youth to build, strengthen or maintain positive, healthy relationships including identification of relative and non-relative persons with whom the youth desires to establish a long-term connection;
- outcomes that will help the youth expand and strengthen independent living skills (daily living, interpersonal, education planning, employment and community living skills); and
- outcomes that will result in the youth establishing an adequate source of income to meet their basic needs. (food, clothing, housing, transportation and medical expenses, etc.)

Ensure the case plan accurately reflects the youth's own vision/goals (including their discharge plan), and that supportive services needed have been identified and are clearly stated in the agreement, including the youth's desired living arrangement.

Assist the youth/young adult to plan for a permanent living arrangement by identifying a safe

and appropriate living arrangement which:

§ is in compliance with related contract, licensing and certification requirements, as applicable;

§ is supportive of continuous skill development by providing the means for the youth/ young adult to practice and gain mastery of adult living skills, such as cooking, cleaning, laundering, etc.; and

§ complements the long term needs of the youth/young adult.

BEST PRACTICE TIP

"Nothing About Me Without Me" must guide the planning for youth living in foster care. One of the most significant concerns expressed by youth in care in survey and forums is the lack of voice they have in planning for their own life. In order to engage the voice of youth in care, the CPS Specialist must convey to the youth that what they think, feel and want really matters. Too often youth tell us that they do not feel that their wants and expressed needs are considered.

Ensure the plan for continued care supports the discharge plan in addressing how basic needs will be met (post-foster care), which includes the establishment of a safe, stable living arrangement, supportive/nurturing relationships and available resources in their community. No young adult may be discharged to a state of homelessness.

The Assistant Program Manager or designee will review and approve or disapprove the case plan for continued care. The Assistant Program Manager or designee may recommend changes in the plan in order for approval to be given.

If the case plan for continued care is not approved, the Assistant Program Manager or designee will meet with the CPS Specialist and young adult to review and remediate concerns with the plan.

Upon approval of the case plan for continued care, provide case planning and services which include, but are not limited to:

- cost of care (includes Independent Living Subsidy for youth who qualify);
- allowances;
- medical and dental services, (through AHCCCS unless the youth is otherwise ineligible);

- transportation;
- counseling;
- independent living skills training, and
- other transitional support services.

The department shall maintain the young adult's current living arrangement. No changes to the living arrangement may occur without the approval of the young adult, unless the living arrangement cannot be maintained due to contract, licensing, certification, safety or other reasons.

The young adult should maintain satisfactory progress as defined in the case plan and/or specific education or training program.

Review the youth's discharge plan during each case plan staffing and additionally, at least 60 days prior to case closure to determine what aftercare services are needed.

DOCUMENTATION :

Document the plan for continued care in the Independent Living Case Plan, obtain the young adult's signature on the case plan and provide a copy to the young adult.

Document any changes in the current living arrangement in the Independent Living Case Plan. Use the explain box to provide information which supports the change in the current living arrangement, including the young adults approval of the new living arrangement.

Update CHILDS to reflect the youth's change in legal status or living arrangement and to extend any purchased services.

Complete form FAA-1097 AFORNA, the DCYF/FAA Turn-Around (TAD), Application and Young Adult Transitional Insurance (YATI) and submit to FAA Internal Operations staff at Site Code 759C. (Retain a copy in the case record.)

Assistant Program Manager

Document review and approval of case plan for continued care.

Revision History:

DES(07-2006)

Previous / Next

16-5

Legal Basis: ARS §46-134 provides the basis for terminating voluntary foster care to young adults 18 through 20 years of age.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 5

Conclusion of Participation in the Voluntary Program

Legal Basis

Policy: Participation in the Independent Living Program or in voluntary continued out-of-home care will be concluded when the young adult has:

- reached the age of 18 and does not desire continued services; or
  - reached the age of 21; or
  - made a voluntary decision to withdraw from the program; or
  - generally demonstrated non-compliance with or refusal to meet the requirements of the case plan.

The department shall not terminate voluntary foster care services until all requirements are satisfied, including the case plan staffing, grievance/complaint process and development and implementation of an appropriate discharge plan.

The department shall not transition a young adult to a state of homelessness.

A case plan staffing shall be held when a decision to remove a young adult from continued placement is under consideration. The appropriateness of ending the department's care and supervision of the young adult will be discussed and include a review of the existing discharge plan.

The department shall ensure an appropriate discharge plan is developed for all youth served which includes:

- the plan to meet the identified needs as gathered from the comments, recommendations, and requests of the youth, caregiver and other service team members; and
- specific plans for obtaining any identified services.

The department shall explore suitable resources and ensure the child and caregivers are provided sufficient information to enable them to contact the service provider and initiate services identified in the discharge plan. When appropriate and with the permission of the

youth, the department may make contact with the service providers.

Implementation and Procedures Guide

Prior to discharge, hold a case plan staffing which includes the following participants:

- § the youth;
- § the CPS Specialist;
- § the Assistant Program Manager or designee;
- § other service team members currently providing services; and
- § the aftercare service provider.

If the youth does not desire to continue in foster care, proceed with the discharge plan and provide information on aftercare services available through the Transitional Independent Living Program.

If the youth desires to continue services, review the current plan and discuss the areas where the youth has not met the obligations of the plan. Assist the youth to identify any barriers to meeting the plan's obligations and if those barriers may be remedied, revise the case plan to include any additional tasks or services needed to assist the youth to meet case plan goals. If the barriers cannot be remedied (i.e., youth is using illegal drugs or alcohol and refuses to participate in treatment or discontinue use) request approval for case closure. The Assistant Program Manager or designee will review the recommendation of the CPS Specialist and approve/disapprove the case closure.

If the Assistant Program Manager or designee approves the recommendation for case closure, the young adult will be notified by phone and in writing. If the young adult agrees with termination of foster care services, the CPS Specialist will proceed with case closure. The CPS Specialist shall contact the youth in person to:

- Review the discharge plan with the youth and refer the youth to available aftercare services.
- Provide the youth with their original birth certificate, state identification card and social security card.
- Follow up by sending a closure letter to the youth confirming the date of closure, right to appeal and statement of aftercare services available through the Transitional Independent Living (including the opportunity to re-enter DCYF supervised services)

and Young Adult Transitional Insurance program as well as other resources available in their community.

If the young adult does not agree with termination of services, the Assistant Program Manager or designee shall advise the youth and their caregiver, and community advisor or advocate, of the youth's right to file an appeal/grievance of the termination of services and provide the DES/DCYF ACF-1095 AFORNA.

All services including out-of-home care will remain intact until such time that the complaint/ grievance process is complete.

DOCUMENTATION :

Document the youth's voluntary termination of services (including the reason for termination) in the Case Notes window designated as Child Contact.

Document approval, using the Case Notes window designated as Supervisory type.

Document assistance provided to youth to complete and submit the DES/DCYF Client Complaint/Grievance, form ACY-1095A.

Update CHILDS to end all authorized and pending Independent Living Subsidy Program purchased services, if applicable.

Complete the Foster Care Discharge Summary Report for Young Adults 18 and Over, FW 177; send the completed FW-177 to the Independent Living Specialist at Site Code 186C.

Give the young adult the Notification to Young Adult Leaving Foster Care, FW-502; and the Post-Discharge Questionnaire, FC-191, with a stamped envelope addressed to the Department of Economic Security, Independent Living Specialist, 1818 E. Southern, Suite 17B (Site Code 186C), Mesa, AZ 85204.

Notify the young adult of the requirement to complete an annual review through Financial Assistance Administration (FAA) to continue health services and to contact FAA to update their current residential address.

Update the YAP/ILS Enrollment window.

Revision History:

DES(07-2006)

Previous / Next

16-6

Legal Basis: ARS §8-521.01 describes qualifications for participation in the Transitional Independent Living Program.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 6

Overview of the Transitional Independent Living Program

Legal Basis

Policy: Young adults who were in out-of-home placement in the custody of the department or a licensed child welfare or tribal child welfare agency while age 16, 17 or 18, but have not reached the age of 21, may received transitional living support services through an individualized, written agreement which complements their own efforts to achieve self-sufficiency and which assures acceptance of personal responsibility for preparing for and transitioning from adolescence to adulthood.

Young adults who were in out-of-home care in the custody of the department, a licensed child welfare agency or tribal child welfare agency on their 18th birthday, but have not reached the age of 21, may additionally receive assistance with room and board costs. Funds may not be used for room and board payments for youth who left their out-of-home placement and were no longer in the custody of the department prior to their 18th birthday.

The department will provide young adults who exited foster care at age 18 or older the opportunity to re-enter services under the supervision of the Division of Children, Youth, and Families (DCYF), at any time until the young adult reaches age 21.

The young adult must have a service plan which includes independent living objectives and tasks related to these objectives.

Implementation and Procedures Guide

CPS Specialists, Supervisors, Assistant Program Managers, District Program Managers and Administrative Staff will be knowledgeable of and share information with youth, caregivers, FCRB, Juvenile Court, Court Appointed Special Advocates and others on current contract agencies providing aftercare services through the Transitional Independent Living Program.

The department shall facilitate a meeting with the youth and contract provider prior to the

termination of case management services, if the youth is willing to accept a referral for aftercare services.

Young Adults who desire to re-enter services under the supervision of the DCYF may do so by contacting the local Transitional Independent Living Program (TILP) contract provider. The TILP contract provider will:

§ Provide services and support (including available financial assistance through the TILP) that will assist the Young Adult to resolve current housing, mental health, employment or other crises.

§ Confirm the Young Adult's desire to receive long term case management and other services; (Youth who do not desire to return to DCYF for services may continue to receive aftercare services through the TILP.).

§ Assist the Young Adult to develop an individualized plan which includes goals, objectives and tasks which will lay the foundation for the Young Adult's eventual self-sufficiency in the areas of housing, employment, education, physical and mental health, etc.

§ Notify the local DCYF Independent Living (IL) Coordinator of the potential case transfer.

§ Monitor the Young Adult's compliance with the individualized plan for a period of **up to 90 days**.

If the Young Adult maintains satisfactory progress toward meeting their case plan goals for a period of **up to 90 days**, the TILP contract provider will schedule a staffing with the local DCYF Independent Living (IL) Coordinator for the purpose of facilitating transfer of services to DCYF. DCYF may accept the case earlier than **90 days**.

The local DCYF IL Coordinator will meet with the Young Adult and the TILP contract provider to coordinate the transfer of services. The local DCYF IL Coordinator will:

§ Affirm the Young Adult's desire to resume supervision and services through the DCYF.
§ Identify the assigned DCYF CPS Specialist.
§ Review the requirements and responsibilities of Young Adults in continued services.
§ Review the current individualized plan, services provided and the Young Adult's

progress in services.

§ Facilitate any service or other revisions needed to the plan.

§ Arrange for cost of care to support the current or anticipated living arrangement through the use of the Independent Living Subsidy stipend or other resources.

Young Adults participating in services and supervision through the DCYF must cooperate with the assigned CPS Specialist in developing an agreement which identifies how they will increase their skills to become self-sufficient. The agreement must document the young adult's acceptance of personal responsibility to:

§ Maintain enrollment in, or enroll in an education, training or employment program of their choice.

§ Participate in the education or training program of their choice by attending classes and earning related credits/certificate/license/degree.

§ Prepare for financial self-sufficiency by participating in employment or employment readiness activities of their choice, which may include paid employment, volunteer work or other activities defined in the case plan that will assist the youth to strengthen their employability.

§ Identify personal physical and mental health needs and participate in health services, including mental health services of their choice.

§ Identify and maintain a safe living arrangement.

The assigned CPS Specialist will be responsible for evaluating the need for continued case management and other services, including financial assistance for room and board related costs, every six months, or more often if needed. Services may only be discontinued as described in Conclusion of Participation in the Voluntary Program (Chapter 16, Section 5)

Revision History:

DES(07-2006)

Previous / Next

16-7

Legal Basis: ARS §§28-3160 and 28-3161 sets forth the requirements for the issuance of a driver's instruction permit or license to a minor. The person who signs the application for the permit or license is liable for any negligence or willful misconduct of the minor when driving a motor vehicle on a highway.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 7

Obtaining a Driver's License

Legal Basis

Policy: The department shall not sign for a driver's instruction permit or a driver's license.

When the youth is a ward of the court, the department cannot sign for a driver's instruction permit or a driver's license. The Department of Motor Vehicles sets out the requirements for parent/guardian signature for a minor's driver's instruction permit or license as follows:

- A person who is at least fifteen years of age, who is attending school and who is not living or residing with the person's parent or guardian may apply for a restricted instruction permit issued pursuant to section 28-3155. An approved instructor of the drivers training program for which the permit is issued may sign the application in lieu of the requirements of section 28-3160.
- The permit is valid only when the instructor who signed the application is in the vehicle with the permittee.
- If the person is under eighteen years of age, an approved instructor assumes the obligations imposed on a person signing the application of a minor only when the instructor who signed the application is in the vehicle with the permittee.
- The application for a restricted instruction permit shall include a statement that the instructor who signs the application understands that the instructor is liable for damage caused by negligence or willful misconduct of the permittee while operating a motor vehicle when the instructor is in the vehicle.

The following person or persons shall sign and verify, before a person authorized to administer oaths, the application of a person under eighteen years of age for an instruction permit, a class G or M driver license or an endorsement to a class G or M driver license:

- if neither parent of the applicant is living, the person or guardian who has custody of the applicant or an employer of the applicant;
- if the applicant resides with a foster parent, the foster parent; and.
- if there is no guardian or employer of the applicant, a responsible person who is willing to assume the obligation imposed by this chapter on a person who signs the application of a minor.

The person who signs the application of the minor accepts all responsibility for the actions of the minor when driving a motor vehicle. The department does not accept responsibility for the actions of the minor when driving a motor vehicle.

BEST PRACTICE GUIDE:

Youth growing up in foster care have many limitations in their lives—and seek to have what they perceive to be "normal" adolescent experiences. For most of us, getting our driver's license was a significant passage to adulthood. It signified freedom and it was a statement of trust from the adult world. Youth in care should have the same experiences as other adolescents their age. CPS Specialists should take the time to ensure that whenever possible youth involved in the child welfare system have an option to obtain their driver's license.

Sometimes foster parents have established a "rule" for all of the children in their care that children in their home cannot obtain a driver's license. This "rule" is contrary to allowing children in care to have as many "normal" life experiences as possible. If foster parents are reluctant to allow a child in their home to obtain their driver's license, the CPS Specialist should engage in a conversation with them about their concerns.

For additional information on applications for minors and liability, please refer to **ARS §28-3160** and **ARS §28-3161**.

Revision History:
DES(07-2006)

Previous / Next

16-8

Legal Basis: The Adoption and Safe Families Act of 1997 (P.L. 105-89) specifies that, if the state concludes, after considering reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, that the most appropriate permanency plan for a child is placement in another planned permanent living arrangement (APPLA), the state must document to the court the compelling reason for the alternate plan.

Examples of a compelling reason for establishing such a permanency plan may include the tribe's identification of another planned permanent living arrangement for the child [45 CFR 1356.21(h)(3)(iii)]. Another example of a compelling reason is a youth who opposes termination and adoption.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 16: Section 8

Long Term Foster Care As a Planned Permanent Living Arrangement

Legal Basis

Policy: The department shall establish long term foster care as another planned permanent living arrangement (APPLA) only when the permanency options of adoption and guardianship are not in the best interests of a child, the child is expected to remain in out-of-home care at least until the age of majority and the foster home provider has made a commitment to continue as a permanent supportive adult in that child's life.

The department shall establish a formalized agreement between the agency, foster home provider and child to support the continuity and stability of the placement.

When a child's planned permanent living arrangement is long term foster care, the department shall maintain contact with the child's parents or extended family, whenever possible, to:

- Inform and involve the family in decisions about their child where feasible.
- Stay informed of changes in the family situation that might indicate a need to re-evaluate the permanency goal of long-term foster care, unless such contact would compromise the safety of the child.

Consider the following questions in deciding upon a planned living arrangement of foster care:

Is the child expected to remain in out-of-home care until the age of majority?

- Is there a compelling reason why the foster home provider cannot or will not pursue adoption or guardianship of the child, and is it in the child's best interest to remain with the provider?
- Have you documented a compelling reason that adoption or guardianship is not in the child's best interest?

§ Have the benefits of adoption and guardianship been explored with the child?

§ Is the child over 12 years of age and unwilling to consent to an adoption?

§ Has the foster care provide verbalized their commitment to continue as a permanent supportive adult in that child's life?

§ Has the foster care provider verbalized their commitment to ensure the child maintains connections with their immediate and extended family?

BEST PRACTICE TIP:

No child should leave the child welfare system without a legal relationship to an adult who cares about them and is unconditionally committed to them. This is the definition of permanency. Sometimes we give up on permanency for older youth too soon—we don't think that they are "adoptable". It is critical that CPS Specialists continue to search out permanent options for children in care. However, the reality is that there are times when children are not placed for adoption, or do not have legal guardians. While this should be rare as it is very difficult for children to leave the child welfare system without consistent and reliable adult supports, and the Adoption and Safe Family Act does not allow for Long Term Foster Care as a viable permanency option, it does happen.

First and foremost, we should attempt to prevent this lack of permanency. We know from studies across the country that when permanency planning begins at the point of placement, when kin are identified early in the process and when CPS Specialists are diligent in their efforts to identify permanency options for children, the number of youth "aging out of care" decreases.

When this work has not been done early in the process, we need to ask the youth who matters in their life. Youth are very often able to identify possible permanency options, if just asked. We also need to go back and review the file of the youth, often kin were identified during the early phases of serving the child and family, but they were not pursued as permanency options.

When there appears to be no way for the child to have a legal relationship with an adult when leaving the child welfare system, we need to seek out adult connections for the youth. Several states call Youth Connection meetings prior to the youth's 18th birthday, bringing adults who care about the child together to create a plan –identifying which adults can support the youth during predictable tensions and struggles. When youth leave the system foster parents often serve as an informal support for the youth. CPS Specialists should meet with the foster parents and the youth to help them clarify the continued relationship.

Obtain the program manager or designee's approval prior to pursuing a plan of foster care as a planned living arrangement.

Formalize the plan through the Long Term Foster Care Agreement, FC-092.

Request the court to grant physical custody of the child to the out-of-home provider**.**

Continue to provide all case planning and case management services, as described in Family Centered Case Planning (Chapter 9).

Support continued contact between the child and his or her parents, siblings and extended family members, unless such contact would be detrimental to the child.

Whenever possible, maintain contact with the child's parents or extended family, to:

- Inform and involve the family in decisions about their child where feasible.
- Stay informed of changes in the family situation that might indicate a need to re-evaluate the permanency goal of long-term foster care, unless such contact would compromise the safety of the child**.**

DOCUMENTATION :

Document the selection of long term foster care as APPLA as the chosen living arrangement in the Permanency Goal window.

Document the formalization of long-term foster care, using the Long Term Foster Care As a Planned Living Arrangement Agreement, FC-092.

Revision History:

DES(07-2006)

Previous

17-1

Legal Basis: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193) requires the department to consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant state child protection standards.

ARS §8-105(M) identifies individuals who are exempt from adoption certification by the court. These individuals include a person who is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle, grandparent or great-grandparent of the child by the whole or half-blood or by marriage or adoption.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 17: Section 1

Approval of Relative Adoptive Family

Legal Basis

Policy: The department shall complete an extensive and documented search for relatives who can provide safe and permanent adoptive homes for children needing adoptive placement. See Relative Search Best Practice Guide (Exhibit 12)**.**

The department shall accept an application for adoption from a relative who is not required to be certified and who intends to adopt a related child who is a court ward.

The department shall make available a maximum of thirty hours of Arizona PS-MAPP Training to relatives wanting to adopt a relative child who is a court ward

The department shall approve for adoption placement the home of an adult relative who is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle, grandparent or great-grandparent of the child by the whole or half-blood or by marriage or adoption when the relative is assessed as acceptable to adopt.

Approved relative adoptive families shall be entered into the CHILDS Provider (Adoption) registry.

When considering relatives for adoptive placement, consider the following:

- Does the relative offer the child a positive connection to his/her heritage and to extended family members, specifically siblings not placed together?
- How will the relative's relationship with the child's parents impact upon the child's needs for a safe and nurturing home?
- Can the relative family meet the child's identified physical, social and emotional needs?
- Is there any background information about the relative family that would adversely

affect the family's ability to provide a safe and nurturing environment?

- Does the family appear to understand and accept the dynamics of adoption, including the child's knowledge of his or her birth parents?
- Do all family members - and the family unit collectively - appear stable enough to accept the changes that the addition of an adopted child will bring to the family?

BEST PRACTICE TIP:

Relatives play a role in raising children when their parents cannot care for them. The care, nurturing and protection of children by extended family is a long standing tradition in all cultures. The child welfare system should make the kinship care process fit neatly into the foster care licensing process. Kin are family and as such, CPS Specialists, private and contract agency case managers, need to consider how this tie to family, roots and culture can and should outweigh circumstances like not enough bedrooms or bathrooms and other physical plant considerations that have influenced our thinking in foster care.

For more information on Commitment to Kinship Care go to the Casey Family Programs Website http://www.casey.org/Resources/Publications/CommitmentToKin.htm

Implementation and Procedures Guide

View relevant birth certificates and/or marriage license/registration to confirm that the interested relative is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle, grandparent or great-grandparent of the child by the whole or half-blood or by marriage or adoption.

According to district procedure, provide to the relative who is not required to be certified and who intends to adopt a related child who is a court ward an application for adopt.

Provide to the relative who wants to adopt a related child who is a court ward the opportunity to attend all or part of Arizona PS-MAPP Training.

Ensure that the relative and all adults permanently living in the household have:

§ completed fingerprinting and have a state and federal criminal history records clearance within the last year; and

- a current Child Protective Services records clearance.

If the fingerprint and criminal history records check are not current within the last year, provide information to the relative on arranging for the relative and all adults permanently living in the household to complete:

- Request for Licensing/Employment Information, J-709;
- FBI Fingerprint Card, FD-258; and
- AN-048, Adoptive Families CPS Records Clearance.

Schedule a case conference if the fingerprinting has not been initiated within 30 days. The conference should include the child's CPS Specialist, his/her supervisor, and the relative. It should focus on resolving any barriers to completion of the fingerprinting and home approval process or, if necessary, on planning for selection of another family.

If the Child Protective Services records clearance was not previously completed or is not current, complete a search of the Child Protective Services Central Registry and CHILDS Case Management Information System for current or prior child abuse and neglect reports and history. Confirm the outcome of any child abuse or neglect reports.

When the relative and all adults permanently living in the household have a criminal history records clearance and Child Protective Service records clearance, assess the relative's ability to parent the child by:

- reviewing and/or updating the Assessment for Kinship Foster Care or Significant Person Placement report;
- reviewing the child's assessed placement needs in CHILDS and/or the child's hard copy record; and
- reviewing any other relevant documentation in determining the relative's ability to meet the child's assessed needs.

If not already completed, conduct an assessment of the relative family using the Assessment for Kinship Foster Care or Significant Person Placement, CT01100, found in the Court Document Detail.

If the relative is assessed as capable of meeting the child's placement needs and is determined to be the most appropriate placement, obtain supervisory approval of the relative as an adoptive home for the child.

DOCUMENTATION :

Enter the approved relative adoptive family into the CHILDS Provider (Adoption) Registry according to district operating procedures or:

§ Complete a person search in CHILDS using the Find Person window.

§ Confirm and update the Address and Phone Number window when the relative is identified in CHILDS.

§ Confirm that the relative who is identified in CHILDS has a High Level Client Index Number in the Participant Detail window.

§ Complete the Person Detail, Address and Phone Number, Participant Detail and High Level Client Index Directory windows when the relative is not identified in CHILDS.

§ Confirm, update or complete name, address, non-profit status and phone and fax numbers in the Provider Maintenance Detail window.

§ Confirm, update or complete facility ID, operating hours, secure facility and mail warrants here fields in the Provider Maintenance Facility Detail window.

§ Confirm, update or complete contact person and role fields in the Provider Maintenance Contact window.

§ Select the ADOPTION service group and ADREL-NONCERT service type on the Provider Maintenance Service Detail window. Use the date of supervisory approval as the effective date the home was approved for adoption.

§ Confirm, update or complete household member and role fields in the Provider Maintenance Household window.

§ Confirm, update or complete address and phone number fields in the Provider Address and Phone Numbers window.

§ Complete the Adoptive Family Evaluation window once the child is placed in the relative adoption provider home.

§ Do not complete Provider Maintenance Preference Detail, Provider Maintenance Special Capabilities, Provider Maintenance Certification List, Provider Maintenance Status

List, and Provider Maintenance Homestudy.

§ Document supervisory approval of the relative as an approved relative adoptive family using the Case Notes window designated as Supervisory Contact type.

For More Information on completing the service authorization and approval process see CHILDS Users Guide in public folder, Creating an Adoption Case.

Revision History:

DES(07-2006)

Next

17-2

Legal Basis: ARS §8-103 specifies that "any adult resident of this state, whether married, unmarried or legally separated is eligible to qualify to adopt children."

ARS §8-105(A) requires an individual to be certified by the court as acceptable to adopt a child before filing a petition to adopt a child.

ARS §8-105(M*)* identifies individuals who are exempt from adoption certification by the court. These individuals include a person who is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle, grandparent or great-grandparent of the child by the whole or half-blood or by marriage or adoption.

ARS §8-105(D) specifies that the division shall not present for certification a prospective adoptive parent unless that person has a valid fingerprint clearance card pursuant to title 41, chapter 12, article 3.1 or provides to the division documentation of the person's application for a fingerprint clearance card. The prospective adoptive parent must certify on forms that are provided by the division and that are notarized whether the prospective adoptive parent is awaiting trial on or has ever been convicted of any of the criminal offenses listed in section 41-1758.03, subsection B and C in this state or similar offenses in another state or jurisdiction.

The Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188) prohibits the denial to any person the opportunity to become an adoptive or foster parent on the basis of the race, color or national origin of the person, or of the child involved.

Rules: Section R6-5-6505 of the Arizona Administrative Code provides procedures for the processing of certification applications.

Section R6-5-6506 of the Arizona Administrative Code sets priorities for receipt of services.

Section R6-5-6509 of the Arizona Administrative Code sets fees for certification, investigations and reports.

Revision History:
DES(07-2006)

Chapter 17: Section 2

The Adoption Application Process

Legal Basis

Policy: The department welcomes applications for adoption of eligible children in its care, custody and control and shall consider requests from any individual who meets the criteria specified by Arizona law.

The department's priorities for accepting and processing certification applications and for providing services shall be:

- § applicants seeking to adopt a particular adoptable child with special needs;
- § applicants who wish to adopt a child with special needs;
- § applicants who have indicated they would consider adopting a child with special needs;
- § applicants for whom the court has ordered the department to do a certification investigation and report; and
- § all other applicants.

Before accepting applications, the department shall provide prospective adoptive families with the information necessary to make an informed decision about adoption.

Prior to accepting a formal application to adopt from a person contemplating adoption of a special needs child, the department shall provide **a maximum of 30 hours** of Arizona PS-MAPP Training.

To be considered as a potential adoptive parent - whether for a specific child or for a child unknown to the applicant - an individual must complete and submit a formal application for adoption, along with a certification fee (unless it has been waived or deferred). The application process includes submission of:

- § a completed Foster Home License, Adult Developmental Home License or Adoption

Certification Application, LCR-1032, which includes a financial statement;

§ a Fingerprint Clearance Card Application, DPS 802-06857, for each adult member of the household; and FBI Fingerprint Card, FD-258;

§ a Physician's Statement, LCR-1040, for each parent; and

§ a Criminal Records Self-Disclosure, LCR-1034B.

Requests for waivers or deferments of certification investigation and report fees must occur prior to the filing of the formal application to adopt, by completing AN-058, Application for Waiver of Adoption Certification Fee or AN-060, Application for Deferment of Adoption Certification Fee.

Implementation and Procedures Guide

Certification Specialist:

Before accepting applications, conduct a group or individual meeting with prospective adoptive parents. Ensure that they understand:

- the characteristics of children that are available for adoption through the department;
- the dynamics of the adoption process, including the child's knowledge of and/or relationship to his or her birth family;
- the application and approval processes, including the $800 certification investigation and report fee and provisions for waiver or deferment; (**R6-5-6509**)
- the selection, placement and post-placement supervision processes;
- the adoption subsidy program;
- the foster-adoptive program; and
- provide the name of agencies that place children for adoption.

BEST PRACTICE TIP:

Children from the child welfare system may continue to have strong connections to their family. Adoptive parents should be encouraged to consider continuing contact between the child and their family following the adoption. The amount and type of contact is dependent upon the circumstances of the family and the desires of the child. Continuing contact should be based on the best interest of the child currently and in the future.

Provide interested individuals with application forms and application for waiver or deferment of fee, if applicable. Arrange additional meetings to help families clarify their feelings about adoption, if necessary.

Help to arrange for fingerprint clearance of prospective adoptive parents and all adults permanently living in the household using the following forms:

- § Fingerprint Clearance Card Application, DPS 802-06857;
- § FBI Fingerprint Card, FD-258; and
- § Criminal records Self-Disclosure, LCR-1034B.

To accept a completed application, follow **R6-5-6505**.

DOCUMENTATION :

Enter a prospective adoptive family into CHILDS as an applicant according to district operating procedures or by completing the Person Detail, Address and Phone Numbers, Provider Maintenance Detail and Provider Maintenance Certificate List Detail windows.

Complete determination section of Application for Waiver of Adoption Certification Fee, AN-058 or Application for Deferment of Adoption Certification Fee, AN-060.

If applicable, collect $800 certification investigation and report fee and forward to ACYF Budget Unit, Site Code 940A.

Revision History:
DES(07-2006)

Previous / Next

17-3

Legal Basis: ARS § 8-105(A) requires that an individual must be certified by the court as acceptable to adopt prior to filing a petition to adopt.

ARS § 8-105(E) and (G) requires the department to investigate individuals who wish to adopt, identifies information which must be reported to the court and provides a timeframe for submitting information to the court.

ARS § 8-105(H) requires the court to certify the adoptive applicants as acceptable or non-acceptable to adopt within 60 days of receiving an investigation report. An adoption certification remains in effect for 18 months and may be extended for additional one year periods.

ARS § 8-105(M) identifies individuals who are exempt from adoption certification by the court. These individuals include a person who is the spouse of the natural or legal parent of the child to be adopted, or is the adult sibling, aunt, uncle, grandparent or great-grandparent of the child by the whole or half-blood or by marriage or adoption.

Rules: Section R6-5-6605 of the Arizona Administrative Code discusses certification investigation.

Section R6-5-6606 of the Arizona Administrative Code contains Rules pertaining to home studies.

Revision History:
DES(07-2006)

Chapter 17: Section 3

The Family and Home Evaluation and Certification Process

Legal Basis

Policy: The department shall conduct a Family and Home Evaluation (home study) for all individuals who submit a completed application for adoption.

The **Family and Foster Home Evaluation** (home study) (Exhibit 41) shall be completed **within 90 days** after the application to adopt is submitted. [ARS §8-105(G)] If the study is not completed **within 90 days,** the department shall request an extension from the court.

The department encourages families to realistically appraise their potential to parent children in the department's care, custody and control during the Family and Foster Home Evaluation (home study) process.

The department shall contact at least three references who have known the family for two years or more years and no more than two references shall be related to the applicant by blood or marriage.

At the conclusion of the Family and Home Evaluation (home study) process, the department shall recommend to the court whether the applicant is acceptable or not acceptable to adopt.

The department will not conduct a family and home evaluation for a spouse of the natural or legal parent of a child to be adopted, or an adult sibling, aunt, uncle, grandparent or great-grandparent by whole or half-blood, or by marriage or adoption unless ordered by the court.

If the department recommends that an applicant is *not* acceptable to adopt, the family shall be informed:

- of the specific reasons for the recommendation;
- of their right to appeal the decision [ARS §8-105(J)]; and
- that if they are certified as non-acceptable to adopt, they may not reapply for one year. [ARS §8-105(K)]

Families wishing to participate in the Foster-Adoptive Program shall be provided thorough

information regarding their role as foster-adoptive parents as well as the risks and benefits involved. The Foster-Adoptive Family will undergo the same Family and Foster Home Evaluation (home study) and certification process as other adoptive families.

At the court's order, the department shall perform adoptive Family and Home Evaluations (home studies) for private adoptive placements.

The Child Abuse Hotline shall perform Child Protective Services Central Registry clearance checks for private and contracted adoption agencies. The Child Protective Services Central Registry clearance check shall include *only* substantiated reports of child abuse and neglect [ARS §804] [ARS §8-807(C)(14)].

The department charges a fee of $800 to complete a certification investigation and report. The department may grant a waiver or deferment to an applicant who is planning to adopt a child with special needs.

In deciding whether a family is acceptable to adopt, consider these questions:

- Will the family be able to meet a child's basic physical needs?
- Will the family be able to meet a child's basic needs for safety, nurturance and guidance?
- Does the family appear to understand and accept the dynamics of adoption, including the child's knowledge of his or her birth parents?
- Do all family members - and the family unit collectively - appear stable enough to accept the changes that the addition of an adopted child will bring to the family?

BEST PRACTICE TIP:

A family evaluation for adoption presents an opportunity to help families understand the needs of children being adopted out of the child welfare system. It presents an opportunity to understand the family's needs and desires, and it also provides the opportunity to help the family understand why adopting a child from the child welfare system presents a unique set of rewards as well as challenges. Not only must the family understand the need to be open to the child having ongoing interaction with their birth family, if the child is from a different race or

culture than the adoptive family, they need to understand the importance of ensuring that the child maintains a connection to his/he culture and racial identity. Children who have been adopted and whose adoptive parents did not ensure this connection report that they often struggled with understanding who they were and where they fit. This willingness to allow children to explore their culture and their race demands a level of cultural competence by the adoptive parents. See Cultural Competence Continuum (Exhibit 39).

When children of color are adopted by families of different race and ethic backgrounds, CPS Specialists and private and contract agency case managers need to explore the issue of race and racial biases with the families.

Implementation and Procedures Guide

Certification Specialist:

Use the Arizona PS-MAPP Family Profile both to gather information for the Family and Home Evaluation (home study) as well as to help the prospective adoptive family clarify their wishes and expectations for an adoptive child and explore issues relating to their parenting.

For a couple, conduct a minimum of two joint interviews and one individual interview with each spouse. For a single applicant, conduct a minimum of three interviews. In both cases, also conduct one individual interview with every household member over the age of five.

Use **Family and Foster Home Evaluation,** (Exhibit 41), as a guide for writing the evaluation report, unless the court has prescribed a different format.

Contact at least three references who have known the family for two years or more years. At least two of the references must be contacted personally or by phone and not more than two references shall be related to the applicant by blood or marriage.

Check the Foster Home license, Adult Developmental Home License or Adoption Certification Application for Court/Agency Actions involving:

- § allegations of abuse or neglect of a child;
- § a dependency action on a child; or
- § a termination of parental rights.

If so, gather additional information:

§ If the case was within the department, review the department's record to obtain the information necessary to answer the questions in the Court Action section of the Family and Home Evaluation (home study).

§ If the department was not involved in the case, contact the Attorney General's Office for help in making an application to review the court file. Obtain the following information from the court file and include it in the Family and Home Evaluation (home study):

- § the year, title, case number and county of the court action;
- § the name, birthdate, and birthplace of the child involved in the action;
- § the name of the CPS Specialist, attorney and judge involved in the action;
- § the outcome of the action;
- § whether the applicant was a party to the action; and
- § other information that appears relevant to the application to adopt.

If the Family and Home Evaluation is being completed by department staff, conduct a search of the Child Protective Services Central Registry of substantiated reports of child abuse and neglect.

If the family appears inappropriate to adopt, consult with your supervisor. If your supervisor concurs, meet with the family to discuss:

§ specific changes that the family must make in order to be considered as a potential adoptive family;

§ any additional information that may affect the assessment;

§ voluntary withdrawal by the family; and/or

§ the consequences of a recommendation that the family is not acceptable to adopt and the family's right to appeal.

If the family appears appropriate to adopt, request that the family provide the following documentation:

§ medical information on each adult in the home, provided by a licensed medical practitioner on the Physician's Statement, LCR-1040;

§ medical information on each child in the home, provided by a licensed medical practitioner on the Health and Information and Medical Examination of Child, FW-005,

§ a recent picture of the family members and their home;

§ proof of marriage(s);

§ proof of divorce(s);

§ military discharge papers;

§ pay stubs, to verify earnings of each employed family member;

§ bankruptcy filed in the past seven years (if applicable);

§ written statement from the family's health insurance company, if any, regarding coverage available to the adoptive child upon placement in the home and after the adoption is finalized; and

§ verification of legal alien status for non-citizens.

At the conclusion of the family and home evaluation (home study) process, submit the Family and Home Evaluation report (home study) and results of the application for a fingerprint clearance card or proof of application for the finger print clearance card, Child Protective Service Central Registry records check of substantiated reports--along with the recommendation that the family is "acceptable" or "not acceptable" to adopt--to the court for action. The report (home study) must be signed by both the Certification Specialist and supervisor.

DOCUMENTATION :

Complete and/or update the CHILDS Provider Maintenance Homestudy and Provider Maintenance Status List Detail windows to show that the Family and Home Evaluation (home study) has been completed**.**

If the family withdraws from consideration prior to certification, update CHILDS by completing the Provider Maintenance Certification List Detail, Provider Maintenance Homestudy and Provider Maintenance Status List Detail windows to indicate the case is closed.

Revision History:

DES(07-2006)

Previous / Next

17-4

Legal Basis: Not applicable

Rules: Section R6-5-6507 and Section R6-5-6508 of the Arizona Administrative Code addresses services for families after certification.

Revision History:
DES(07-2006)

Chapter 17: Section 4

Services for Families after Certification

Legal Basis

Policy: After a prospective adoptive family has been certified by the court, the department shall work actively to match the family with a waiting child whose needs the family can successfully meet.

The department shall initially help families to consider adoption of children listed on the CHILDS Adoption Registry; if no appropriate children are available, the department shall help families identify children listed on the National Adoption Exchange (NAE) or other state or regional exchanges.

Families may want to register with the AdoptUSKids if:

- They wish to adopt a child over age six.
- They wish to adopt a child with a moderate to severe handicap.
- They are of minority ethnic status.

If a family seeks to adopt a child from another country, the department shall cooperate with the international agency to provide necessary pre-placement information and may provide assistance and services to the family if resources are available to do so.

When the department receives adoptive home studies with court certification from private agencies, the court or out-of-state authorized entities, these families will be considered for placement in the same manner as families that applied for adoption through the department.

Court certification remains in effect for 18 months and can be extended for additional one year periods. [**ARS §8-105(H)**]

A certified adoptive family may petition to adopt more than one child during a certification period. [**ARS §8-105(H)**]

A family may remain on the CHILDS Provider (Adoption) Registry as long as they are certified

to adopt.

Adoptive families certified by the court in a specific county and relocating to another county in the state may remain available for placement on the CHILDS Provider (Adoption) Registry until the certification expires.

Implementation and Procedures Guide

Certification Specialist

Establish a review file that will be used to present the prospective family to CPS Specialists of children awaiting adoption. It should include:

- a copy of the completed Foster Home license, Adult Developmental Home License, or Adoption Certification application, LCR-1032;
- a copy of the Court Certification;
- a copy of the initial Family and Home Evaluation Report; and
- if possible, a picture of the prospective adoptive family and their home.

Upon request, send the review file to CPS Specialists who have identified the family as a possible match for a waiting child.

If a family has not received a child within a 18 months, extend the certification by completing the Family and Home Reevaluation CT05400, found in the Court Document Detail or Resource Family and Home Reevaluation (Exhibit 40) and submit the report to the court for extension of certification no later than 30 days prior to certification expiration.

National Adoption Exchange

If a family chooses to be registered on the AdoptUSKids, the Adoption Specialist can provide information on registering families on AdoptUSKids.

If a family is interested in a child listed on a state or regional exchange, obtain a release from the adoptive parents before sending their home study or other confidential materials to that state.

DOCUMENTATION :

Certification Specialist:

After receiving the order of certification, ensure that the family is entered into the CHILDS Provider (Adoption) Registry by completing the following windows:

- Provider Maintenance Homestudy Approval
- Provider Maintenance Facility Detail
- Provider Maintenance Contacts
- Provider Maintenance Service Detail
- Provider Maintenance Household
- Provider Addresses and Phone Numbers
- Provider Maintenance Special Capabilities
- Provider Maintenance Preference Detail

If an extension of certification has been approved by the court update the following windows:

- Provider Maintenance Certificate List Detail,
- Provider Maintenance Homestudy
- Provider Maintenance Status List Detail
- Provider Maintenance Homestudy Approval

For families referred by the Division of Developmental Disabilities, private agencies, the court or out-of-state authorized entities: the Central Office Adoption Specialist will enter the family on the CHILDS Provider (Adoption) Registry and establish two files: a permanent Registry file and a duplicate file available for field office review.

For approved out-of-state and private agency adoptive families referred directly by the agency and not already entered in CHILDS: enter the families into the CHILDS Provider (Adoption) Registry according to district operating procedures or by completing the following windows:

- Person Detail, Address and Phone Numbers
- Provider Maintenance Detail
- Provider Maintenance Certificate List Detail
- Provider Maintenance Homestudy
- Provider Maintenance Status List Detail
- Provider Maintenance Home Study Approval
- Provider Maintenance Facility Detail, Provider Maintenance Contacts
- Provider Maintenance Service Detail

- Provider Maintenance Household
- Provider Addresses and Phone Numbers
- Provider Maintenance Special Capabilities
- Provider Maintenance Preference Detail

Update the appropriate fields of the CHILDS Provider (Adoption) Registry at the following points:

- whenever there is a change in the family's circumstances (for example, changes in address, family composition, income, preferences and special capabilities of child desired, etc);
- after the family's certification has been extended; or
- if the family chooses to withdraw from consideration.

Revision History:

DES(07-2006)

Previous / Next

17-5

Legal Basis: ARS §8-105(O) requires the division or agency conducting certification investigations to complete only an update report on any changes in circumstances that affect an applicant's parenting ability since the previous certification or licensing evaluation when the applicant has adopted a child in Arizona preceding the current application or is a foster parent licensed by this state.

Rules: Section R6-5-6607 of the Arizona Administrative Code addresses Rules pertaining to recertification for second and subsequent adoptions.

Revision History:
DES(07-2006)

Chapter 17: Section 5

Second and Subsequent Adoptions or Adoptions By Foster Parents Licensed By the State of Arizona

Legal Basis

Policy: A family may apply to adopt an additional child or children at any time. A new Family and Home Evaluation (home study) shall be required, unless the family is certified to adopt, or has previously adopted a child in Arizona or is a resource family licensed by this state.

The department shall complete an update report on any changes in circumstances that have occurred since the previous certification when the applicant is not certified and has previously adopted a child in Arizona.

The department shall complete an update report any changes in circumstances since the most recent licensing report when the applicant is foster parent licensed by this state.

Implementation and Procedures Guide

For a prospective adoptive parent who is not certified to adopt or, who has not completed an adoption in Arizona or who is not a resource family licensed by this state, complete the certification process as specified in Adoptive Family and Home Evaluation and Certification Process (Chapter 17 Section 3).

If the original Foster Home Licensing or Certification Evaluation (home study) was not completed by the department, request a copy from the agency that completed it.

Have the applicant who is a former adoptive parent or resource family complete the Family and Home Reapplication, FC-003.

Use the Family and Home Reevaluation to update changes in circumstances since the previous report for:

- a family who is not certified, but has previously adopted a child in Arizona, and is applying to adopt another child; or
- foster family licensed by this state.

Within 30 days of receiving the completed FC-003, write and submit the Family and Home

Reevaluation report to the court with the following attachments:

§ for applicants who have previously adopted a child in Arizona, the initial adoptive home study and all extension reports;

§ for applicants who are foster parents licensed by this state, the initial licensing home study and all re-licensing evaluations; and

§ other documents or information as required by the court.

DOCUMENTATION :

After receiving the completed FC-003, enter the prospective adoptive parent as an applicant in CHILDS.

For applicants who have previously adopted and are identified in the CHILDS Provider (Adoption) Registry, update the following windows using the same High Level Client Index Number.

- Person Detail,
- Address and Phone Numbers,
- Provider Maintenance Detail,
- Provider Maintenance Certificate List Detail

For resource family applicants, update the Provider Maintenance Certificate List Detail window**.** Update CHILDS Provider Maintenance Homestudy and Provider Maintenance Status List Detail windows to indicate that the Family and Home Reevaluation has been completed.

After receiving the order of certification, enter or update the family in the CHILDS Provider (Adoption) Registry by completing the following windows:

- Provider Maintenance Homestudy Approval,
- Provider Maintenance Facility Detail,
- Provider Maintenance Contacts,
- Provider Maintenance Service Detail,
- Provider Maintenance Household,
- Provider Addresses and Phone Numbers,
- Provider Maintenance Special Capabilities
- Provider Maintenance Preference Detail.

Revision History:

DES(07-2006)

Previous / Next

17-6

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 17: Section 6

Adoption by ACYF or Contract Employees

Legal Basis

Policy: To avoid the possibility of a conflict of interest, the department strongly encourages DCYF or contract employees who are interested in adoption to apply for certification with a private, licensed adoption agency.

If a DCYF or contract employee submits an application for adoption to the department, the Program Manager or designee will assign a CPS Specialist to the case. If the potential for conflict of interest exists, the Program Manager may request that a CPS Specialist from an adjacent district be assigned to the case.

If a DCYF or contract employee wants to adopt a child whom he or she knows, the placement must be approved by the Program Manager in the district in which the child is a court ward as well as by an independent review team selected by that Program Manager.

If a DCYF or contract employee wants to adopt a child whom he or she does not know and whose case is located in another district, the placement will follow routine agency procedures.

A CPS Specialist's adoption of a child on his or her own caseload will be considered only under exceptional circumstances.

Prior to placement of a child with a DCYF or contract employee, the Program Manager in the district in which the child will be placed shall approve arrangements for supervision of the placement.

If the person wishing to adopt is the Program Manager, the approvals described above shall be the responsibility of the Program Administrator.

Revision History:

DES(07-2006)

Previous

18-1

Legal Basis: The Indian Child Welfare Act of 1978 (25 USCA §1901 et seq.) requires states to adhere to certain standards and procedures when Indian children are involved in involuntary child custody proceedings in state court. An involuntary proceeding includes the removal of an Indian child from the child's parent, guardian or Indian custodian, or an action for foster care placement of or the termination of parental rights to an Indian child.

The Act defines an Indian child as an unmarried person who is under the age of eighteen and is either a member of an Indian tribe or is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.

ARS §8-815 provides that at the beginning of any hearing in a state court dependency proceeding, the court shall inquire if any party has reason to believe that any child who is subject to the proceeding is subject to the ICWA. The inquiry is not required if the court has already determined that the Act applies.

Rules: Guidance for interpretation of the Act in state court proceedings may be found in the Guidelines for State Courts; Indian Child Custody Proceedings (Federal Register, April 23, 1979).

Revision History:
DES(07-2006)

Chapter 18: Section 1
Identification of Any Child as A Native American Child

Legal Basis

Policy: The department shall make diligent efforts to identify children who are subject to the ICWA **within five days** of case opening for investigation.

The department shall provide child protective services that ensure the health and safety of Native American children while protecting their cultural heritage to the greatest extent possible.

The department shall make active efforts to contact, within 48 hours of the child being taken into custody, the social services program of the Indian child's tribe to:

- Notify the tribe that the child is in DES custody.
- Explore available services of the tribe that may address the safety needs of the child.
- Assist the parent to retain custody of the child.

The department shall explore with the tribe whether the tribe may accept responsibility of the child.

To determine whether any child is subject to the ICWA, consider these questions:

- Is the child a member of a federally recognized Indian tribe?
- Is the child eligible for membership in a federally recognized Indian tribe?
- Is the child the biological child of a member of a federally recognized Indian tribe?

In order to obtain this information the CPS Specialist should:

Ask the child (if age appropriate), caretaker and any other person with knowledge of the child

or parent whether the child or parent has any American Indian ancestry. As in so much of the work done in child welfare services, the CPS Specialist's views have a direct impact on permanency outcomes for Native American Children.

The Fact Sheet on Native American Children in Arizona (Exhibit 10) published by NICWA may inform your work.

If the child or the child's parent has American Indian ancestry, gather the following information from the child or parent or any other person with knowledge of the child's or parent's tribal affiliation:

- § the name of the tribe that the child or parent is a member of or eligible for membership;
- § the tribal enrollment or identification numbers of the parents and child(ren);
- § name of the child's:
  - F birth mother's maiden name;
  - F maternal and paternal grandparents;
  - F alleged and/or legal father;
- § birth places of the child and parents;
- § Social Security Numbers for the child and parents;
- § degree of Indian Blood and/or Certificate of Indian Blood (CIB) of the child and parents;
- § if birth mother was adopted, obtain the name of the mother's birth mother (if available);
- § other information about extended family members including the names, clan affiliation, date of births, and addresses of grandparents, aunts, uncles, cousins, great grandparents, step-parents, first and second cousins.

Implementation and Procedures Guide

Confirm the tribe's status as a federally recognized tribe by reviewing the most current Federal Register (see Public Folders/All Public Folders/DCYF Public Folders/Policy/Indian Child Welfare Act) and if the tribe is a federally recognized tribe, identify:

- § the geographic location and Bureau of Indian Affairs Area Office of the tribe using the Federal Register; and
- § the name and address of the Indian Child Welfare Designated Agent for the tribe as provided in the Federal Register.

Contact the Indian Child Welfare Designated Agent and identify the name and address of the local tribal social service program and/or ICWA representative of the tribe.

Contact the tribal social service and/or ICWA representative and request that the tribe confirm the child's membership in or eligibility for membership in the tribe. Provide the social service and/or ICWA representative all identifying information listed above to assist in the confirmation or determination of membership.

Add the child's tribe as a Case Associate using the Case Creation window.

Inform the duty Assistant Attorney General that there is reason to believe that the child is an Indian child and subject to the requirements of the ICWA prior to filing a dependency petition.

Complete the Indian Child Information Report, FW-106, and forward a copy to the ACYF Central Office Indian Child Welfare Specialist, Site Code 940A, within five working days.

Contact the ACYF Central Office Indian Child Welfare Specialist, Site Code 940A if there are questions about the child's status as an Indian child or any of the following are true:

- § There is reason to believe that the child may be an Indian child based on the removal from a location that is within close proximity to an Indian reservation or community.
- § The child's surname or appearance indicates that the child may be of Indian ancestry.
- § Identity or location of the parents, Indian custodians or tribe cannot be determined.

When the whereabouts of the child's parent or Indian custodian are unknown, complete a diligent search using the Parent Locator Service and the tribal social services.

In order to determine if the tribe may accept responsibility the CPS Specialist should:

Contact the tribal social service and/or ICWA representative and inform the tribe of the child's removal and that a dependency petition may be filed in state court concerning a child that may be an enrolled member or eligible for membership.

Ask the tribe's designated social service and/or ICWA representative if the tribe can assume custodial responsibility for the child.

Assist the Indian child's tribe to determine the tribe's ability to assume custodial care, offer services or placement assistance for the child by providing the following information:

- § information about any relative or other significant person who is willing and able to care for the child, at least on a short term basis;
- § any special needs that the Indian child may have;
- § resources needed to meet the needs of the child;
- § legal status of the child, alternatives to filing a dependency petition and time frame for filing a dependency petition; and
- § services available to the parents.

DOCUMENTATION :

Update the Person Detail Window to reflect American Indian ethnicity.

Complete the American Indian Detail Window.

File a photo copy of the child's and parent's tribal enrollment or identification numbers in the hard copy record and document the numbers using the Case Notes window.

It is extremely important to document in the Case Notes all investigation inquiries and contacts made to investigate whether or not a child is an Indian child using the Case Notes.

Document all contact with child's parents, Indian custodian and tribal social services using the Case Notes window. File copies of all written correspondences in the hard copy case record.

Document acceptance of the tribe to assume physical custody of the child using the Case Notes

window designated as Collateral Contact type.

Document the transfer of physical custody of the child using the Case Notes window designated as Collateral Contact type.

Terminate all open service authorizations.

Revision History:
DES(07-2006)

Next

18-2

Legal Basis: The Indian Child Welfare Act of 1978 (25 USCA §1901 et seq.) requires that notice be provided to the parent or Indian custodian and the Indian child's tribe by registered mail with return receipt requested, of the pending dependency proceedings and of the right to intervene.

ICWA mandates that in any state court proceeding for the foster care placement of, or termination of parental rights to an Indian child, the Indian custodian of the child and the Indian child's tribe shall have the right to intervene at any point in the proceeding.

Rules: Guidance for interpretation of the Act in state court proceedings may be found in the Guidelines for State Courts; Indian Child Custody Proceedings (Federal Register, April 23, 1979).

Revision History:
DES(07-2006)

Chapter 18: Section 2

Tribal Involvement Prior To Filing A Dependency Petition

Legal Basis

Policy: Within 72 hours of the child being taken into custody, the department shall make active efforts to contact the social services program of the Indian child's tribe to:

- Notify the tribe that the child is in the department's custody;
- Explore available services of the tribe that may address the safety needs of the child; and
- Assist the parent to retain custody of the child.

The department shall explore with the tribe whether the tribe will accept responsibility of the child, but only if the parent agrees to tribal intervention or placement.

Implementation and Procedures Guide:

Within 72 hours of the child being taken into custody, contact the tribal social service and/or ICWA representative and inform the tribe of the child's removal and that a dependency petition may be filed in state court concerning a child that may be a member or eligible for membership. Contact may be made through the District ICWA liaison, if appropriate.

Ask the tribe's designated social service and/or ICWA representative if the tribe can assume custodial responsibility for the child.

Assist the Indian child's tribe to determine the tribe's ability to assume custodial care, or offer services or placement assistance for the child, by providing the following information:

- information about any relative or other significant person who is willing and able to care for the child, at least on a short term basis;
- any special needs that the Indian child may have;

- resources needed to meet the needs of the child;
- legal status of the child, alternatives to filing a dependency petition and time frame for filing a dependency petition; and
- services available to the parents and child.

If the tribe indicates that the tribe will assume responsibility for the child within 72 hours:

- Obtain the parent's, guardian's, caretaker's or Indian custodian's (if available) agreement with the child's transfer to the tribe (if the parent objects to transfer to the tribe, contact the Attorney General's office).
- Obtain the date, time and name of the tribal representative who will take physical custody of the child.

Provide the following information to the tribe:

- why temporary custody is necessary;
- recommendations concerning continued custody of the child;
- identifying information about the child and parent;
- a copy of the temporary custody notice; and
- any other available information the tribe may request.

Coordinate with tribal social services and/or an ICWA representative regarding transfer of the case. Provide protective services to the child until responsibility for the case is resolved.

If a dependency petition is filed, tribal officials may notify the Arizona Superior Court of the tribe's intention to intervene as a party and/or request transfer of jurisdiction of the case.

Request dismissal of the dependency petition if the Arizona Superior Court transfers jurisdiction of the case to the tribe.

If the tribe does not assume responsibility for the child within 72 hours, follow procedures in Providing Out of Home Services Under a Dependency Petition (Chapter 6, Section 3).

Terminate all open service authorizations.

DOCUMENTATION :

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

It is extremely important to document in the Case Notes window all contacts with the child's parents, Indian custodian and tribal social services.

File copies of all written correspondence in the hard copy case record.

If the tribe takes physical custody of the child, the acceptance and transfer of custody should be documented using the Case Notes window designated as Collateral Contact type. Written verification of the tribal representative's authority and acceptance of custody should be obtained and filed in the hard copy case record, if possible. Terminate all open service authorizations.

Revision History:
DES(07-2006)

Previous / Next

18-3

Legal Basis: The Indian Child Welfare Act (25 USC §1912(d) and (e)] requires that any party seeking to effect a foster care placement of an Indian child shall make active efforts to provide remedial services and rehabilitative programs designed to prevent the break up of the Indian family and be prepared to show that these efforts have been unsuccessful. The intent of the Act is that these services will be provided prior to removal of the child, except in extreme circumstances such as severe physical abuse or abandonment.

The Act (25 USC §1922) provides that the tribe has exclusive jurisdiction of an Indian child who is a resident of or domiciled on an Indian reservation, but allows the state to take emergency custody of a child who is temporarily located off the reservation in order to prevent imminent physical damage or harm to the child. The emergency placement must terminate immediately when such removal is no longer necessary to prevent such damage or harm.

ARS §8-821 establishes that CPS may take temporary custody of any child if he or she is "suffering or will imminently suffer abuse or neglect".

ARS §8-822 requires that the department "review each removal of a child which is expected to result in a dependency petition to assess options other than continued out-of-home placement, including in-home services to the family."

ARS §8-823(A) requires notice of temporary custody be provided to the parent or Indian custodian.

Rules: The Arizona rules pertaining to temporary custody are found in Sections R6-5-5512 and 5513 of the Arizona Administrative Code and in the Rules of Procedure for the Juvenile Court.

Rules pertaining to Removal Review are found in Section R6-5-5514 of the Arizona Administrative Code.

Federal rules and guidance are contained in the "Department of the Interior Bureau of Indian Affairs Guidelines for State Courts; Indian Child Custody Proceedings" (44 Federal Register 67584-95) and the Code of Federal Regulations.

Revision History:
DES(07-2006)

Chapter 18: Section 3

Removal and Temporary Custody of a Native American Child

Legal Basis

Policy: If an Indian child, regardless of his or her residence or domicile, is in danger of imminent abuse or neglect, the department shall provide emergency intervention to ensure the child's safety.

In any case where the removal of a child is expected to result in a dependency petition, the department shall conduct a Removal Review Team Conference within 72 hours after removal. See Reviewing Emergency Removals (Chapter 3, Section 3). If the child is or may be an Indian child, the District ICWA liaison shall be included in the Removal Review Team Conference. Other qualified professionals, such as a tribal social services representative, may be included in the Removal Review Team Conference.

The department shall engage the child's family and Indian tribe to the greatest extent possible in planning for voluntary interventions that minimize department intrusion while ensuring the safety of the Indian child. Alternatives that may be considered include:

- § providing additional safeguards or resources so that the Indian child can remain in the home;
- § assisting the child's parent(s), guardian or Indian custodian in identifying a relative or friend who can care for the Indian child temporarily during the investigation;
- § assisting the child's parent, guardian or Indian custodian and child to leave the home and go to a safe situation; or
- § placing the child in voluntary foster care upon written consent before a judge of competent jurisdiction.

BEST PRACTICE TIP:

In order to determine if the services can be provided on a voluntary nature, assess how motivated the family is to cooperate. Do they see the need? Do they agree that the children in the family are in need of additional food, clothing, supervision, etc.? Do they understand

the concept of risk? The CPS Specialist cannot assume that terms that are familiar to child welfare are familiar to every family. The CPS Specialist should practice full disclosure and describe the process and terms and make the considerations of risk very transparent to the family.

Prior to Removal consider these questions to assess if a voluntary safety plan can be developed:

§ What types of services or supports are currently in place that enhance the child's safety at home while the family addresses safety factors that necessitated DES involvement?

o In particular, are there reliable individuals, such as extended family members, teachers, therapists, or school counselors, who have contact with the child on a regular basis and can monitor his or her safety?

§ Are existing services or supports adequate to conclude that the child appears to be safe in the home? If not, are there additional services or supports that can be accessed to enhance the child's safety?

If no voluntary emergency intervention can ensure the Indian child's safety, the department shall:

- Take temporary custody of the child to provide emergency out-of-home placement, following the ICWA placement preferences, if possible; or
- Take temporary custody of the child for medical or psychological examination.

An Indian child who is taken into temporary custody because he or she is suffering or will imminently suffer abuse or neglect (imminent physical damage or harm) must be returned to the parent **within 72 hours**, excluding weekends and holidays, unless a dependency petition is filed or a voluntary foster care agreement is executed before a judge.

The department shall make every effort to contact the child's parents, guardians or Indian custodians and the child's tribe immediately, either in person or by phone, if a child is taken into

temporary custody when the parent, guardian or Indian custodian is not present. In addition, parents, guardians, or Indian custodians and the child's tribe, shall be provided with written notice of the temporary custody [ARS §8-823(A)].

An Indian child who is a resident or domiciled on an Indian reservation and taken into temporary custody because he or she is suffering or will imminently suffer abuse or neglect (imminent physical damage or harm) must be returned to a parent or custodian, or transferred to the jurisdiction of the Indian child's tribe, when the reason for removal is no longer necessary.

If the child's Indian tribe is unwilling to assume responsibility for the child within 72 hours, follow procedures in Providing Out of Home Services Under a Dependency Petition (Chapter 6 Section 3).

An Indian child who is taken into temporary custody for medical or psychological diagnosis must be returned within 12 hours, excluding weekends and holidays, unless the examination reveals abuse or neglect.

BEST PRACTICE TIP:

If the emergency removal of a child is necessary, consider what the experience is like for the child.

- Are there special items that belong to the child that the CPS Specialist can gather to take with into care?
- Does the child understand what is happening?
- Can the CPS Specialist provide an opportunity for the child to say goodbye to siblings (if they are not being removed?)
- If there are two individuals involved in the process of removing the child, can one of the individuals sit in the back seat with the child?

During the ride, try to stay in constant communication with the child—NEVER forget the fear that the child/youth may be experiencing. .

If a dependency petition is filed, the court must hold a Preliminary Protective Hearing to review temporary custody within five to seven days after the child's removal, excluding Saturdays, Sundays, or court holidays.

To determine what kind of emergency intervention is most appropriate, consider these questions:

1. Can the child remain at home with additional safeguards or resources?

§ What factors contribute to your judgment that the child is at risk of imminent harm?

§ Can these risks be successfully removed or modified by making specific, immediate changes in the living environment for example:

- o identifying a relative, neighbor or friend who can provide support for the parent and/or ensure the child's safety in the home;
- o ensuring that the family receives emergency food, clothing, shelter, utilities or other necessities; or
- o removing the allegedly abusive person from the home?

How can you be sure these changes will take place and will make enough of an impact to consider the child safe?

2. Can the parent, guardian or Indian custodian identify a relative or friend while the department completes its investigation**?**

§ Can the parent, guardian or Indian custodian identify a relative who is willing and able to care for the child immediately, at least on a short-term basis?

§ Is there an indication that the parent, guardian or Indian custodian will follow through with the agreement to place the child with a relative?

§ Is the relative willing and able to protect the child from imminent abuse or neglect?

3. Can the parent, guardian or Indian custodian and child leave home and go to a safe situation?

§ Is the non-abusing parent, guardian or Indian custodian willing to leave home?

§ Can the parent, guardian or Indian custodian identify a relative or friend who can provide safe temporary housing?

§ Is there a shelter available that can provide temporary housing?

4. Can the child be placed in voluntary foster care?

   § Is the parent, guardian or Indian custodian willing to place the child voluntarily?

   § Is there indication that the parent, guardian or Indian custodian will abide by the terms of the voluntary foster care agreement?

   § Is it likely that the parent, guardian or Indian custodian will be able to resolve the problems leading to the child's risk of imminent abuse or neglect within the 90 day voluntary foster care period? See Chapter 18: Section 4, Voluntary Consent for Foster Care Placement of a Native American Child.

5. Is it necessary to take temporary custody to ensure the child's safety?

   § Is the parent, guardian or Indian custodian unable or unwilling to acknowledge the risk of imminent abuse or neglect and to cooperate with a plan to make the child safe?

   § Are the reasons why the child is at risk of imminent abuse or neglect too extensive, persistent, or long-term to be addressed by a short-term, voluntary intervention?

Implementation and Procedures Guide:

Assess the health and safety of each child in the home.

If any child appears to be at risk of imminent harm, work with the family to identify and implement any emergency interventions that can ensure the child's safety.

If the parent, guardian or Indian custodian agrees to place the child in voluntary foster care, consult with the Office of the Attorney General and follow the procedures described in Chapter 18, Section 4, Voluntary Consent for Foster Care Placement of a Native American Child, regarding written consent for voluntary foster care placement and placement preferences.

If no voluntary emergency intervention can ensure the child's safety, consult with your supervisor, and when possible with the Assistant Attorney General before removing the child from the home.

The CPS Specialist may remove the child *without* prior supervisory consultation in an emergency

or if failure to do so would likely endanger the child.

BEST PRACTICE TIP:

While there are certain times that we must remove children from care in order to ensure their safety, we must never assume that harm does not come from the very process of removal; emotional harm and relational harm often occurs. So it is imperative that the CPS Specialist take the time to explain to the child in a language that they can understand 1) what is happening, 2) that their parent's love them and they will see their parents as soon as a visit can be arranged. It is also important that you encourage the child/youth to take with them a few personal items such as toys, blankets, music, pictures, etc. They need to be able to look at their room and see something of their own. It is really important that you see or communicate with the child in some way, as soon as possible after placement. Put yourself in the situation of being removed from everything that you know and being placed in a home where you know no one and do not understand the "rules" will help you understand the trauma the child is experiencing.

Whenever possible, siblings should be placed together. If they cannot be placed together (and that should be rare) then develop an agreement between the resource families that they will ensure the children talk to one another frequently, e-mail one another and see one another as often as possible.

If emergency removal of a child is necessary and prior consultation with a supervisor is not possible, notify the supervisor within two hours if the removal occurred during regular working hours, or by 8:30 a.m. the next morning if removal occurred after regular hours.

If a relative or kin is identified, prior to making the emergency out-of-home placement with a relative:

- Complete a Child Protective Services Central Registry (CPSCR), a CHILDS Case Management Information System, and a criminal history check on all individuals in the home age 18 or older;
- Complete a preliminary home study using the Assessment for Kinship Foster Care or Significant Person Placement, CT01100, found in the Court Document Detail. Determine if there is any information which would preclude the relative from providing a safe, nurturing environment for the child; and
- Complete the Agreement for Child Placement, PS055.

See Providing Kinship Care Services (Chapter 6, Section 6)

If a parent, guardian or Indian custodian is present at the removal of the child, provide him or her with:

- The Temporary Custody Notice, CPS-1000A; and
- A Guide to Child Protective Services, PAC-518

If a parent, guardian or Indian custodian is *not* present when the child is removed:

- Attempt to notify the parent, guardian or Indian custodian and the child's tribe immediately, either in person or by phone.
- Notify the parents, guardian or Indian custodian in writing by delivering (or mailing, if necessary) the Temporary Custody Notice, CPS-1000A, and A Guide to Child Protective Services, PAC-518.

Provide the parent, guardian or Indian custodian with written notification of the removal **within six hours** if he or she lives in Arizona, or **within 24 hours** if he or she lives out of state.

If the address of the parent, guardian or Indian custodian is not known, make reasonable efforts to obtain it by contacting the tribe, relatives, friends, and/or employers. If the address cannot be obtained, initiate a search for missing parent with the Parent Locator Service according to district operating procedures.

Send a copy of the Temporary Custody Notice, CPS-1000A, to:

- any divorced, non-custodial parent, regardless of the specific arrangements of the divorce agreement; and
- any man alleged to be the child's father, whether or not his name appears on the birth certificate and whether or not paternity is established.

If known, write the date, time and place of the Preliminary Protective Hearing on the Temporary Custody Notice, CPS-1000A.

If the date, time and place of the Preliminary Protective Hearing is not available at the time the

Temporary Custody Notice is served, provide written notice of this information to the parent or guardian **within 24 hours** of filing the dependency petition.

Submit the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing as described in Preparing Court Reports for CPS Cases, (Chapter 20 Section 6). This report must be submitted to the court no later than **the day before** the hearing.

In addition, complete the Verification Form, CT04600, found in the Court Document Detail, and submit the Form to the Attorney General's Office for filing with the dependency petition.

If possible, obtain the parent's, guardian's or Indian custodian's authorization to provide emergency medical care for the child. If the parent, guardian or Indian custodian refuses or is unavailable, consult with a supervisor regarding authorization for procedures.

DOCUMENTATION :

File a copy of the Temporary Custody Notice, CPS-1000A in the hard copy record.

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

Document the need for emergency intervention and specific intervention taken on the Emergency Intervention and Legal Status windows.

If the parent, guardian or Indian custodian places the child with a relative or non-relative, document the placement on the Placement/Location Detail Window.

Document the following using the Case Notes window:

Pre-placement preventive efforts and alternatives to placement that were discussed with the parent, guardian or Indian custodian;

Recommendations concerning continued custody of the child; and

Dates and results of any medical or psychological examinations of the child.

Document removal and temporary custody of the child using the Removal Status, Legal Status and Custody Notices windows.

Document the child's out-of-home placement using the Service Authorization Request and Service Authorization Provider Match windows and by following the procedures outlined in Providing Out-of-Home Care Under a Dependency, (Chapter 6 Section 3).

If the child is placed in voluntary foster care, document the placement as described in Providing Voluntary Child Protective Services (Chapter 4 Section 4).

Revision History:
DES(07-2006)

Previous / Next

18-4

Legal Basis: The Indian Child Welfare Act of 1978 (25 USC §1901 et seq.) sets forth standards for obtaining consent to a foster care placement of an Indian child. Voluntary consent will not be valid unless the following conditions are met:

§ Consent must be in writing and signed before a judge of a court of competent jurisdiction.
§ The written consent must be accompanied by the presiding judge's certificate that the terms and consequences of the consent were fully explained in detail and were fully understood by the parent or Indian custodian.
§ The court shall also certify that either the parent or Indian custodian fully understood the explanation in English or that it was interpreted into a language that the parent or Indian custodian understood.
§ Any consent given prior to, or within ten days, after the birth of the Indian child shall not be valid.
§ Any parent or Indian custodian may withdraw consent to a foster care placement under the Act and under state law at any time. Upon such withdrawal, the child shall be returned to the parent or Indian custodian unless a dependency petition is filed.

ARS §8-806 authorizes the department to provide voluntary foster care placement for children.

The federal Family Preservation and Support Act of 1994 (P.L. 103-66), renamed Promoting Safe and Stable Families by the Adoption and Safe Families Act of 1997 (P.L. 105-89), provide family preservation services, community-based family support services, time-limited family reunification services, and adoption promotion and support services.

Rules: The Arizona rules pertaining to temporary custody are found in Sections R6-5-5512 and 5513 of the Arizona Administrative Code and in the Rules of Procedure for the Juvenile Court.

Rules pertaining to Removal Review are found in Section R6-5-5514 of the Arizona Administrative Code.

Guidance for interpretation of the Act in state court proceedings may be found in the Guidelines for State Courts; Indian Child Custody Proceedings (Federal. Register, April 23, 1979; 44 Federal Register 67584-95).

Revision History:
DES(07-2006)

Chapter 18: Section 4

Voluntary Consent for Foster Care Placement of a Native American Child

Legal Basis

Policy: The department shall consult with the Assistant Attorney General in making the necessary arrangement to have a parent sign a consent to voluntary foster care placement in the presence of a judge.

A full explanation shall be given in the language the parent understands to ensure the parent fully understands the consequences of his/her consent.

The department shall return the child to the custody of the parent at any time upon request unless the child cannot live safely at home.

The department shall give preference to placement of an Indian child with:

- a member of the Indian child's extended family;
- a foster home licensed, approved, or specified by the Indian child's tribe;
- an Indian foster home licensed or approved by an Indian tribe; or
- an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs.

To determine whether voluntary foster care is appropriate for an Indian child, consider the following questions, in addition to following the Decision Making Guide found in Providing Voluntary Child Protective Services, (Chapter 4, Section 4).

- Is this child a resident and/or domiciled on an Indian reservation? (If yes, a voluntary placement agreement is not appropriate.)

§ Is this child a ward of the tribal court? (If yes, a voluntary placement agreement is not appropriate.)

§ If the parent does not object to contact with the child's Indian tribe, is the tribe able and willing to provide available services, including placement, that may address the safety needs of the child and address the problems that led to the decision to place the child in foster care? (If yes, a voluntary placement agreement may not be necessary.)

§ Is there a Native American cultural and/or services center that may have human resources available to assist the child and the family that would eliminate the need for a voluntary placement?

§ Have efforts been made to explore alternatives to foster care placement, including the other parent? If the non-custodial parent is appropriate and able to care for the child, every effort should be made to locate and notify that parent of the possible foster home placement prior to accepting a voluntary consent**.**

To determine whether a child can safely return home at the end of the voluntary foster care placement or to recommend the filing of a dependency action, consider the Decision Making Guide questions in Determining Whether to Open the Case for Ongoing Services (Chapter 5, Section 1)

To determine when to close the case, consider the Decision Making Guide questions in Terminating Voluntary Child Protective Services (Chapter 4, Section 5).

Implementation and Procedures Guide:

Inform the parent of placement preferences and that, unless the parent objects, efforts will be made to notify the child's tribe and extended family members.

Consult with your supervisor regarding the appropriateness of a voluntary foster care placement. If necessary, convene a case conference to discuss the placement with your supervisor, the parent, the child (if age appropriate), designated ICWA liaison or the ACYF Indian Child Welfare Specialist and the Assistant Program Manager or designee.

Complete the Parental Assessment Financial Statement, FC-009, found in the Forms Registry, and determine the amount that the parent will be assessed for the cost of the child's care. Have the parent sign the form.

Consult with the Assistant Attorney General to make the necessary arrangements to have the parent sign a consent to voluntary foster care placement in the presence of a judge.

Explain the terms and consequences of the parent's consent in a manner to ensure that the parent understands what he or she is doing, including providing an interpreter if necessary.

DOCUMENTATION :

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

File copies of all correspondences with tribal staff in the hard copy case record.

File a copy of signed consent documents and the judge's certification in the hard case record.

Document all contacts with the Indian child's and/or the parent's tribe including the name, address, title, telephone number of the person contacted and the results of these contacts using the Case Notes window designated as Collateral Contact type**.**

File copies of all correspondence with tribal staff in the hard copy case record.

File a copy of signed consent documents and the judge's certification in the hard copy record.

Revision History:
DES(07-2006)

Previous / Next

18-5

Legal Basis: The Indian Child Welfare Act of 1978 (25 USC §1901 et seq.) requires that any party seeking to effect a foster care placement of, or termination of parental rights to, an Indian child under state law shall satisfy the court that ***active efforts*** have been made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family and that these efforts have proved unsuccessful.

The federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires states to make reasonable efforts to return children to their families if removal from home is necessary.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires the department to make reasonable efforts to reunify families if removal is necessary.

ARS §8-845 requires the court to reunify families insofar as possible.

ARS §8-862 requires the court to hold a Permanency Hearing not more than 12 months after the child's initial removal from the parent or guardian. The purpose of the hearing is to determine the future permanent legal status of the child and to order the accomplishment of the permanency plan within a specified time period. Examples of a permanency plan include reunification, guardianship, adoption and another permanent planned living arrangement (which includes independent living or long term foster care).

Rules: Not Applicable

Revision History:
DES(07-2006)

Chapter 18: Section 5

Providing Services to Facilitate Family Reunification

Legal Basis

Policy: The Indian child's health and safety shall be the paramount concern when making permanency planning decisions and providing services.

The department shall provide reunification services to the family of an Indian child when the child is placed in out-of-home placement. The department's first priority shall be to facilitate family reunification as quickly as possible.

In all cases involving an Indian child, active efforts to reunify the family must be made.

From the beginning of the case, the department shall involve parents, other family members and, to the greatest extent possible, the Indian child's tribe in developing a case plan aimed at enabling the family to care for the Indian child safely at home. If it appears that, even with active efforts, it is unlikely the child will be returned to the parent(s) within 12 months after removal, the department, in collaboration if possible with the Indian child's tribe, the parents, and extended family members, will develop a concurrent case plan aimed at identifying a permanent placement for the child. In such a case, the department will strongly and regularly encourage the tribe to assist in the early identification of an appropriate permanent placement for the child.

BEST PRACTICE TIP:

A critical aspect of being able to engage families is to be able to work with them in the context of their culture and ethnicity. Working with Native American Families means that CPS Specialists must explore how culture and rituals have influenced parenting decisions, what services and supports will be most effective and honoring of tribal practices. CPS Specialists must ensure that they weave the issues of culture into the planning for services and the evaluation of the efficacy of services. Sometimes we are afraid to talk about race and cultural differences in this country. Working effectively with families means that we enter their culture, become a student of their culture and make plans with a family's culture and race in the forefront of our minds.

To facilitate family reunification, the department shall provide services which support families in developing their strengths and address the risk factors that necessitate the Indian child's out-of-home placement. Services may be delivered either directly by department staff or through referral to community resources, or referral through tribal social services or organizations which provide remedial services and rehabilitative programs to Indian children and families.

Remedial services and rehabilitative programs shall be provided in a culturally competent manner consistent with the child's and parents' wishes and delivered in a manner that incorporates, when appropriate, Native American ceremonial and religious practices, family group decision-making, talking circle, and tribally operated programs which reflect Native American values and the beliefs of the family.

In determining the type of services that are appropriate, consider these questions in addition to the Decision Making Guide questions found in Providing Services to Facilitate Family Reunification (Chapter 11, Section1).

- § Are the Indian child's or Indian parent's cultural values, beliefs and religious practices tied to the child's Indian tribe?
- § Does the Indian child or Indian parent maintain cultural ties to an Indian tribe?
- § Is the Indian child or parent willing to accept services provided by the Indian child's and/or Indian parent's tribe or an organization such as a Native American cultural and/or service center?
- § Is there an organization such as a Native American cultural and/or service center that can offer culturally appropriate services to Indian children and families in close proximity to the Indian child or parent? Are these services designed to prevent removal or reunify Indian families?
- § Is the Indian child's tribe able and willing to provide services that eliminate the risk factors that prevent the child from living safely at home?
- § Is there a contract provider who has access to culturally competent Native American programs and/or resources?

BEST PRACTICE TIP:

The theory supporting family centered practice and family reunification services is a family-

systems approach. Inherent in this systems approach is the belief that the welfare of any single child or family member is inseparable from the psychological and social functioning of other members of the family. Thus when a family needs assistance, CPS Specialists who are family centered, intervene not only with the individual child but also with the systems to which the child belongs. They understand that in order to successfully make changes in the family system they must 1) listen to the voice of the family and understand their perspectives, values and decision making processes, 2) believe in and respect the expertise of families in understanding their own needs and identifying their own solutions and 3) honor the culture, race and ethnicity of the family they are serving.

Implementation and Procedures Guide:

Develop and implement the case plan for family reunification as described in Developing The Family Centered Case Plan (Chapter 9, Section 1)**.**

Make active efforts to ensure that the Indian child's tribe and/or Indian parent's tribe participates in the development of the case plan. The tribe's participation may be in person, by telephone or another effective means of communication.

Contact the tribal social services and/or ICWA representatives and ask the tribe to assist with the identification and provision of culturally appropriate services and programs available through the tribe and/or an organization such as a Native American cultural and/or service center that may assist the child and parent.

Ask the tribe to provide the following information:

- the name, address, telephone number and a contact person of a tribal program or an organization that provides services to Native American families;
- when appropriate, information about any known person recognized by the Indian community as medicine men or other traditional tribal leaders, such as elders, whose skill can be used to keep the family together;

Contact the Phoenix and/or Tucson Indian Center, the Bureau of Indian Affairs Regional Office, and the local Indian Health Services medical facility social services and ask about available services and programs that may assist the child and the parent.

DOCUMENTATION :

File copies of all correspondences with tribal staff in the hard copy case record.

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

It is extremely important to document all contacts with the Indian child's and/or Indian parent's tribe including the name, address, title, telephone number of the person contacted and the results of these contacts using the Case Notes window designated as Collateral Contact type.

Revision History:

DES(07-2006)

Previous / Next

18-6

Legal Basis: The Indian Child Welfare Act of 1978 [25 USC §1915] sets forth standards that govern where Indian children accepted for foster care or adoption may be placed. These standards are as follows:

The child must be placed in the least restrictive setting which most approximates a family and in which his or her special needs, if any, may be met.

The child shall also be placed within reasonable proximity to his or her home, taking into account any special needs of the child.

In any foster care placement, a preference shall be given, in the absence of good cause to the contrary, to a placement with:

§ a member of the Indian child's extended family;
§ a foster home, licensed, approved, or specified by the Indian child's tribe;
§ an Indian foster home licensed or approved by an authorized non-Indian licensing authority; or
§ an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs.

(Note: These differ from adoptive placement preference.)

ARS §8-514.02 authorizes placement of a child with a relative, subject to specified limitations.

ARS §8-514.03(a) establishes a kinship foster care program to promote the placement of a child with relatives.

ARS §8-824(G)(7) requires the department to report to the court any efforts made to place siblings together, and if they are not placed together, the reason why.

ARS §8-824(G)(8) requires the department to report to the court any efforts made to facilitate communications among siblings.

Rules: Guidance and interpretation for the Act is contained in the BIA Guidelines for State Courts; Indian Child Custody Proceedings (44 Federal Register 67584-95, published November 8, 1979).

Revision History:

DES(07-2006)

Chapter 18: Section 6

Native American Child Placement and Placement Preferences

Legal Basis

Policy: Unless the Indian child's tribe has established a different order of placement preference, prior to placing a child in a non-Indian foster home, the department shall give preference to foster care placement of an Indian child as follows:

- with a member of the child's extended family;
- with a foster home licensed, approved, or specified by the Indian child's tribe;
- with an Indian foster home licensed or approved by an authorized non-Indian licensing authority; and
- with an institution for children approved by an Indian tribe or operated by an Indian organization.

Unless the Indian child's tribe has established a different order of placement preference, the department shall give preference to adoptive placement of an Indian child as follows:

- with a member of the child's extended family;
- with other members of the Indian child's tribe; or
- with other Indian families.

If the state court finds that there is good cause to change the order of placement preference, the department may place the child outside the prescribed order of preference.

To determine the appropriate placement for the Indian child, consider the following questions:

- Is the setting the least restrictive placement which most closely approximates a family?
- Will the setting facilitate frequent contact with parents, siblings, and extended family and is the placement within reasonable proximity to the child's home?
- Does the setting support the Indian child's ties to social and cultural resources and traditions?
- Will the setting meet the child's special needs, if any?
- Do the parents, and the child if age appropriate, support the placement?
- Do the extended family and tribe, if involved, support the placement?

Implementation and Procedures Guide:

Inform the parent, legal guardian, or Indian custodian of:

- placement preference requirements; and
- that the tribe will be contacted to develop placement resources.

Consult with the parents and any known extended family regarding the availability of relatives and family friends as placement resources. Notify potential placements of the need for an assessment of the family and the availability of kinship care resources.

Contact the tribal social services and/or ICWA representative to identify placement resources such as tribally licensed foster homes and relative placements. Consider foster homes licensed by the tribe for placement. Consult with a District ICWA liaison regarding tribally licensed foster homes

If potential placements are located on the reservation, request tribal social services to conduct family assessments of potential placements.

DOCUMENTATION :

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

It is extremely important to document all contacts with the Indian child's and/or Indian parent's tribe including the name, address, title, telephone number of the person contacted and the results

of these contacts using the Case Notes window designated as Collateral Contact type.

All contacts with extended family to develop placement resources should be thoroughly documented in the case record.

File copies of all correspondences with tribal staff in the hard copy case record.

Revision History:
DES(07-2006)

Previous / Next

18-7

Legal Basis: The Indian Child Welfare Act of 1978 (25 USC §1912) requires that any party seeking to effect a foster care placement of, or termination of parental rights to, an Indian child under state law to make active efforts to remedy the situation which cause the child to be in a out-of-home placement. Active efforts is a higher standard than the reasonable efforts standard under state law.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) significantly amends Titles IV-B and IV-E of the Social Security Act by establishing safety, permanency and well-being as national goals for children in the child welfare system.

ARS §8-862 requires the court to hold a Permanency Hearing not more than 12 months after the child's initial removal from the parent or guardian. The purpose of the hearing is to determine the future permanent legal status of the child and to order the accomplishment of the permanency plan within a specified time period. Examples of a permanency plan include reunification, guardianship, adoption, and another permanent planned living arrangement.

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 18: Section 7

Permanency Planning for Native American Children

Legal Basis

Policy: In selecting the permanency goal for the child, the department shall seek to maintain and support the child's relationship to his or her biological parents, extended family members, the child's tribe and other individuals with whom the child has an attachment.

For Indian children receiving in-home services, the initial permanency goal is remain with family.

For all Indian children receiving out-of-home care services, the initial permanency goal shall be family reunification. In rare circumstances, family reunification may not be possible, such as in the case where a parent is deceased, or the whereabouts of the parent is unknown.

If it appears that, even with active efforts, it is unlikely the child will be returned to the parent(s) within 12 months after removal, the department, in collaboration if possible with the Indian child's tribe, the parents, and extended family members, will develop a concurrent case plan aimed at identifying a permanent placement for the child. In such a case, the department will strongly and regularly encourage the tribe to assist in the early identification of an appropriate permanent placement for the child.

Implementation and Procedures Guide

Consult the Assistant Attorney General when considering an initial permanency goal other than remain with family or family reunification.

Develop and implement the case plan as described in Developing The Family Centered Case Plan (Chapter 9, Section 1).

DOCUMENTATION :

Document the selection of the proposed permanency goal using the Permanency Goals window.

Document the revised permanency goal using the Permanency Goals window.

Document justification for selection of the permanency goal or revised permanency goal using the Case Notes window, Staffing type; and in the next Progress Report to the Juvenile Court or Permanency Hearing Report to the Juvenile Court following the case plan staffing.

Document the concurrent permanency goal using the Permanency Goals window.

Document the compelling reason that termination of parental rights is not in the child's best interests by checking the Compelling Reason check box located on the Permanency Goals window. Document the justification using the Explain window.

Document the request for Program Manager or designee review and approval of a long term foster care as an Another Planned Permanent Living Arrangement using the Case Notes window designated as Management Contact type.

Program Manager or designee:

Document approval of a long term foster care as an Another Planned Permanent Living Arrangement using the Case Note Comment window.

Revision History:

DES(07-2006)

Previous / Next

18-8

Legal Basis: ARS §8-861 provides that after the temporary custody hearing, on request of a parent or guardian, the court shall order the child be returned to the child's parent or guardian if the court finds by a preponderance of the evidence that the return of the child would not create a substantial risk of harm to the child's physical, mental, or emotional health or safety.

ARS §8-514.02(A) provides that the department may place a child with a parent or relative.

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 18: Section 8

Reunification of Native American Children With Their Families

Legal Basis

Policy: Reunification of Indian children with their families shall occur as soon as the circumstances which created the risk of serious physical or emotional damage to the child have been alleviated.

To determine whether a child can be returned home safely, consider these questions:

- Has the parent, guardian or Indian custodian made changes in his or her behavior or environment to address each of the identified risk factors that caused or created the risk of serious physical or emotional damage?
- Has visitation (including unsupervised overnight visits) been safe and successful?
- Has the parent, guardian or Indian custodian planned for the child's re-entry into the family and community for example, by making child care arrangements, by considering school placement, by arranging for ongoing support and assistance?
- Has the parent, guardian or Indian custodian been successful in accessing and implementing resources through extended family, community, and/or tribal resources and agencies, including health care resources, which are necessary to support a safe and stable placement?

Implementation and Procedures Guide:

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

Unless the court has ordered immediate reunification, convene a case plan staffing to determine

when family reunification is appropriate.

Bearing in mind the requirement to use active efforts, assist the parent, guardian or Indian custodian in arranging for the child's re-entry into the family by ensuring that the following have been considered and implemented where appropriate:

- § Housing assistance;
- § Child care arrangements;
- § School placement;
- § Health care and mental health services;
- § Physical needs (e.g., bed, formula, etc.);
- § Community or recreational activities for the child; and
- § Other services as needed to ensure reunification.

Transition the child from placement to home with the parent, guardian or Indian custodian utilizing support from the current placement and tribal resources if available and appropriate.

Request that the Attorney General's Office file a motion with the court to change physical custody. See Preparing Court Reports for CPS Cases (Chapter 20, Section 6) for more information.

Upon the child's return home, provide support and supervision following procedures for in-home services specified in Reunifying Families (Chapter 11, Section 3). In particular, during this period:

- § Monitor the child's continued safety by visiting the child and parent in the home at least monthly until the dependency petition is dismissed.
- § Discuss any adjustment problems with the family and tribal caseworkers.
- § Assist the family in securing needed services.
- § Encourage the family to utilize extended family members, churches, neighborhood organizations, and community and tribal networks as an ongoing source of support and assistance.

DOCUMENTATION :

It is extremely important to document all contacts with the parent, guardian, Indian custodian, and the Indian child's and/or Indian parent's tribe including the name, address, title, telephone number of the person contacted and the results of these contacts using the Case Notes window designated as Collateral Contact type.

File copies of all correspondences with tribal staff in the hard copy case record.

Update the Indian Child Information, FW106 and forward the form to the ACYF Central Office Indian Child Welfare Specialist, Site Code 940A.

Revision History:

DES(07-2006)

Previous / Next

18-9

Legal Basis: ARS §8-871 provides for the appointment of a permanent guardian for a child through the juvenile court. Any party to a dependency proceeding may file a motion for appointment of a permanent guardian.

ARS §8-873 specifies that the permanent guardianship continues until the child reaches age 18 unless the court orders revocation upon a showing, based on clear and convincing evidence, that there has been a significant change of circumstances and that revocation is in the child's best interest.

The Indian Child Welfare Act of 1978 (25 USC §1901 et seq.) recognizes a permanent guardianship proceeding as a "child custody proceeding". Before a guardianship plan can be considered, active efforts to provide remedial and rehabilitative services must be provided to prevent the break-up of the Indian family, and there must be evidence beyond a reasonable doubt that return of the child is likely to result in serious emotional or physical damage to the child.

Rules: Not Applicable

Revision History:
DES(07-2006)

Chapter 18: Section 9

Permanent Guardianship

Legal Basis

Policy: The department shall establish a permanency plan of guardianship when guardianship is in the child's best interest, family reunification is not possible, and:

- adoption is remote; or
- termination of parental rights is not in the child's best interests.

Selection of a guardian shall be consistent with the placement preferences of the Indian Child Welfare Act (25 USC §1915), absent good cause to the contrary.

Although a parent may not object to the appointment of a permanent guardian, a hearing under ARS §8-872 is required which must include expert testimony regarding active efforts.

To decide whether a permanency plan of guardianship is appropriate, consider these questions:

§ Does the relative placement, the child's tribe or other Indian tribes have a preference for guardianship over adoption?

§ Have *active efforts* been made to reunite the family and would further efforts be counterproductive?

§ Is adoption remote or termination of parental rights not in the child's best interests?

§ Can the placement be maintained without long-term support services provided through the department?

DOCUMENTATION :

Ensure that the child's tribe has been added to the case as a Case Associate using the Case

Creation window.

Document the selection of guardianship as a permanency goal in the Permanency Goal window.

Update the Indian Child Information, FW-106 and forward to the ACYF Central Office Indian Child Welfare Specialist, 940A.

It is extremely important to document all contacts with the parent, guardian, Indian custodian, and the Indian child's and/or Indian parent's tribe including the name, address, title, telephone number of the person contacted and the results of these contacts using the Case Notes window designated as Collateral Contact type.

File copies of all correspondences with tribal staff in the hard copy case record.

Revision History:
DES(07-2006)

Previous / Next

18-10

Legal Basis: The Indian Child Welfare Act of 1978 (25 USC §1912) governs involuntary proceedings in state court for termination of parental rights. An involuntary proceeding is one in which a parent has not signed a consent for termination or adoptive placement (see Section 8 of this Chapter). An order terminating parental rights must be based on proof beyond a reasonable doubt, including testimony of qualified expert witnesses, that the continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child.

The Indian Child Welfare Act of 1978 (25 USC §1915) governs placement of Native American children in adoptive homes.

ARS §§ 8-531 through 8-544 address termination of parent-child relationships under State law.

Rules: Not Applicable.

Revision History:
DES(07-2006)

Chapter 18: Section 10

Termination of Parental Rights and Adoption

Legal Basis

Policy: The cultural and social values of the Indian child's tribe regarding termination of parental rights and adoption shall be considered. If the child's tribe opposes termination of parental rights based on cultural and social values, a case plan staffing which specifically includes tribal representatives shall be held to identify potential permanent placement alternatives to termination and adoption.

If adoption is selected as the permanency plan, unless the Indian child's tribe has established a different order of placement preference, the department shall give preference to adoptive placement of an Indian child with:

- a member of the child's extended family;
- other members of the Indian child's tribe; or
- other Indian families, including single parent families.

The department shall consider any placement preferences expressed by the parents.

Before considering placement outside the placement preference order, the department shall conduct and document a diligent search to identify a placement within the preference categories by contacting extended family, members of the child's tribe, and through local registries, Indian and Tribal organizations, and regional and national adoption exchanges. See Chapter 18, Section 6, Native American Child Placements and Placement Preferences.

The department shall provide a copy of the final adoption decree to the department of the Interior, Bureau of Indian Affairs, Division of Social Services, 1849 C Street, NW, MS-4603-MIB, Washington, D.C. 20240, and to the child's tribe within 30 days of the adoption finalization. Also send a copy of the final adoption decree to the Bureau of Indian Affairs, Western Regional

Office, P. O. Box 10, Phoenix, AZ 85001, Attention: Regional Social Worker. The copy to the child's tribe shall also be sent to the tribe's social worker or if none is available to the tribal enrollment office.

See Petitioning for Termination of Parental Rights (Chapter 12 Section 3) for detailed procedures for terminating parental rights.

When considering whether adoption is the most appropriate permanency plan, consider the following factors:

- § Does the child's tribe have long-standing social and cultural objections to termination of parental rights, and is adoption recognized by the tribe?
- § If termination and adoption is opposed by the tribe, is there an alternative permanent placement with extended family or other tribal member which will provide comparable stability for the child?
- § What efforts have been made to identify extended family or a member of the Indian child's tribe who will provide a permanent placement for the child?
- § If a placement within the Indian child's tribe cannot be identified, what efforts have been made to identify an adoptive placement not belonging to the tribe, including a non-Indian family?
- § If a placement within the Indian child's tribe cannot be identified, have efforts been made to obtain the tribe's support for an alternative adoptive placement within the placement preference order?
- § Has the child expressed an objection to termination and adoption?
- § If the Indian child's parents expressed a placement preference, what efforts have been made to choose a placement which accommodates their wishes?

Implementation and Procedures Guide

To assess the child's placement needs, gather information by:

- § interviewing the child and his/her caregivers;
- § reviewing the recommendations of the child's immediate and extended family;
- § reviewing the recommendations of medical and behavioral health providers and other professionals who have worked with the child, including tribal representatives and service

providers;

§ reviewing the recommendations of representatives of the child's tribe(s), including recommendations to maintain and develop the child's essential cultural and tribal identity;

§ reviewing the recommendations of other professionals who work with the child;

§ completing the AN-036, Family History (Social History);

§ reviewing the Birth Parent's Interview Form, FC-091 in the child's case record;

§ determining the child's need for adoption subsidy (see Chapter 14, Section 1).

If the child is at risk of, or has one or more of, the following conditions, obtain an evaluation from one or more professionals regarding the impact of the condition on the child's placement needs:

§ developmental disability;

§ emotional disturbances;

§ physical disease or disability; or

§ mental disease or disability.

If adoption is selected as the permanency plan, consider the following factors when assessing the placement needs of a child:

§ characteristics of the child: age, gender, religion, tribal affiliation, primary and secondary (if any) language, physical, emotional, social and educational needs;

§ child's cultural and tribal identity: past participation in tribal religious and cultural practices, knowledge of tribal language, current or past ties with his/her tribal community, clanship if any, child's expressed cultural and tribal identity, and child's non-Indian identity and family ties, if any;

§ child's history: past placements, ties to current or past caregivers, experience with bonding and attachment;

§ child's relationships: extended family, relatives, siblings, foster parents or other significant adults;

§ parent's preferences regarding placement including tribal affiliation, race, color or national origin; and

§ the child's preferences regarding placement.

Conduct a search through available resources to identify and locate a Native American adoptive family. Resources may include tribal social services, the National Indian Child Welfare Association, Indian communities and organizations, the Arizona Adoption Exchange Book, Arizona Statewide Newsletter, Wednesday's Child, National Adoption Exchange, Communities for Children, prior to considering a non-Native American adoptive family.

When providing the final adoption decree to the Bureau of Indian Affairs and the child's tribe(s), include the following information:

- § the name and tribal affiliation of the child;
- § the child's enrollment number and certificate of Indian blood, if available;
- § the child's social security number;
- § the names, addresses and social security numbers of the birth parents;
- § the names and addresses of the adoptive parents; and
- § the identity of any agency having files or information relating to the adoption**.**

DOCUMENTATION :

Document all contacts relating to placement efforts, including but not limited to the Indian child's tribe(s), extended family, and all alternative resources using the Case Notes window.

Document the child's assessed placement needs by completing the following windows: Child Assessment and Special Rate Evaluation, Special Needs Detail, Medical/Dental Condition Detail, Medication Detail, Psychological/Behavioral Condition Detail, Practitioner Detail, Examination Detail, Participant Education Condition, and Hospitalization Detail.

For more information: See Consent and Termination for Adoption (Chapter 12).

Revision History:
DES(07-2006)

Previous / Next

18-11

Legal Basis: The Indian Child Welfare Act of 1978 (25 USC §1913 et seq.) sets forth standards that govern consent for voluntary termination of parental rights for purposes of adoption. The consent is not valid unless the following conditions are met:

§ The consent must be in writing and signed before a judge of competent jurisdiction (may include a tribal court judge).
§ The consent must be accompanied by the judge's certificate that the terms and consequences of the consent were fully explained in detail and were fully understood by the parent.
§ The court must also certify that either the parent fully understood the explanation in English or that it was interpreted into a language that the parent understood.
§ Any consent given prior to birth, or less than ten days after the child's birth, shall not be valid.

Even after a consent is taken, the following may apply:

- A consent to adoptive placement of any Indian child may be withdrawn by the parent for any reason at any time prior to the entry of a final decree of termination or adoption, and the child shall be returned to the parent or a dependency petition filed.
- Up to two years, after the entry of a final decree of adoption of an Indian child in any state court, the parent may withdraw consent and may petition the court to vacate such decree, upon the grounds that consent was obtained through fraud or duress. Upon finding that such consent was obtained through fraud or duress, the court shall vacate such decree and return the child to the parent. No adoption which has been effective for at least two years may be invalidated under the provisions of this subsection unless otherwise permitted under the state law.

ARS §8-106 allows the department to accept a parent's consent to place a child for adoption.

ARS §8-116.01 allows the birth and adoptive parents to enter into a written agreement for post-adoption communications and/or contact which may be approved by a court order, if the adoptive parents and the court agree such contact is in the child's best interests.

Rule: Guidance for interpretation of the Act in state court proceedings may be found in the Guidelines for State Courts; Indian Child Custody Proceedings (Federal Register, April 23, 1979; 44 Federal Register 67584-95).

Revision History:

DES(07-2006)

Chapter 18: Section 11
Consent to Adoption

Legal Basis

Policy: A consent to place an Indian child for adoption may be accepted from a mentally competent parent of a child who is in the care, custody and control of the department.

The department shall consult with the Assistant Attorney General in making the necessary arrangements to have the parent sign a consent to adoption or voluntary termination of parental rights in the presence of a judge of competent jurisdiction. If the child's tribe has intervened or is involved, the appropriate tribal representative shall be notified of the parent's decision and of any court hearing.

The consent must be in writing and signed before a judge and accompanied by the judge's certificate that the terms and consequences of the consent were fully explained in detail and understood by the parent.

A consent to place an Indian child for adoption may be withdrawn, for any reason and at any time, before entry of the final order of termination or decree of adoption.

A consent to place an Indian child for adoption may be withdrawn up to two years after entry of the final order of adoption upon finding by court that the consent was obtained through fraud or duress.

Parents of an Indian child who wish to consent to the adoption of a newborn should be encouraged to contact an appropriate tribal social services agency provided that a dependency petition has not been filed and there is no valid issue of abuse or neglect. If the parent releases the child to the department in lieu of contacting a tribal social services agency, the department will file a dependency petition.

Obtaining a consent to place a child for adoption is preferable to initiating an involuntary termination of parental rights proceeding.

The parent of an Indian child may give consent for a specific person to adopt his or her child. However, if the specified individual(s) do not adopt the child, the consent likely will be deemed void and a new consent (or in the alternative, a proceeding to terminate parental rights) may be necessary to allow for adoption of the child. Use of such a "direct consent" must be approved by a supervisor, in consultation with the Assistant Attorney General.

Unless the Indian child's tribe has established a different placement preference order, the department shall give preference to placement of an Indian child with:

- a member of the Indian child's extended family;
- other members of the Indian child's tribe; or
- other Indian families.

If the parent or Indian child age 12 and over has requested a placement outside these preferences, the request shall be considered and reviewed with the supervisor, the Assistant Attorney General and the child's tribe.

To determine whether voluntary termination is appropriate for the parent of an Indian child, follow the Decision Making Guide listed in Accepting a Consent to Place a Child for Adoption, (Chapter 12, Section 1). In addition, consult with the tribal social services and/or ICWA representative and inform the tribe of the parent's desire to place her/his child for adoption.

Implementation and Procedures Guide:

In addition to the procedures described in Accepting a Consent to Place a Child for Adoption (Chapter 12, Section 1):

- Inform the parent of the placement preferences.
- Inform the parent that in order to find an appropriate adoptive placement, the department will notify the Indian child's tribe. Unless the consenting parent has requested

anonymity, the department also will notify extended family members.

§ Consult with the tribal social services and/or ICWA representative and the parent's attorney if any, and inform the tribe of the parent's desire to place his or her child for adoption, and of the parent's request for anonymity, if applicable.

Provide counseling to ensure that the parent understands the meaning of consent, its implications for the child and parents, and information regarding access to non-identifying information in adoption records.

Conduct a search through available resources to identify and locate a Native American adoptive family. These may include tribal social services, the National Indian Child Welfare Association, Indian communities and organizations, the Arizona Adoption Exchange Book, Arizona Statewide Newsletter, Wednesday's Child, National Adoption Exchange, Communities for Children, prior to considering a non-Native American adoptive family.

Request the Attorney General's Office to file a motion for a hearing on the ICWA consent. Inform the Assistant Attorney General if an interpreter is needed.

Arrange for the parent to be at the hearing.

At the hearing, obtain the original and a certified copy of the ICWA consent and certification order. Provide a copy to the parent, parent's attorney and to the child's tribe.

Ensure that a copy of the final adoption decree is forwarded to the Secretary of the Department of the Interior, Bureau of Indian Affairs, Division of Social Services, 1849 C Street, NW, MS-4603-MIB, Washington, D.C. 20240. Also send a copy of the final adoption decree to the Bureau of Indian Affairs, Western Regional Office, P. O. Box 10, Phoenix, AZ 85001, Attention: Regional Social Worker.

DOCUMENTATION :

Ensure that the child's tribe has been added to the case as a Case Associate using the Case Creation window.

It is extremely important to document all contacts with the Indian child's and/or Indian parent's tribe including the name, address, title, telephone number of the person contacted and the results

of these contacts using the Case Notes window designated as Collateral Contact type.

File copies of all correspondences with tribal staff in the hard copy case record.

File the original and certified copies of the Adoption Consent and Judge’s certification in the hard copy case record.

Revision History:
DES(07-2006)

Previous / Next

18-12

Legal Basis: The Adoption and Safe Families Act of 1997 (P.L. 105-89) specifies that, if the state concludes, after considering reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, that the most appropriate permanency plan for a child is placement in another planned permanent living arrangement (APPLA), the state must document to the court the compelling reason for the alternate plan.

Examples of a compelling reason for establishing such a permanency plan may include the tribe's identification of another planned permanent living arrangement for the child [45 CFR 1356.21(h)(3)(iii)]. Another example of a compelling reason is a youth who opposes termination and adoption.

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 18: Section 12

Foster Care As A Planned Permanent Living Arrangement

Legal Basis

Policy: The department shall establish foster care as another planned permanent living arrangement (APPLA) only when the permanency options of adoption and guardianship are not in the best interests of a child, the child is expected to remain in out-of-home care at least until the age of majority, and the foster home provider has made a commitment to continue as a permanent supportive adult in that child's life.

The department shall establish a formalized agreement between the agency, foster home provider and child to support the continuity and stability of the placement.

When a child's planned living arrangement is foster care, the department shall maintain contact with the child's parents or extended family, whenever possible, to:

- Inform and involve the family in decisions about their child where feasible.
- Stay informed of changes in the family situation that might indicate a need to re-evaluate the permanency goal of long-term foster care, unless such contact would compromise the safety of the child.

Consider the following questions in deciding upon a planned living arrangement:

Is the child expected to remain in out-of-home care until the age of majority?

- Is there a compelling reason why the out-of-home provider cannot or will not pursue adoption or guardianship of the child, and is it in the child's best interest to remain with the provider?
- Have you documented a compelling reason that adoption or guardianship is not in the child's best interest?
- Have the benefits of adoption and guardianship been explored with the child?
- Is the child over 12 years of age and unwilling to consent to an adoption?

§ Has the foster care provider verbalized their commitment to continue as a permanent supportive adult in the child's life?

§ Has the foster care provider verbalized their commitment to ensure the child maintains connections with their immediate and extended family?

BEST PRACTICE TIP:

No child should leave the child welfare system without a legal relationship to an adult who cares about them and is unconditionally committed to them. This is the definition of permanency. Sometimes we give up on permanency for older youth too soon—we don't think that they are "adoptable" and a permanent guardian has not been identified. It is critical that CPS Specialists continue to search out permanent options for children in care. However, the reality is that there are times when children are not placed for adoption, or do not have legal guardians. While this should be rare as it is very difficult for children to leave the child welfare system without consistent and reliable adult supports, and the Adoption and Safe Family Act does not allow for Long Term Foster Care as a viable permanency option, it does happen.

First and foremost, we should attempt to prevent this lack of permanency. We know from studies across the country that when permanency planning begins at the point of placement, when kin are identified early in the process and when workers are diligent in their efforts to identify permanency options for children, the number of youth "aging out of care" decreases.

When this work has not been done early in the process, we need to ask the youth who matters in their life. Youth are very often able to identify possible permanency options, if just asked. We also need to go back and review the file of the youth, often kin were identified during the early phases of serving the child and family, but there were not pursued as permanency options.

When there appears to be no way for the child to have a legal relationship with an adult when leaving the child welfare system, we need to seek out adult connections for the youth. Several states call Youth Connection meetings prior to the youth's 18th birthday, bringing adults who care about the child together to create a plan –identifying which adults can support the youth during the predictable tensions and struggles. When youth leave the system foster parents often serve as an informal support for the youth. CPS Specialists should meet with the foster parents and the youth to clarify the continued relationship.

Implementation and Procedures Guide

Obtain the program manager or designee's approval prior to pursuing a plan of foster care as a planned living arrangement.

Formalize the plan through the Long Term Foster Care Agreement, FC-092.

Request the court to grant physical custody of the child to the out-of-home provider**.**

Continue to provide all case planning and case management services, as described in Developing the Family Centered Case Plan (Chapter 9, Section 1).

Support continued contact between the child and his or her parents, siblings and extended family members, unless such contact would be detrimental to the child.

Whenever possible, maintain contact with the child's parents or extended family, to:

- § Inform and involve the family in decisions about their child where feasible.
- § Stay informed of changes in the family situation that might indicate a need to re-evaluate the permanency goal of long-term foster care, unless such contact would compromise the safety of the child**.**

Complete the Long Term Foster Care Agreement, FC-092.

DOCUMENTATION :

Document the selection of Long Term Foster Care as a planned permanent living arrangement in the Permanency Goal window.

Document the formalization of Long Term Foster Care, using the Long Term Foster Care As Planned Living Arrangement Agreement, FC-092.

Revision History:

DES(07-2006)

Previous / Next

18-13

Legal Basis: ARS §8-521 provides guidelines for the Independent Living Subsidy Program, an experiential living arrangement for youth in out-of -home care.

ARS §46-134 describes guidelines for young adults remaining in foster care or in the Independent Living Subsidy Program beyond their 18th birthday.

ARS §8-521.01 describes qualifications for participation in the Transitional Independent Living Program.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 18: Section 13

Providing Independent Living Services and Supports

Legal Basis

Policy: All youth in out-of-home care who are age 16 and older shall have an independent living plan which supports their individual transition to adulthood including the development of daily living skills, and complements other services being provided towards achievement of the permanency goal.

The department shall provide services and opportunities to support all young people to make sound life decisions and develop a sense of competence, usefulness, belonging and empowerment.

If the team (to include the youth, the CPS Specialist, tribe and others involved in assisting the youth) determines that the youth could benefit from the services and supports offered through the Arizona Young Adult Program, the CPS Specialist should refer the youth for these services including:

- participation in the Arizona Young Adult Program specialized case management (where available);
- independent living skills training;
- educational and employment training opportunities (including the Education and Training Voucher (ETV) Program);
- independent Living Subsidy;
- voluntary continued out-of-home care for young adults 18 through 20; and
- other activities such as local youth advisory boards, youth conferences, etc.

All youth who are working toward emancipation shall be referred for Independent Living Services and Supports. For the purpose of this policy, “emancipation” refers to the acquisition of adequate skills and resources which will enable the youth to live independently, (outside of the state foster care system) at age 18 or older.

The department shall consult with the child's tribe and family, if available, in determining the needs and services for independent living.

BEST PRACTICE TIP:
Shortly after the passage of ASFA, the National Resource Center for Youth Services (NRCYS) looked at what "permanency planning" means for adolescents. The result of this year-long effort is the publication, *Permanency Planning: Creating Life Long Connections: What Does it Mean for Adolescents?*
This publication, available on the NRCYS website **http://www.nrcys.ou.edu**, offers three compelling conclusions:

- § Adolescents need connections to adults and peers throughout their lifetime.
- § Adolescents need to be taught skills that will prepare them to live independently.
- § All youth, but particularly adolescents, must be seen as central actors in their own futures.

These findings underscore that young people need permanency planning services concurrent with independent living services. The study recommends that "concurrent planning be incorporated into any effective strategy to prepare adolescents for permanency…" and that states "engage in concurrent planning, continue to discuss adoption while putting independent living programs into place, and continue to provide training in life skills while adoption is pending. It is not an either/or choice."
Significant research underscores the fact that consistent, secure, permanent relationships with adults are a strong indicator of "resilience" in children, a factor which helps determine the extent to which they are able to overcome obstacles and avoid negative outcomes. Young people themselves repeatedly indicate their desire for these permanent family connections.

Implementation and Procedures Guide:

Refer all Indian children who are in out-of-home care and age 16 and older for independent living services and supports according to district operating procedures.

Provide the youth with the PAC-533, Questions and Answers About Youth Rights in Foster Care, and with any additional program material available.

Describe aftercare support and services available including:

- transitional living and support services (through the Transitional Independent Living Program-TILP);

- education and employment training opportunities (including the Education and Training Voucher (ETV) which is available to age 23);
- re-entry into DCYF supervised services after exiting care at age 18 or older; and
- health insurance (for eligible youth through AHCCCS).

See Chapter 16, Independent Living Service and Supports, for more information on providing independent living services and supports to Indian children.

DOCUMENTATION :

Document the referral for independent living services and supports in Case Notes.

Document tasks related to the independent living plan using the Case Plan Tasks window, Independent Living plan type.

Identify and document tasks related to the development of self-sufficiency skills using the Case Plan Tasks window, Independent Living plan type.

For More Information: See Independent Living Services and Supports (Chapter 16) for more information on selection and implementing Independent Living Services and Supports.

Revision History:
DES(07-2006)

Previous / Next

Chapter 18: Section 14

Glossary To Assist In Working With Tribes

Active efforts: active efforts require that a case manager actively assist the client in accessing and participating in necessary and culturally appropriate remedial and rehabilitative services. Examples of active efforts may include making appointments for the client with particular providers, providing transportation to and from such appointments, closely monitoring a client's participation in such services, and continuing with ongoing efforts to secure a placement within the ICWA placement preferences.

American Indian Detail Window: means a window in CHILDS pertaining to identifying information about any child, parent, guardian, or custodian with American Indian heritage.

Child custody proceeding: For placement purposes, includes:

- foster care placement which shall mean any action removing an Indian child from its parent or Indian custodian for temporary placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where the parental rights have not been terminated;
- termination of parent rights which shall mean any action resulting in the termination of the parent-child relationship;
- pre-adoptive placement which shall mean the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement; and
- adoptive placement which shall mean the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption. Such term or terms shall not include a placement based upon an act which, if committed by an adult, would be deemed a crime or upon an award, in a divorce proceeding, or custody to one of the parents.

Clan: means a Tribal system of kinship/extended family relationships.

Culturally appropriate services: means services which will support and recognize a parent or child's cultural customs, traditions, and beliefs. Examples include healing ceremonies, consultation with a traditional practitioner, and referral of parents to professionals trained in

provision of services to American Indian people. Services should be sought from community and tribal resources as well as from ADES contracted providers.

Extended Family Member: means a person having reached the age of eighteen and who is the Indian child's grandparent, aunt, uncle, brother, sister, brother-in-law, sister-in-law, niece, nephew, first or second cousin, or step-parent or as defined by the law or custom of the child's tribe.

Indian: means a person who is either a member of or eligible to be a member of a federally recognized tribe, including Eskimo, Aleut, or other Alaska Native.

Indian Child: means an unmarried person under age 18 or younger and who is either; (a) a member of a federally recognized Indian tribe, including Eskimo, Aleut, or other Alaska Native; or (b) eligible for membership in a federally recognized tribe, including Eskimo, Aleut, or other Alaska Native, and is the biological child of a member of a federally recognized Indian tribe.

Indian Child Information Report: (FW 106) form to document pertinent information regarding an Indian child and his or her family and Tribal relationships.

Indian Child's Tribe: means the Indian tribe in which an Indian child is a member or eligible for membership or in the case of an Indian child who is a member of or eligible for membership in more than one tribe, the Indian tribe with which the Indian child has the more significant contacts.

Indian Child Welfare Act: "ICWA" 25 U.S.C. 1901 et seq.

Indian Custodian: an Indian person having legal custody of an Indian child under tribal law or custom or under State law or to whom temporary physical care, custody and control has been transferred by the parent of such child.

Indian Organization: means any group, association, partnership, corporation or other legal entity owned or controlled by Indians or a majority of whose members are Indians, and which provides social or child welfare services to Indian families.

Indian Reservation: Indian country, as defined in 18 U.S.C. Sec. 1151 and any lands, not

covered under such section, title to which is either held by the United States in trust for the benefit of any Indian tribe or individual or held by any Indian tribe or individual subject to a restriction by the United States against alienation.

Indian Tribe: any Indian tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in section 1605(c) or Title 43.

Native American: means any person who is a member of an Indian tribe, or who is an Alaska Native and a member of a Regional Corporation.

Parent: means any biological parent or parents of an Indian child or any Indian person having lawfully adopted an Indian child, including adoptions under tribal law or custom. The term does not include the unwed father where paternity has not been acknowledged or established under state law or tribal law or custom.

Rehabilitative services and programs: means services and programs individually tailored and designed to assist the family in improving a parent's ability to safely care for the child in the home. Services should be culturally appropriate, identified in the case plan, and may include but are not limited to substance abuse treatment programs, vocational training, parenting classes, and psychological counseling.

Relative: means an individual related to an Indian child by blood, marriage, or Tribal custom.

Remedial services: means services designed to remedy the circumstances which cause or may cause continued placement of the child outside the home.

Secretary: means the Secretary of the Interior.

Tribal Court: a court with jurisdiction over child custody proceedings and which is either a Court of Indian Offenses, a court established and operated under the code or custom of an Indian tribe, or any other administrative body of a tribe which is vested with authority over child custody proceedings.

Tribal designated agent: means individuals specifically identified in the Federal Register to

receive legal notice of child custody proceedings. The list of these individuals is located in the DCYF Public Folders, Indian Child Welfare Act - List of Tribal Agents.

Tribal/ICWA representative: means an individual identified by a Tribe to exchange information with the department and to assist with the identification of appropriate resources.

Revision History:

DES(07-2006)

Previous

19-1

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 19: Section 1

Establishing ACYF Case Records

Legal Basis

Policy: To ensure thorough and orderly documentation of information regarding children and families, ACYF shall establish the following types of case records:

- Child Protective Services;
- Adoption;
- Independent Living;
- Family Foster Home Licensing;
- Adoptive Home Certification;
- Adoption Subsidy;
- Guardianship Subsidy; and
- Interstate Compact on the Placement of Children (ICPC).

Case records include an electronic and hard copy record. The electronic record is maintained in CHILDS and includes windows data and electronically created documents. The hard copy record is maintained in the local office. The hard copy includes:

- Documents generated outside the Division of Children, Youth and Families (DCYF);
- Documents that require signatures from individuals outside DCYF; and
- Hard copy forms not maintained electronically.

Implementation and Procedures Guide

Establish Child Protective Services case records *by family units*. Include in the Child Protective Services case record information relating to CPS involvement of *all* members of the family unit, *except:*

- children who have been legally freed for adoption; and
- young adults whose cases have been transferred to an Independent Living program.

In each of the above cases, establish a new case record *by child*. If other children who are

receiving child protective services remain in the family, keep the family's Child Protective Services record open; if not, close the family record.

Establish Family Foster Care Licensing records by family unit for each family that applies for licensure or is licensed as a foster family.

Establish Adoptive Home Certification records by family unit for each family that applies for certification or is certified as an adoptive family. Include relatives and step-parents who are adopting in this record.

Establish Adoption Subsidy records for each child whose adoption is subsidized.

Establish case records by name of the permanent guardian when the guardianship is established and the guardianship subsidy application has been approved.

Establish case records by child for each out-of-state child placed in Arizona under the Interstate Compact on the Placement of Children, or by sibling group if the siblings are placed together. (Information on Arizona children who are placed out-of-state under the Compact remains in the family CPS record, unless the child/ren are legally free for adoption.)

BEST PRACTICE TIP:
While documentation is often perceived to be unimportant and taking away from the work of child protection, often the quality of the documentation dictates case decision making for years to come. It is important for the CPS Specialist to remember that they are chronicling the story of the family's involvement in the child welfare system. The information will be used by the courts, supervisors, the family and future CPS Specialists in the system. It is important that documentation reflect the following:

- Perspectives of the family in the voice of the family;
- Perspectives of other family members and others who know the family well;
- Perspectives of others involved in the situation (school, mental health providers; law enforcement, etc.) and
- Conclusions that reflect critical thinking and a flow from one decision point to the next. A supervisor or new CPS Specialist should be able to pick up the file and understand the goals for the family, how the decisions were made, why specific services were provided, and the outcomes of those services.

Revision History:

DES(07-2006)

Next

19-2

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 19: Section 2

Organizing Case Records

Legal Basis

Policy: All ACYF case records shall be complete, accurate and current.

All ACYF case records shall be updated no more than ten days from the date of the event being documented.

Documentation shall be recorded using the Case Notes window unless otherwise specified.

Districts are responsible for establishing and maintaining organizational guidelines for all hard copy records, except child welfare agency licensing records and adoption subsidy case records.

Central Office is responsible for establishing and maintaining organizational guidelines for child welfare agency licensing case records and adoption subsidy case records.

All public or private child welfare agencies that provide care for foster children or place children in foster homes shall keep case records in a manner that the department prescribes. (ARS §8-519)

Revision History:
DES(07-2006)

Previous / Next

19-3

Legal Basis: Safeguarding of case records and files is addressed in many statutes, including the following:

§ ARS §8-120: requires safeguarding of records and files concerning adoption;

§ ARS §8-519: requires child welfare agencies to safeguard records and information regarding children and their care;

§ ARS §8-541: requires safeguarding of records and files regarding termination of parental rights;

§ ARS §8-804: requires safeguarding of information contained in the Central Registry and specifies the purposes of the Central Registry;

§ ARS §8-807 and ARS §41-1959: require safeguarding of information on individuals who are the subject of a child protective services investigation, alleged victims, their siblings, and parents or guardians; and the identity of the reporting source; and

§ The Child Abuse Prevention and Treatment Act (P.L. 104-235), as amended by the Keeping Children and Families Safe Act (P.L. 108-36), requires states to maintain CPS information as confidential in order to protect the rights of the child and the child's parents or guardians. The Child Abuse Prevention and Treatment Act (CAPTA) further mandates that states *shall only* release CPS information (including reports and records) to specific persons or entities.

§ Title XX, IV-A and IV-B of the federal Social Security Act (42 U.S.C.§602): require that safeguarding of information on applicants and recipients is a condition for receiving federal funds.

Rules: Rules pertaining to the safeguarding of case records are found in Sections R6-5-5601 through R6-5-5610 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 19: Section 3

Safeguarding of Case Records

Legal Basis

Policy: ACYF case records are confidential and shall not be released, except as specified by law. (ARS §8-807)

To safeguard case records, districts shall establish procedures governing:

- storage of case records;
- access to case records; and
- removal of case records from local offices.

As specified by law, the department shall release confidential CPS information contained within CPS case records to the following individuals or entities upon request:

- a court, a party in a dependency or termination of parental rights proceeding or the party's attorney, the Foster Care Review Board or a Court Appointed Special Advocate (CASA);
- domestic Relations, Family or Conciliation court if the information is necessary to promote the safety and well-being of children;
- a person or agent of a person who is the subject of CPS information and only information about that person. (The person can not waive the confidentiality of CPS information concerning any other person.);
- a person conducting a forensic medical evaluation, including social and family history regarding the child, the child's siblings and the child's parents or guardians;
- a prospective adoptive parent, foster parent or guardian if the information concerns a child the prospective adoptive parent, foster parent or guardian seeks to adopt or provide care for;
- if there is a reasonable need for to provide the information to federal, state, or tribal agencies, county or municipal agencies, a county attorney, a school, a community service provider, a contract service provider or any other person that is providing services for the following purposes:

- Ø to meet its duties to provide for the safety, permanency and well-being of a child;
- Ø to provide services to a parent, guardian or custodian or to family members to strengthen the family; or
- Ø to enforce or prosecute any violation involving child abuse or neglect, including provision of the CPS information to a defendant after a criminal charge has been filed.

§ If the information is reasonably necessary to perform the person's official duties, to:

- o federal or state auditors;
- o persons conducting any accreditation deemed necessary by the department;
- o a standing committee of the legislature, or committee appointed by the President of the Senate or the Speaker of the House of Representatives for purposes of conducting investigations related to the legislative oversight of the department (Forward these requests to the department's Legislative Services Office.);
- o a Legislator responsible for oversight of the enabling or appropriating legislation in carrying out that official's functions (Forward these requests to the department's Legislative Services Office.); and
- o a Citizen Review Panel, Child Fatality Review Team and the Office of the Ombudsman-Citizen's Aide.

Confidential CPS information may be released:

§ to confirm, clarify or correct information concerning an allegation or actual instance of child abuse or neglect that has been made public by sources outside the department. (Forward these requests to the department's Public Information Office.)

§ on request, summary information regarding a fatality or near fatality caused by abuse or neglect. (Forward these requests to the department's Public Information Office.)

§ to a person conducting bona fide research which may be beneficial in improving Child Protective Services. (Forward these requests to the department's Public Information Office.)

§ a summary of the outcome of a Child Protective Services investigation to the reporting source.

§ to a parent, guardian or custodian of the child if the information is reasonably necessary to promote the safety, permanency and well-being of the child.

A person who appeals a finding of abuse or neglect pursuant to ARS §8-811 may obtain a copy of records that are sent to the Office of Administrative Hearings in connection with the appeal.

A person who is not specifically authorized to obtain CPS information may petition a judge of the superior court to order the department to release that CPS information. The court may order release of otherwise confidential CPS information only if the rights of the parties seeking the CPS information and any benefits from releasing the information sought outweigh the rights of the parties entitled to confidentiality and any harm that may result from releasing the information.

If a judge of the superior court determines that a person is the subject of an unsubstantiated (unfounded) report that was made in bad faith or with malicious intent, the court may order the release of the identity of the reporting source if the disclosure would not be likely to endanger the life or safety of the source.

Before CPS information is released, the department shall take whatever precautions that are reasonably necessary to protect the identity and safety of the reporting source and to protect any other person the department believes that disclosure of the information would be likely to endanger the life or safety of the person. These precautions include the redaction of personally identifiable information related to the reporting source and the identity of any person whose life may be endangered by the disclosure.

The department is not required to release CPS information if the disclosure would compromise the integrity of a Child Protective Services or criminal investigation.

The department may charge a fee for copying and costs required to prepare the CPS information for release.

All information regarding contacts between ACYF personnel and the Attorney General's Office is protected by attorney-client privilege and shall not be released.

Implementation and Procedures Guide

Always confer with your supervisor prior to agreeing to the release of any confidential information.

Release confidential information only if you and your supervisor are certain that the request falls within the department's legal mandate. Refer any questions to the Attorney General's

Office.

Release information to a person who is the subject of CPS information or the agent of the person; or to the parent, guardian, or custodian of the child if the information is reasonably necessary to promote the safety, permanency and well-being of the child after:

- the individual submits a Child Protective Services Records Request, PS-072; and Child Protective Services Record Index, CPS -1004AFORCC; and
- redacting the records following the ACYF Procedures for Redacting and Releasing Confidential CPS Records and Files.

Refer requests for information from a state legislator to the department's Legislative Services Office.

Refer the following requests for public release of CPS information to the department's Public Information Office:

- requests for information regarding child fatality or near fatality;
- requests to confirm, clarify or correct information concerning an allegation or actual instance of child abuse or neglect that has been made public by sources outside the department;
- requests for information to conduct a bona fide research which may be beneficial in improving Child Protective Services; and,
- requests for information from any individual not entitled to access to confidential information under ARS §8-807.

Refer requests for information from individuals who are appealing a proposed substantiated finding to the Protective Services Review Team.

Refer requests for information from an individual who believes he/she may be the subject of a CPS report, or an individual who is seeking a copy of the CPS report to the Central Registry Coordinator at the Child Abuse Hotline. The Coordinator will:

- request that the individual submit a request for Child Protective Services Report, PS-042;
- redact the records, as necessary; and
- provide information allowable by law.

DOCUMENTATION :

Document all requests for confidential information using the Case Notes Window, designated as Collateral Contact type.

If information is provided, record who asked for the information, the type of information provided, and the date on which the information was provided.

If the request is referred to the department's Legislative Services Office or the Public Information Office or the district coordinator for the release of information, note the referral and date in the record using the Case Notes window designated as Collateral Contact type.

Document all conversations and contacts with the Attorney General's Office using the Case Notes window designated as AG Contact type. Do not release this information to anyone as the information is protected by attorney-client privilege.

Revision History:

DES(07-2006)

Previous / Next

19-4

Legal Basis: The department is authorized to release CPS information to various persons and entities as specified in ARS §8-807.

Prior to the release of confidential CPS information, the department shall take whatever precautions it determines are necessary to protect the identity and safety of a person who reports abuse or neglect or any other person, if disclosure of that information would be likely to endanger the life or safety of that person. These precautions may include withholding or editing portions on the CPS information contained in the files. [ARS §8-807(J)]

The department may charge a fee for copying costs required to prepare CPS information for release. [ARS §8-807(R)]

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 19: Section 4

Redaction of CPS Case Records

Legal Basis

Policy: The department shall redact CPS information in accordance with the ACYF Procedures for Redacting and Releasing Confidential CPS Records and Files.

Each district shall be responsible for redacting or coordinating the redaction of CPS information as prescribed by law, and for providing redacted records to the individual who request them.

Implementation and Procedures Guide

Refer requests for information from a state legislator to the department's Legislative Services Office.

Refer the following requests for public release of CPS information to the department's Public Information Office:

- § requests for information regarding child fatality or near fatality;
- § requests to confirm, clarify or correct information concerning an allegation or actual instance of child abuse or neglect that has been made public by sources outside the department;
- § requests for information to conduct a bona fide research which may be beneficial in improving Child Protective Services (The Public Information Office will coordinate with the Division's Research Committee); and
- § requests for information from any individual not entitled to access to confidential information, under ARS §8-807.

Consult your supervisor and, if necessary, an Assistant Attorney General if questions arise concerning requests for information or requirements for redaction of case records.

Revision History:

DES(07-2006)

Previous / Next

19-5

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 19: Section 5
Closing Case Records in CHILDS

Legal Basis

Policy: Close the case by completing the windows required in the CHILDS system.

Implementation and Procedures Guide:

For cases closed at investigation:

- Update case contacts using the Case Notes windows.
- Complete the Determination of Case Status windows.
- End all service authorizations using the Provider Service Authorization window and notify the case participant and provider of the end date and case closure.
- Complete the Case Closure window to indicate the reason for case closure, the reason the case was open, outcome of services offered, the current status of the family and the aftercare plan.

For cases closed by ongoing:

- Update case contacts using the Case Notes windows.
- End all service authorizations using the Provider Service Authorization window and notify the case participant and provider of the end date and the case closure.
- Update the child's legal status using the Legal Status window.
- For children who were removed, update the child's return home date using the Removal Status window.
- Complete the Case Closure window to indicate the reason for case closure, the reason the case was open, outcome of services offered, the current status of the family and the aftercare plan.

Print the Case Closure report and file the report in the hard copy record.

CPS Supervisor - Investigations:

Complete the following:

- § the FW-181A, Supervisory Case Record Review Guide-Investigation,
- § the Determination of Case Status Approval window, and
- § the Case Closure Approval window.

For a case closed after on-going services, complete the Case Closure window.

CPS Supervisor - Ongoing:

Complete the following:

- § the FW-181B, Supervisory Case Record Review Guide-Ongoing, and
- § the Case Closure Approval window.

Revision History:
DES(07-2006)

Previous / Next

19-6

Legal Basis: ARS §8-120(E) addresses retention of adoption records.

ARS §8-804 addresses retention of Central Registry records.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 19: Section 6

Retention and Disposition of Case Records

Legal Basis

Policy: ACYF will retain and dispose of records according to the schedule prescribed by the Records Management Division, Department of Library, Archives and Public Records.

Implementation and Procedures Guide

Send closed hard copy records to Closed Records, following district procedures.

For More Information: Contact the Record Management Division at (602) 542-3741.

Revision History:
DES(07-2006)

Previous

20-1

Legal Basis: Children's services are governed by federal and state laws that are cited throughout this manual.

Key *federal* statutes affecting children's services include the following:

Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272): This statute amends the Social Security Act to provide federal funding for state child welfare programs that meet specific requirements. The Act provides for federal funding of foster care maintenance payments under Title IV-E for states that provide required protections for children and families.

Required protections include:

- Judicial determinations (A) in the first court ruling sanctioning the child's removal that continuation in the home would be contrary to the welfare, or that placement would be in the best interest, of the child, (B) except in voluntary foster care cases, no later than sixty days from the date of removal, that reasonable efforts were made to prevent removal of the child from the home, or reasonable efforts to prevent removal are not required due to aggravated or extenuating circumstances, and (C) within twelve months of the date the child entered foster care and at least once every twelve months thereafter, that the department has made reasonable efforts to finalize the permanency plan in effect at the time of the ruling;
- A case plan for each child in out-of-home care that includes specific information; and
- The periodic review of the case of each child in out-of-home placement by a court or through an administrative review process.

The Act also provides:

- Federal funding for Adoption Assistance payments to facilitate the adoption of children with special needs; and
- Federal funding for a broad range of child welfare services under Title IV-B.

Family Preservation and Family Support Act of 1994 (P.L. 103-66): The Adoption and Safe Families Act of 1997 amended the Family Preservation and Family Support Act by renaming it, *Promoting Safe and Stable Families*. Its purpose was expanded to include promoting family strength and stability, enhancing parental functioning and child protection. It provides a capped entitlement to states to provide family preservation services, community-based family support services, time-limited family reunification services, and adoption promotion and support services. It also provides funding for Improvements to state courts.

Indian Child Welfare Act (25 U.S.C.§1901 et seq.:) Passed by Congress in 1978, this Act is aimed at preserving Native American families and tribes. The Act:

- establishes legal standards for removal of Native American children from their families,
- represents a placement preference for Native American children who are placed outside their parents' home, giving priority to relatives and members of the child's tribe; and
- requires notification to the parent or Native American custodian and the Native American child's tribe when a Native American child is placed involuntarily into out-of-home care, including foster care or adoption placement.

Title XIX of the Social Security Act: This Title of the Social Security Act provides federal funding for an array of medical and behavioral health services for children who meet financial eligibility criteria. (See Chapter 2, Federal Support for ACYF Programs, for more information

Multiethnic Placement Act of 1994 (P.L. 103-382): Part of the Improving America's Schools Act of 1994, the Multiethnic Placement Act requires states to diligently recruit potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed.

Interethnic Adoption Provisions of the Small Business Protection Act of 1996 (P.L. 104-188): This Act amends the Multiethnic Placement Act by repealing Section 553. The Act provides that neither the state nor any other entity in the state that receives funds from the federal government and is involved in adoption or foster care may:

- deny or delay the placement of a child for adoption or foster care, on the basis of race, color, or national origin of the adoptive or foster parent or the child involved; and
- deny to any person the opportunity to become an adoptive or foster parent, on the basis of race, color, or national origin of the person or of the child involved.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L.104-193): This Act requires states to consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant state child protection standards.

Adoption and Safe Families Act of 1997 (P.L. 105-89): This Act significantly amends Titles IV-B and IV-E of the Social Security Act by establishing safety, permanency and well-being as national goals for children in the child welfare system.

The Act provides that:

- the child's health and safety be the paramount concern in determining and making reasonable efforts with respect to a child;
- reasonable efforts shall not be required with respect to a parent of a child if a court determines that the parent:

§ committed murder or manslaughter of another child of the parent, or aided or abetted, attempted, conspired, or solicited to commit such murder or manslaughter;
§ committed a felony assault that resulted in serious bodily injury to the child or another child of the parent;
§ subjected the child to aggravated circumstances, or
§ has had parental rights to a sibling involuntarily terminated.

- a permanency hearing be held within 30 days of a court determination that reasonable efforts with respect to a parent are not to be made;
- reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan and to complete necessary steps to finalize the permanent placement of the child when the court determines that reasonable efforts are not to be made or that continuation of such efforts are inconsistent with the permanency plan;
- reasonable efforts to place a child for adoption or with a legal guardian may be made concurrently with reasonable efforts to preserve and reunify families;
- a petition to terminate parent rights be filed while concurrently identifying and approving families for adoption for children under the state's responsibility and in out-of-home care when:

§ the child has been in out-of-home care for cumulative total period of 15 of the most recent 22 months;
§ a court has determined the child to be an abandoned infant;
§ a court has determined that the parent committed murder or manslaughter of another child of the parent, or aided or abetted attempted, conspired, or solicited to commit such murder or manslaughter;
§ committed a felony assault that resulted in serious bodily injury to the child or another child of the parent,

- exceptions to the termination of parental rights requirement when:

§ the child is being cared for by a relative,
§ the state has not complied with court ordered reunification services, or
§ the case plan documents a compelling reason that termination of parental rights is not in the child's best interest.

- documentation of steps taken to find and place the child into an adoptive home or other permanent living arrangement and to finalize the adoption or legal guardianship when the child's permanency plan is adoption or placement in another permanent home;
- for the effective use of cross-jurisdictional resources to facilitate timely and permanent placements for children awaiting adoption;

- prohibits the denial or delay of placement of a child for adoption when an approved family is available outside the state and requires states to grant an opportunity for a fair hearing to an individual who alleges such denial or delay;
- foster and pre-adoptive parents or relatives providing care for the child be provided notice of and given the opportunity to be heard at any review or hearing with respect to the child;
- state child welfare agencies be authorized to use the Federal Parent Locator service to assist in locating absent parents; and
- eligibility for the child's adoption assistance continue in cases of dissolved adoptions.

Foster Care Independence Act of 1999 (P.L. 106-169): This Act amends Title IV-E of the Social Security Act to provide states increased funding and flexibility to implement programs designed to help children transition from foster care to self-sufficiency.

The Act amends Sec. 477 of the Social Security Act to read "John H. Chafee Foster Care Independence Program" and requires States to:

- Provide assistance and services to children up to age 21 years who have left foster care because they have attained 18 years of age.
- Provide appropriate support and services to former foster care recipients between 18 and 21 years of age.
- Make benefits and services under the program available to Indian children in the State on the same basis as to other children in the State.
- Provide training to help foster parents, adoptive parents, case managers and group home staff understand and address issues confronting adolescents preparing for independent living, and ensure other certifications.

The Act additionally increases the amount of assets allowable to children in foster care and includes a State option of Medicaid coverage for adolescents leaving foster care.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191):

- allows for the exchange of Protected Health Information (referred to as PHI) between covered entities for purposes of treatment, payment and health care operations;
- limits the use and disclosure of Protected Health Information;
- establishes an individual's right to control access to and use of their Protected Health Information; and,
- balances health information protection and individual rights against public health and safety needs.

Arizona revised statutes, Title 8, contains most of Arizona's state statutes related to child

protection, dependency, guardianship and adoption. Specifically:

- ARS §8-223 requires the court to set the hearing to terminate parental rights before a jury if requested by the parent whose rights are sought to be terminated.
- ARS §8-224 allows a person, who is the subject of an investigation, to request that a hearing or trial relating to the dependency proceeding be open to the public. The court shall order the hearing open to the public unless the court determines for good cause that all or part of the hearing or trial should be closed.
- ARS §8-800 sets forth the primary purposes of child protective services as to protect children by investigating allegations of abuse and neglect, promoting the well-being of the child in a permanent home, coordinating services to strengthen the family and prevent, intervene in and treat abuse and neglect of children.
- ARS §8-801 defines protective services as a specialized child welfare program that is administered by the department and investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family.
- ARS §8-829 requires the court to make protecting the child from abuse or neglect the first priority when making judicial determinations.

Other state statutes that affect children's services include the following:

- ARS §25-801 et seq.: Establishment of paternity
- ARS §13-3620: Mandated reporting of child abuse and neglect
- ARS §13-3623: Definitions and classification of child abuse
- ARS §15-763.01: Surrogate parents
- ARS §36-3431 et seq.: Behavioral health
- ARS §36-551 et seq.: Developmental disabilities
- ARS §41-1959: Confidentiality
- ARS §41-1991 et seq.: Hearings and appeals
- ARS §44-133. Emergency consent for hospital care, medical attention or surgery by person in loco parentis
- ARS §46-134: Powers and duties
- ARS §46-135: Power to promulgate Rules about confidentiality
- ARS §46-141: Criminal history record information checks

Rules: Title VI, Chapter 5, of the Arizona Administrative Code provides Rules that govern the implementation of certain areas of ACYF's programs. Rules affecting children's services include the following:

- Article 24: Appeals and Hearings

- Article 55: Child Protective Services
- Article 58: Family Foster Parent Licensing Requirements
- Article 56: Confidentiality and Release of CPS Records
- Article 59: Group Foster Home Licensing
- Article 65: Department Adoption Functions and Procedures for Providing Adoption Services
- Article 66: Adoption Services
- Article 67: Adoption Subsidy
- Article 69: Child Placing Agency Licensing
- Article 70: Adoption Agency Licensing
- Article 74: Licensing Process and Licensing Requirements for Child Welfare Agencies operating Residential Group Care Facilities and Outdoor Experience Programs
- Article 75: Appeal and Hearing Procedures for Adverse Action Against Family Foster Homes, Adoption Agencies, and Child Care Providers.
- Article 80: Interstate Compact on the Placement of Children

In addition, the Rules of Procedure of the Juvenile Court specify requirements for hearings that affect children's services cases.

Revision History:
DES(07-2006)

Chapter 20: Section 1

Laws and Rules that Govern Children's Services

Legal Basis

Policy: ACYF policy shall support the implementation of all federal and state laws as well as state Rules governing children's services.

The department shall take steps to ensure that ACYF direct service staff are familiar with the statutory requirements that affect children's services.

For More Information: Regarding particular statutory requirements, consult the Attorney General's Office.

Revision History:
DES(07-2006)

Next

20-2

Legal Basis: The following statutes discuss hearings that affect ACYF cases.

- ARS §8-823: Pre-hearing conference
- ARS §8-824: Preliminary protective hearing
- ARS §8-843: Initial dependency hearing
- ARS §8-824 and §8-844: Dependency adjudication hearing; settlement conference or mediation
- ARS §8-844 and §8-845: Disposition hearing
- ARS §8-515: Emergency extension hearing
- ARS §8-847: Periodic review hearings (report and review hearing)
- ARS §8-861: Return of child hearing
- ARS §8-862: Permanency hearing and review hearing after permanency hearing
- ARS §8-863: Initial hearing on motion to terminate parental rights
- ARS §8-872: Hearing on Motion for Permanent Guardianship
- ARS §8-515.03: Foster Care Review Board (FCRB) hearing/review
- ARS §8-537: Termination of parental rights hearing
- ARS §8-113(A): Removal of adoptive child from certified home hearing
- ARS §8-113(C): Hearing on a petition to adopt
- ARS §8-113 (D): Expedited adoption hearing
- ARS §8-272 (H): Inpatient psychiatric acute care services hearing
- ARS §8-272 (K): Inpatient psychiatric acute care services review hearing
- ARS §8-273 (A): Residential treatment services hearing
- ARS §8-273 (H): Residential treatment services review hearing

Rules: Rule 16 of the Rules of Juvenile Court Procedure addresses preliminary protective hearings and pre-hearing conferences. Rules 16.2 through 16.4 address dependency hearings.

Revision History:
DES(07-2006)

Chapter 20: Section 2

Hearings and Reviews that Affect ACYF Cases

Legal Basis

Policy: ACYF shall comply with state statutes regarding hearings and reviews of ACYF cases.

The Attorney General's Office shall represent the department in all contested hearings that affect ACYF cases.

CPS Specialists shall attend all hearings affecting their cases and submit reports to the court within the required time frames. For termination of parental rights hearings tried before a jury, the CPS Specialist or supervisor must be present throughout the trial.

For termination of parental rights hearings tried before a jury, the CPS Specialist or supervisor must be present at the pre-trial conference if requested by the assigned Assistance Attorney General, and throughout the trial including jury selection, jury deliberation, and return of the verdict. The CPS Specialist and any employee who will be providing testimony should contact the assigned Assistant Attorney General to discuss and prepare for testimony.

Implementation and Procedures Guide

Work with the Attorney General's Office to ensure that your cases receive timely and necessary legal services.

At any dependency hearing, the court's first priority is the protection of the child from abuse or neglect. Some of the hearings that affect ACYF cases are as follows:

- **Pre-hearing conference:**

  This is a mandatory meeting of all parties to the dependency action and other interested persons as permitted by the court and is held immediately before the preliminary protective hearing. The purpose of the meeting is to attempt to reach an agreement about temporary custody and placement of the child, services to be provided to the child, parent or guardian and visitation of the child. The availability of reasonable services to the parent or guardian shall be considered. The child's health and safety shall be a paramount concern.

- **Preliminary protective hearing:**

This hearing is held on each case, **no less than five and not more than seven working days**, excluding Saturdays, Sundays and state holidays, after the child is taken into custody and a dependency petition is filed. The court may grant one continuance not to exceed five days. The purpose of the hearing is to determine whether temporary custody of the child is clearly necessary to prevent abuse or neglect pending the hearing on the dependency petition. The court will receive any agreement reached at the pre-hearing conference. The parent or guardian is advised of his or her rights and will admit or deny the allegations in the petition. The court will determine if reasonable efforts were made to prevent or eliminate the need for removal of the child and if services are available that would eliminate the need for continued removal. The court will enter orders regarding the child's placement and visitation, if the child is not returned to the parent or guardian. The court will order the department to make reasonable efforts to provide reunification services unless the court finds that the provision of such services are contrary to the best interest of the child. The court will inform the parent or guardian that the hearing may result in further proceedings to terminate parental rights. The court will give paramount consideration to the child's health and safety in making determinations.

- **Initial dependency hearing:**

The initial dependency hearing must be held **within 21 days** of the date on which the dependency petition was filed as to a parent or guardian not present at the preliminary protective hearing. An initial dependency hearing is not held as to a parent or guardian who denies the allegations at the preliminary protective hearing. At the initial hearing, the parent or guardian is advised of his or her rights and will admit or deny the allegations in the petition. The court will determine if reasonable efforts were made to prevent or eliminate the need for continued removal of the child and if services are available that would eliminate the need for continued removal. Unless the court finds reunification is contrary to the best interests of the child, the court will order the department to make reasonable efforts to provide reunification services, if the child is not returned to the parent or guardian. The court may stay the proceeding and order In-Home Intervention.

- **Emergency extension hearing:**

This hearing is held only if a child must remain in a receiving foster home or shelter facility for a period of **more than three weeks**. The court must review the case at least once a week, beginning from the date of the first order extending the placement.

- **Status conference or pre-trial conference:**

This is an optional hearing that may occur after an initial dependency hearing and prior to a contested dependency adjudication hearing.

- **Settlement conference or mediation:**

The settlement conference or mediation is set when the parent or guardian denies the allegations in the petition and must occur prior to the pre-trial conference or dependency adjudication hearing. All parties to the contested action must participate in the settlement conference or mediation. The purpose of the settlement conference or mediation is to attempt to settle the issues of dependency and disposition in a non-adversarial manner and to avoid a trial. Any agreement reached is reduced to writing and submitted to the court for approval.

- **Contested dependency adjudication hearing:**

This hearing must be completed **within 90 days** of service of the dependency petition on the parent or guardian. If critical circumstances exist, the court may extend this deadline **by 30 days**. At this hearing, the court determines whether the allegations of dependency are sustained by a preponderance of the evidence. If the allegations are sustained, the court may either proceed with a disposition hearing or set the disposition hearing **within 30 days.**

- **Disposition hearing:**

This hearing must be held at **the same time of or within 30 days** of the dependency adjudication hearing. The purpose of this hearing is to obtain specific orders regarding the child's placement, services and appropriateness of the case plan. The court considers the goals of the placement, appropriateness of the case plan, services that have been offered to reunify the family and the efforts that have been or should be made to evaluate or plan for other permanent placement. If the court does not order reunification of the family, the court shall order a plan of adoption or other permanent plan that is in the child's best interest.

- **Report and review hearings:**

These hearings (also known as periodic review hearings) are held at least once **every six months** after the disposition hearing to review the dispositional orders of the court. They may be either contested or uncontested.

- **Return of the child hearing:**

This hearing is held after the preliminary protective hearing and as ordered by the court upon a motion by a parent or guardian for return of the child. This hearing may be ordered when all parties are not in agreement with the return of the child. The court will order that the child be returned to the parent or guardian if the court finds that return of the child would not

create a substantial risk of harm to the child's physical, mental or emotional health or safety. Failure of the parent or guardian to comply with the terms of the case plan is considered evidence that return of the child would create a substantial risk of harm to the child.

- **Permanency hearing:**

This hearing is held **within 30 days** of the disposition hearing if reunification services were not ordered, or **within 120 days** of the initial permanency hearing. The court will determine the permanent plan for the child and order the plan to be accomplished within a specified period of time. If the court finds that termination of parental rights or permanent guardianship is in the child's best interest, the court will order a motion to terminate parental rights or for permanent guardianship be filed within ten days.

- **Initial hearing on motion for permanent guardianship:**

This hearing is held within 30 days after the permanency hearing. If the permanent guardianship is contested, the court shall set a date for the trial on the motion for permanent guardianship **within 90 days** after the permanency hearing. At this hearing, the court determines whether the prospective guardian is a fit and proper person to become a permanent guardian and whether the best interests of the child would be served by granting the permanent guardianship.

- **Review hearing after permanency hearing:**

This hearing must be held at least once a year if the court determines the child should remain in out-of-home care **more than 18 months** from the date of the permanency hearing. This hearing provides an opportunity for the court to reconsider and modify the permanent plan for the child. The court may order another permanent plan for the child or reaffirm the prior plan.

- **Foster Care Review Board hearings:**

These hearings are held within six months of out-of-home placement and at least **once every six months** thereafter to review the case of every child who is the subject of a dependency action and remains in out-of-home care **at least six months**.

- **Termination of parental rights hearing:**

This hearing applies to termination of parental rights petitions filed on behalf of children entering out-of-home care prior to July 1, 1998. The parent whose rights are sought to be terminated may request this hearing be tried to a jury. At this hearing, the court determines

whether there are sufficient grounds to terminate the parent-child relationship. It is also known as a severance hearing. *(For children entering out-of-home care on or after July 1, 1998, see initial hearing on motion to terminate parental rights, below.)*

- **Initial hearing on motion to terminate parental rights:**

This hearing applies to children entering out-of-home care on or after July 1, 1998. The hearing is held **within 30 days** of the permanency hearing when the court orders the filing of the motion to terminate parental rights. The parent whose rights are sought to be terminated may request this hearing be tried to a jury. If the parent contests the motion, the court must set a date for trial **within 90 days** of the permanency hearing. At this hearing, the court determines whether there are sufficient grounds to terminate the parent-child relationship. It is also known as a severance hearing.

- **Hearing on a Petition to Adopt:**

At this hearing, the court determines whether to grant the adoptive parent(s)' petition to adopt a child.

- **Removal from a certified adoptive home hearing:**

This hearing is necessary to remove a child who is placed in a certified adoptive home prior to finalization of the adoption.

- **Expedited adoption hearing:**

This hearing is held when the court determines, based on a sworn affidavit filed with the court, that the hearing is in the best interests of the child and the child is diagnosed as suffering from a debilitating, progressive or fatal disease or the prospective adoptive parent is diagnosed as terminally ill, or the court finds other compelling reasons relating to the special needs and welfare of the child.

- **Inpatient psychiatric acute care services hearing:**

This hearing is required **within 72 hours** of filing a motion for inpatient psychiatric acute care services. This hearing provides the court the opportunity to review the results and recommendations of an inpatient or outpatient assessment completed by a psychiatrist, psychologist, or physician and approve or deny the admission of the child for inpatient psychiatric acute care services.

- **Residential treatment services hearing:**

This hearing is held only when all parties to the motion for residential treatment services are not in agreement with the motion. The court will consider the written psychological, psychiatric or medical assessment recommending residential treatment and the statement from the medical or clinical director of the residential treatment facility or director's designee that the facility's services are appropriate to meet the child's needs. The court, on a finding of good cause, may waive the written assessment. The court will order residential treatment services if the court finds that residential treatment services are required to address the child's behavioral, psychological, social or mental health needs and available alternatives were considered, but residential treatment services are the least restrictive available alternative.

- **Residential treatment services review hearing*:***

This hearing is only held if ordered by the court due to a request by the child, or by another party or the court's own motions. In all other instances, the court conducts a paper review of the child's continuing need for residential treatment services. A paper review or review hearing is required at least **every 60 days** after the date of the treatment order.

- **Inpatient psychiatric acute care services review hearing:**

This hearing is only held if ordered by the court due to a request by the child, or by another party with good cause shown. In all other instances, the court conducts a paper review of the child’s continuing need for inpatient psychiatric acute care services. A paper review or review hearing is required at least every sixty days after the date of the treatment order.

- **Residential treatment services hearing:**

This hearing is held only when all parties to the motion for residential treatment services are not in agreement with the motion. The court will consider the written psychological, psychiatric or medical assessment recommending residential treatment and the statement from the medical or clinical director of the residential treatment facility or director's designee that the facility's services are appropriate to meet the child's needs. The court, on a finding of good cause, may waive the written assessment. The court will order residential treatment services if the court finds that residential treatment services are required to address the child's behavioral, psychological, social or mental health needs and available alternatives were considered, but residential treatment services are the least restrictive available alternative.

- **Residential treatment services review hearing:**

This hearing is only held if ordered by the court due to a request by the child, or by another

party or the court's own motions. In all other instances, the court conducts a paper review of the child's continuing need for residential treatment services. A paper review or review hearing is required at least every sixty days after the date of the treatment order.

In addition to the above, the court may order special hearings or reviews to address specific case-related issues.

Consult your supervisor if you have concerns about whether you will be able to attend a hearing. Notify the Attorney General's Office of any anticipated problems or concerns.

DOCUMENTATION :

Document all juvenile court hearings using the Case Notes window designated as Court Hearing type and the Hearing Documentation window.

Document special or unusual court orders using the Special Order window.

Document contacts with the Attorney General's Office using the Case Notes window designated as AG Contact type.

File court minute entries in the hard copy case record.

Revision History:
DES(07-2006)

Previous / Next

20-3

Legal Basis: ARS §8-225(I) provides for the appointment of a guardian ad litem in dependency actions in which the petition alleges the child is abused or neglected.

ARS §8-522 provides for the appointment of a Court Appointed Special Advocate and describes his or her responsibilities.

Rules: Rule 22 of the Rules of Juvenile Court Procedure addresses the role of the guardian ad litem.

Rule 22.1 of the Rules of Juvenile Court Procedure addresses the role of the Court Appointed Special Advocate.

Revision History:
DES(07-2006)

Chapter 20: Section 3

Participating in the Legal Process: *Understanding Roles*

Legal Basis

Policy: ACYF staff shall understand and respect the varying roles of all parties to legal actions that affect ACYF cases.

Implementation and Procedures Guide

To participate in the legal process effectively, understand the role of each of the parties described below**:**

- The *juvenile court* is responsible for hearing all actions that concern issues of dependency, termination of parent-child relationship, adoption and guardianship.

- The *Attorney General's Office* is responsible for representing ACYF in actions concerning ACYF cases. Assistant Attorneys General within the Economic Security Division of the Attorney General's Office appear in court cases on behalf of ACYF.

- The *guardian ad litem* is appointed by the court to represent the child's best interest in a dependency case. Representing the child's best interest is not necessarily the same as representing the child's wishes.

- *Private counsel* represents parents or other parties to an action. The court will appoint private counsel for the parent or guardian if they are unable to afford an attorney. (In many cases, the child will have private counsel to represent his or her wishes in addition to a guardian ad litem to represent his or her best interest.)

- All *parents or legal guardians* of a child are considered to be parties to any action affecting the child, unless their parental rights have been terminated by the court or they have relinquished legal custody of the child.

- The *child*, who is the subject of the dependency, permanent guardianship or termination of parental rights proceeding, is a party to the action. The child, through his/her attorney, has the

right to be informed of, to be present at and to be heard in any proceeding involving dependency or termination of parental rights.

- *Other relatives or individuals* may petition the court to be considered interested parties to an action.

- *Other interested party* having a legitimate interest in the welfare of the child may file a petition to adopt. Other interested party may be a person or agency.

- *Foster parents, pre-adoptive parents and relatives* are considered an interested party to an action concerning a child who is in their care or who has been in their care within the last six months. Receiving foster parents and shelter care facilities where the child is currently placed and has been placed for **at least 30 days**, or where a child was placed for **more than 30 days within the last six months** are also entitled to receive notice of and given an opportunity to be heard at any review or hearing concerning the child.

- The *CPS Specialist* appears in court as a representative of the agency in all hearings affecting a child or family about which he or she has relevant information. The CPS Specialist is expected to attend all hearings concerning his or her cases.

- The *Court Appointed Special Advocate (CASA*) is a volunteer who is appointed by the court to advocate for a dependent child. The CASA's first priority is to advocate for the child's safety; the CASA must meet with the child. The CASA follows the child's case from the time dependency is established until either the court relieves the advocate of responsibility or the court dismisses the action before it. The CASA may appear in court on behalf of the child. [ARS §8-522(C)]

- The *Foster Care Review Board (FCRB*) is a group of volunteers who, under the auspices of the Arizona Supreme Court, review the case of every child who is the subject of a dependency action and who remains in out-of-home care, at least **every six months**. The Foster Care Review Board fulfills the mandate for periodic review under the federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). The FCRB cannot direct the agency to take specific actions concerning a child; however, it may make recommendations to the court regarding plans and services for a child or family. [ARS §8-515.03]

The *subject of a CPS investigation* may request through juvenile court that a hearing or trial relating to a dependency proceeding be open to the public. Juvenile court shall order the

hearing to be open to the public unless the court determines for good cause that all or part of the hearing should be closed.

Revision History:

DES(07-2006)

Previous / Next

20-4

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 4

Responding to Subpoenas

Legal Basis

Policy: ACYF employees shall appear in court or before the Office of the Ombudsman-Citizens Aide when required to do so by subpoena.

Implementation and Procedures Guide

Inform your supervisor when you receive a subpoena to appear in court or before the Office of the Ombudsman-Citizens Aide. If you anticipate any problem in appearing at the required time, contact the Attorney General's Office immediately.

If you receive a subpoena for your confidential records, contact the Attorney General's Office immediately**.**

Revision History:

DES(07-2006)

Previous / Next

20-5

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 5

Testifying in Court

Legal Basis

Policy: When called upon to do so, ACYF employees shall provide testimony in a professional manner.

Implementation and Procedures Guide

Consult with your supervisor and/or the Attorney General's Office if you have questions about what you will be asked or what information you should be prepared to discuss.

Review the case record prior to appearing in court.

Arrive at court on time.

Dress in a professional manner.

Answer questions truthfully and directly.

Provide facts only; don't draw conclusions or give your opinion unless you are specifically asked to do so.

For More Information: See the *ACYF Child Welfare Case Manager Core Training Handbook for Legal Aspects in Child Protection*.

Revision History:

DES(07-2006)

Previous / Next

20-6

Legal Basis: ARS §8-824 discusses the requirements for the Report to Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing.

ARS §8-516 discusses the requirements for the Progress Report to the Juvenile Court.

ARS §8-803 discusses the requirement to provide all verbal or written responses to the allegation and any documentation provided by the subject of a CPS investigation to the court prior to a hearing or trial relating to the dependency petition.

ARS §8-536 discusses the Social Study Report to accompany the petition to terminate the parent-child relationship.

ARS §8-112 discusses the requirements of the Social Study Report to the court prior to a hearing on a petition to adopt.

ARS §8-872(E) discusses the requirements of the report to the court to establish permanent legal guardianship.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 6

Preparing Court Reports for CPS Cases

Legal Basis

Policy: ACYF shall provide the court with accurate, thorough and timely reports, as required by law or by judicial order.

All court reports shall be prepared by the assigned CPS Specialist and reviewed and signed by the unit supervisor or designee.

Implementation and Procedures Guide

Prepare reports to the court for CPS cases as described below:

***Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing*:**

Prepare this report for the preliminary protective hearing and/or the initial dependency (21 Day) hearing, following the format found in Court Document Detail, CT01200. Provide all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation.

Distribute as follows:

Send the report and the proposed case plan to the juvenile court, FCRB, and the Attorney General's Office not later than **the day before** the preliminary protective hearing. If the report is prepared for the initial dependency hearing, send the report to the juvenile court, FCRB and the Attorney General's Office at least **ten working days prior to the hearing.**

Report to the Juvenile Court for In-Home Intervention:

Prepare the report to Juvenile Court for the Initial Dependency Hearing (also known as a 21-Day Hearing) using the Report to Juvenile Court for In-Home Intervention, CT05500, found in the Court Document Detail. Provide all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation.

Distribute as follows:

Submit the report and the proposed case plan to the juvenile court and the Attorney General’s

Office at least **ten working days prior to the hearing.**

Report to the Juvenile Court for Dependency Adjudication Hearing and Disposition Hearing:

Prepare this report for the dependency adjudication hearing and disposition hearing following the format found in the Court Document Detail, CT05100. If not already provided to the juvenile court, include all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation.

Distribute as follows:

Send the report and permanent case plan to the juvenile court, FCRB and the Attorney General's Office at least **ten working days prior to the hearing.**

Report to the Juvenile Court for the Permanency Hearing:

Prepare this report for the permanency hearing following the format found in Court Document Detail, CT 05000. If not already provided to the juvenile court, include all verbal and written response to the allegation and any documentation obtained from the subject of a CPS investigation.

Distribute as follows:

Send the report and permanent case plan to the juvenile court, FCRB and the Attorney General's Office at least **ten working days prior to the hearing.**

***Progress Report to the Juvenile Court*:**

Prepare this report for report and review hearings, review hearings after permanency hearing, and for Foster Care Review Board hearings, following the format found in the Court Document Detail, CT04400. If not already provided to the juvenile court and Foster Care Review Board, include all verbal and written responses to the allegation and any documentation obtained from the subject of a CPS investigation.

Distribute as follows:

Send the report and the permanent case plan to the juvenile court, the Foster Care Review Board and the Attorney General's Office at least **ten working days prior to the hearing.**

Report to the Juvenile Court for Permanent Guardianship:

Prepare this report for the hearing on the motion for permanent guardianship following the format found in the Court Document Detail, CT04900.

Distribute as follows:

Send the report and permanent case plan to the Attorney General in the time frame specified by the assigned attorney in order to prepare the motion for permanent guardianship.

The following attachments are required when submitting the report to the court:

- A copy of the case plan.
- For children in out-of-home care, include the Medical Summary Report.
- Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A; found in Court Document Detail.
  - Ensure that the child's school name and address are recorded on the FC-064-A.
  - Include on the FC-064-A the name and address of:
    - the foster parent, pre-adoptive parent, kinship foster parent, or other significant person who is caring for the child or who has cared for the child in the last six months;
    - the receiving foster parent or shelter care facility where the child is currently placed and has been placed for at least 30 days, or where a child was placed for more than 30 days within the last six months;
    - any juvenile probation officer of a child; and
    - any RBHA case manager of a parent or a child.
- Parental Assessment Financial Statement, FC-009, documented in the Forms Registry, and
- Reports from service team members.

For Reports to the Juvenile Court for Permanent Guardianship, also send the following documents:

- Referral for Guardianship, FC-116;
- Results of the State and Federal Criminal History Records Check;
- Child's Birth Certificate;
- Parent's Death Certificate (if applicable), and
- Written Correspondence to and from tribes regarding the plan of permanent

guardianship.

Send the report to the attorneys and/or guardians ad litem representing the parents, guardians and child in the dependency actions and to the Court Appointed Special Advocate (CASA), with all of the above attachments *except*:

§ Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A; found in the Court Document Detail.

Send the CPS Specialist's written report and the case plan to:

§ if not represented by an attorney or guardian ad litem, the parents, guardians and child, age 12 and older;

§ the foster parent, pre-adoptive parent, kinship foster parent, or other significant person who is caring for the child or who has cared for the child in the last six months;

§ the receiving foster parent or shelter care facility where the child is currently placed and has been placed for at least 30 days, or where a child was placed for more than 30 days within the last six months;

§ any person who has filed a petition to adopt or a foster-adoptive parent who has physical custody of the child pursuant to court order; and

§ any other individual given "interested party" status by the court.

If a foster parent or shelter care facility does not wish to receive copies of the CPS Specialist's written report, have the foster parent or a shelter facility representative check the box on the FC-011, Child Placement Summary/Agreement found in the Placement Packet.

Extension Report:

Submit this report to the juvenile court whenever a child has remained in a receiving foster home or shelter facility for a period of three weeks or longer. Use the format found in the Court Document Detail, CT01000, Emergency Extension Report to the Juvenile Court.

***Addendum Report*:**

Following the format found in the Court Document Detail, CT00200, submit addendum report:

§ to provide new and updated information including new and updated information on efforts to locate parents and provision of services;

§ When making a special request to the court (such as a request for a change in physical custody or a request for out-of-state travel).

***Special Court Reports/Orders*:**

Submit an addendum report to the court and request a special court order when a dependent child:

- Plans to travel out-of-state for **more than 30 days**;
- Plans to travel out of the country;

Complete the Addendum Report attached to the Motion for Placement CT03300 found in the Court Document Detail when a dependent child:

- requires non-routine surgery, general anesthesia or a blood transfusion and the permission of the parent cannot be obtained;
- is placed in out-of-home care other than a licensed facility;
- has a physical custody order that is currently in effect and is moved to a new placement;
- will be discharged from an acute care or residential treatment facility;
- will be transferred from one acute care or residential facility to another; or
- requires hospitalization for inpatient psychiatric acute care services.

Ø See Arranging for Inpatient Psychiatric Assessment or Acute Care (Chapter 8, Section 2), or Arranging for Residential Treatment Services (Chapter 8, Section 1) for more information.

Also submit a special court report:

- **within 72 hours** of the death of a dependent child; or
- to request a waiver of a parental assessment for parents who are or will be incarcerated.

File a copy of all court orders in the hard copy record.

Send a copy of any court order or minute entry that orders or changes a parental assessment to the Parental Assessment Specialist, Site Code 940A.

For More Information: See, Arranging for Inpatient Psychiatric Assessment or Acute Care Services (Chapter 8 Section 2).

Revision History:

DES(07-2006)

Previous / Next

20-7

Legal Basis: ARS §8-243 addresses assessment of parents for the cost of their dependent child's care.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 7

Assessing Parents' Financial Responsibility for Children in Care

Legal Basis

Policy: The department shall make recommendations to the court concerning parent's financial responsibility for the care of dependent children, as required by law.

Implementation and Procedures Guide

Prior to the Preliminary Protective Hearing or Initial Dependency (21 Day) Hearing, whichever occurs first, request that parents provide information required by the Parental Assessment Financial Statement, FC-009, found in the Forms Registry.

Use the schedule on the form to determine the parent's financial responsibility. Request that the parent sign the form, agreeing to the assessment.

If the parent will not provide necessary information or refuses to sign the form, submit a request in the court report that the parent be ordered to complete the Parental Assessment Financial Statement, FC-009, within ten days or be assessed the complete cost of care. Also, ask the Assistant Attorney General to obtain an order for the parental assessment.

Update the Parental Assessment Financial Statement, FC-009, prior to the Permanency Hearing, each Report and Review Hearing, and each Review Hearing after Permanency Hearing, or anytime there is a change in the parent's financial status.

For parents who are or will be incarcerated, you may submit a waiver of a parental assessment to the court. When the parent is released, submit a Parental Assessment Financial Statement, FC-009, to the court and to the Parental Assessment Specialist, Site Code 940A.

Attach an original Parental Assessment Financial Statement, FC-009, to the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing, to the Report to the Juvenile Court for the Initial Permanency Hearing and Permanency Hearing, or to the Progress Report to the Juvenile Court, and disseminate copies to all parties, *except* those persons given "interested party" status by the court.

Send one copy to the Parental Assessment Specialist, Site Code 940A, and file a copy in the hard copy.

Revision History:

DES(07-2006)

Previous / Next

20-8

Legal Basis: ARS §8-236 addresses appeals of a final order of juvenile court.

Rules: Rules 24-28 of the Rules of Juvenile Court Procedure address appeals.

Revision History:
DES(07-2006)

Chapter 20: Section 8

Appealing Decisions

Legal Basis

Policy: The department will appeal appropriate cases in consultation with the Attorney General's Office.

Implementation and Procedures Guide

If you have concerns about the appropriateness of the court's decision or about a specific court order, consult your supervisor immediately. Remember that not all cases are appealable, but for those that are, appeals must be filed **within 15 calendar days**.

If your supervisor concurs, consult with the Program Manager or designee.

To initiate an appeal, the concern must be raised through the ACYF Program Administrator to the DCYF Deputy Director. The Deputy Director must submit a written Request to Appeal to the Attorney General's Office.

Revision History:

DES(07-2006)

Previous / Next

20-9

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires the periodic review of the cases of all children in out-of-home placement under supervision of the state.

ARS §8-515.01 through 515.04 establishes the Arizona Foster Care Review Board and discusses its duties. The court is required to review Foster Care Review Board findings and recommendations, and to address the recommendations on the record at the next scheduled hearing. The department is required to provide written notice of the department's intent to accept or not implement the Board's recommendations within ten business days of receipt.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 9

Participating in Foster Care Review Board Hearings and Responding to Foster Care Review Board Recommendations

Legal Basis

Policy: The department shall work collaboratively with the Foster Care Review Board (FCRB) to ensure that all cases of children in out-of-home placement for six months or longer and under supervision of the state are reviewed at least **every six months**.

Cases that require review include:

- dependent children who are placed in out-of-home care, including relative care; and
- children who were initially in foster care under a Voluntary Foster Placement Agreement.

The Foster Care Review Board is responsible for setting hearing dates, inviting parties, conducting the hearing and formulating findings and recommendations to the court.

The CPS Specialist is responsible for providing information and reports required by the Foster Care Review Board.

If the Foster Care Review Board is unable to assure timely review of a case for any reason, the department shall conduct an administrative case review.

The department shall provide written notice of the department's intent to accept or not implement the Board's written recommendations **within ten business days** of receipt of the recommendations.

Implementation and Procedures Guide

Provide the Report to the Juvenile Court for Preliminary Protective Hearing and/or Initial Dependency Hearing and the Report to the Juvenile Court for Dependency Adjudication Hearing and Disposition Hearing, found in the Court Detail Document, CT01200 and CT05100, respectively to the FCRB:

- at the time it is submitted to the juvenile court;
- upon their request;
- at the direction of the court; or
- three months following out-of-home placement, if not previously submitted**.**

Review the monthly listing of hearing dates provided by the FCRB to determine when FCRB hearings are scheduled. Contact the FCRB immediately if it appears that a case is not scheduled for a necessary review.

Update the Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in the Court Document Detail, to include current information on all parties listed on the form. Submit the forms, along with the Report to the Juvenile Court for Initial Permanency Hearing and Permanency Hearing and the Progress Report to the Juvenile Court, found in Court Detail Document, CT05000 and CT04400, respectively, to the FCRB at least ten working days prior to a scheduled hearing.

Attend the first FCRB hearing in person (or arrange for your supervisor to do so).

Either attend subsequent hearings in person or be available for a telephone conference, if in person attendance is not possible. Notify the FCRB as soon as possible if telephone attendance is necessary.

Notify the FCRB as soon as possible if unusual circumstances make it impossible for either you or your supervisor to attend a scheduled hearing.

If hearings are running late, wait for **at least 30 minutes** after the scheduled start time. If the FCRB is not ready to begin the hearing and you believe you need to leave, consult with your supervisor.

If the FCRB disagrees with the case plan, review the case with your supervisor to determine if the plan should be modified. Notify the Program Manager or designee of the outcome of the review. The Program Manager or designee may take further action, if necessary.

If you believe that any party should not receive a copy of the FCRB's recommendations, make the request to the FCRB in writing prior to the hearing or verbally at the hearing. (If the recommendations are made after you have left the hearing, you may call the FCRB staff **the next working day**.) The FCRB will make a recommendation to the juvenile court, which will decide whether or not the party receives the report.

When a case is transferred, the receiving supervisor notifies the FCRB and parties listed on the Foster Care Plan and Progress Report, FC-064, and FC-064-A, Attachment A, found in the Court Document Detail, of the transfer and the name of the new CPS Specialist. The receiving supervisor, in consultation with the sending supervisor, determines which CPS Specialist can best present the case at the next FCRB hearing.

FCRB Recommendations:

The FCRB will e-mail the Observations/Concerns and Review Board Recommendations section of the FCRB report to the CPS Specialist and supervisor.

Upon receipt of the e-mail containing the Observation/Concerns and Review Board Recommendations section of the FCRB report,

- Review each observation and concern.
- Review each recommendation that directs the department to take a specific action.
- Respond to each recommendation directed toward the department; in the e-mail indicate:
  - § agreement with the recommendation; or
  - § intent not to implement the recommendation. For those recommendations that the department does not intend to implement, indicate the reasons for the decision.

Forward the e-mail response to the supervisor.

CPS Supervisor

Review the CPS Specialist's response to the each FCRB recommendation, and, if appropriate, modify the response.

Print the approved response form and send it to the Foster Care Review Board **within ten business days** of receipt of the recommendations using one of the following methods:

Fax: FCRB at 602-307-1214,
Mail: FCRB, 1501 W. Washington #128, Phoenix, AZ 85007

E-mail a copy of the response to the CPS Specialist and the assigned Assistant Attorney General. -

CPS Specialist

Attach a copy of the response to the next report submitted to the juvenile court.

DOCUMENTATION :

Document the FCRB hearing using the Case Notes window designated as Court Hearing type and the Hearing Documentation window.

Document the outcome of the supervisory review of a case plan which the FCRB disagrees with using the Case Notes window designated as Case Conference type.

Document notification of the outcome of the review to the Program Manager or designee using the Case Notes window designated as Management Contact type.

File a copy of the response to the FCRB recommendations in the hard copy case record.

Program Manager or designee:

Document the review of the outcome and any action taken using the Case Note Comment Window.

Revision History:

DES(07-2006)

Previous / Next

20-10

Legal Basis: The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) requires that the cases of children in out-of-home placement under supervision of the state be reviewed at least every six months, either by a court or by administrative review.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 20: Section 10

Participating in Administrative Case Reviews

Legal Basis

Policy: The department shall conduct an administrative case review when the Foster Care Review Board is unable to conduct a review within the time frames mandated by law.

Administrative case reviews shall:

- Be open to the participation of the child's parents.
- Be conducted by a panel of appropriate people, at least one of whom is not responsible for delivery of services or case management for the child or parents who are subject of the review. (P.L. 96-272)

Administrative case reviews shall:

- Determine the safety of the child.
- Consider the continuing necessity for and appropriateness of placement.
- Determine the extent of compliance with the case plan.
- Determine the extent of progress which has been made toward alleviating or mitigating the causes necessitating out-of-home placement.
- Project an anticipated date by which the child may be returned to and safely maintained in the home, placed for adoption, or achieve permanent placement through legal guardianship, long term foster care or independent living. (P.L. 96-272)

Implementation and Procedures Guide

Initiate an administrative case review when:

- The FCRB has received referral of a case from the juvenile court but cannot ensure a review of the case within six months of the child's out-of-home placement.
- A case has not been referred to the FCRB by the court and is due for a six month review.
- It appears that the FCRB, for any other reason, will not be able to review the case within

six months of out-of-home placement (including time in voluntary foster care placement) or six months of the previous review. Out-of-home placement includes placement with non-parent relatives.

Consult your supervisor to determine who should serve on the review panel.

Schedule the review and invite all parties, including the "objective party" required by law, using the Notification window. The administrative review may be conducted as a part of a case plan staffing.

If you are conducting the administrative case review as a part of a case plan staffing, list the Administrative Case Review as an agenda item on the Notification window.

After the administrative case review, assure that the objective party completes the Department-Initiated Administrative Review Minutes, FC-187.

DOCUMENTATION :

If the parent's whereabouts are unknown, document efforts made to notify the parent using the Case Notes window designated as Parent/Caretaker contact type.

Document the case plan staffing and the Administrative Case Review using the Case Notes window designated as Staffing type.

Retain a copy of the Department-Initiated Administrative Review Minutes, FC-187, in the hard copy.

Revision History:

DES(07-2006)

Previous / Next

20-11

Legal Basis: The Child Abuse Prevention and Treatment Act (P.L. 93-247), amended by The Child Abuse Prevention and Treatment Act Amendments of 1996 (P.L. 104-235), establishes the Citizen's Review Panel.

ARS §8-822.01 establishes the Family Advocacy Office.

ARS §36-3501 establishes the Child Fatality Review Team.

ARS §§41-1092 et. seq. establishes the Office of Administrative Hearings.

ARS §41-1291 establishes the Joint Legislative Committee on Children and Family Services.

ARS §41-1371 establishes the Ombudsman-Citizens Aide.

ARS §§41-3802 establishes the Human-Rights Committee on Children, Youth and Families.

ARS §46-205 gives state departments the authority to hold appeal hearings, and establishes appeal rights for applicants or recipients.

Rules: Rules pertaining to the DES Office of Appeals are found in Title 6, Chapter 5, Article 24, Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 20: Section 11

Cooperating with Children's Services Oversight Entities

Legal Basis

Policy: The department shall cooperate to support the purposes of the following Children's Services oversight entities:

- **The Family Advocacy Office:** The Family Advocacy Office is administered by the department to review and respond to complaints regarding individual cases that involve the child welfare system and, upon request, review the removal of a child before a dependency petition is filed. Some complaints may be reviewed using a multi-disciplinary team of public members who are not department employees or contracted with the department. The Office makes recommendations to the department director and the legislature for improvement of the child welfare system.

- **The Child Fatality Review Team**: The statewide Child Fatality Review Team is administered by the Department of Health Services and includes representatives from the Office of the Attorney General; the Division of Developmental Disabilities; the Division of Children, Youth and Families; various programs from the Department of Health Services; the Governor's Office for Children; the Administrative Office of the Courts; the Parent Assistance Office of the Supreme Court; the Department of Juvenile Corrections; and the Arizona Chapter of a National Pediatric Society. Other members, including a medical examiner; a representative of the Arizona Sudden Infant Death Advisory Council; a public member; and representatives from tribal, military, prosecuting attorney, law enforcement, county health, and child advocacy organizations; are appointed for three year terms.

The state Child Fatality Review Team collects data on child fatalities, submits an annual report on the incidence and causes of child fatalities in Arizona, supports the development of local child fatality review teams, develops protocols for child fatality investigations, recommends and implements changes to decrease preventable child fatalities, and increases public awareness regarding the incidence, causes and prevention of child fatalities. Local child fatality teams may be formed and have similar membership, including a representative from a local Child Protective Services office. The local review teams review the death certificates of all children who die within the team's jurisdiction and call meetings of the team

when necessary, collect child fatality data, and submit reports to the state team.

- **The Office of Administrative Hearings:** The Office of Administrative Hearings has the authority to schedule and conduct hearings on appealable state agency decisions, upon the request of an agency or the filing of a notice of appeal. Appealable decisions heard by the Office of Administrative Hearings and affecting ACYF cases include child welfare agency licensing decisions, Protective Services Review Team (PSRT) decisions, and RBHA decisions denying mental health services for dependent children.

- **The Joint Legislative Committee on Children and Family Services:** This Committee, consisting of five members of the Arizona Senate and five members of the Arizona House of Representatives, meets within thirty days of presentation by a legislator of a written constituent complaint and request to review. The legislator who made the request may be present when the committee reviews the case and may receive and review all information presented pertaining to the matter under review. The Committee may meet with the person who filed the written complaint without the presence of any representative of the department. The Committee must meet, at least annually, to review child fatalities related to abuse or neglect. The Committee reviews reports of child abuse, neglect and dependency and actions taken by the department to protect children, monitors children and family services and legislative recommendations concerning children and family services, provides a forum for persons to express their concerns about state programs that relate to children and family services, makes administrative and legislative recommendations concerning children and family services, and works with the Ombudsman-Citizens Aide Office to make systemic recommendations to improve the system that delivers services to children and families. The committee has access to all CPS records of the department on request of a chairperson of the Committee or a majority vote of the Committee.

- **Ombudsman-Citizens Aide:** This state agency investigates complaints against other state agencies, such as Child Protective Services, and offers information and referral services to Arizona citizens. The Ombudsman-Citizens Aide completes impartial investigations and makes recommendations to the agency to resolve both individual complaints as well as systemic issues. The Ombudsman-Citizens Aide has access to all confidential CPS files and makes requests for these records through a department designated liaison. If the Ombudsman-Citizens Aide has requested testimony or evidence and the agency has failed to comply with the request in a reasonable amount of time, the Ombudsman-Citizens Aide may issue a subpoena.

- **The Human Rights Committee on Children, Youth and Families:** This Committee is

administered by the department to promote the rights of persons who receive services from the Division of Children, Youth and Families. The Committee consists of seven to fifteen members with expertise in psychology, law, medicine, education, special education, and/or social work; and at least two parents of children who receive services from the Division for Children, Youth and Families and who are not the perpetrator in a substantiated report of abuse. The Committee provides independent oversight to ensure that the rights of children are protected, and reviews incidents of possible abuse, neglect or denial of a client's rights. The Committee submits to the department director written objections to specific problems or violations of client rights by department employees or service providers.

- **The Citizen Review Panels:** These Panels are required by the federal Child Abuse Prevention and Treatment Act (CAPTA) and consist of volunteers from the community with expertise in the prevention and treatment of child abuse and neglect. Each Panel meets at least once every three months to evaluate state and local child protection agencies. The Panels examine agency policies, evaluate agency effectiveness in discharging its child protection responsibilities, and assess other child protection related criteria such as compliance with federally mandated child protection provisions and performance in cases of child fatality or near fatality. The Citizen Review Panels have access to all confidential CPS records and make requests for these records through a designated department liaison.

- **DES Office of Appeals:** The DES Office of Appeals holds hearings when requested by an applicant or service recipient because the department did not act with reasonable promptness on an application, or the application was denied wholly or in part. Appealable decisions heard by the DES Office of Appeals and affecting ACYF cases include those related to adoption subsidy, guardianship subsidy, foster parent licensing, and out of state adoptive placements.

Implementation and Procedures Guide

If contacted by a member of a children's services oversight entity, contact the ACYF Central Office Policy Unit to learn the name of the department's liaison to the particular oversight entity. Coordinate with the department's liaison to provide the requested information and records within the time frames requested.

If subpoenaed by the Ombudsman-Citizens Aide to appear at a hearing, provide testimony, or provide records, contact the Attorney General's Office within one work day.

For More Information: On procedures for cooperation with the Family Advocacy Office see

Family Advocacy Office (Exhibit 14).

Revision History:

DES(07-2006)

Previous / Next

20-12

Legal Basis: ARS §41-621 et seq. discusses department employees' coverage for liability.

Rules: Section R2-10-107 of the Arizona Administrative Code provides Rules regarding coverage and liability.

Revision History:
DES(07-2006)

Chapter 20: Section 12

Liability

Legal Basis

Policy: The Department of Administration's Risk Management Section shall cover ACYF employees for liability for acts or omissions of any nature while acting within the course and scope of their employment.

Coverage shall apply only to defense in civil lawsuits, not to defense in criminal actions.

Coverage shall include:

- representation by an Assistant Attorney General, Insurance Defense Section, or appointed private counsel;
- services of the Risk Management Section;
- court costs, including costs of the plaintiff's attorney, if necessary; and
- costs of a judgment or settlement.

Employees involved in a lawsuit shall cooperate in the defense of the case.

If an employee is involved in an auto accident while in the course and scope of his or her employment, personal automobile insurance shall be considered primary.

Employees shall *not* be considered to be within the course and scope of their employment in a *private car* while driving:

- from home to their regular work site;
- to and from lunch in the area of employment and not on authorized state business; and
- on other than state-authorized business.

Accidents that occur while an employee is in a *state car* are covered through Risk Management if he or she is driving:

- on authorized state business,

- outside the area of regular employment on authorized state business, or
- at any other specifically-authorized time outside regular hours.

If you are named in a lawsuit, anticipate the following actions:

- *Claim Letter*: This letter is sent to representatives of the state and to all individuals named in the suit. It informs defendants of the claimed liability. Notify your supervisor and Risk Management immediately if you receive a Claim Letter.

- *Complaint and Summons*: This must be delivered personally or sent by mail if two forms of acknowledgment and a prestamped return envelope are included. Notify your supervisor and Risk Management immediately if you are served.

- *Pre-trial Discovery*: You will generally be asked to take part in depositions (testimony under oath), interrogatories (written questions answered under oath) and request for production (an exchange of documents between the parties).

- *Settlement Decision*: The decision to settle may be made by the Attorney General, Risk Management and the Legislature for a variety of reasons. A decision to settle is not necessarily an indication that the employee is at fault.

- *Trial*: You will be required to be present if you are the main defendant.

For More Information: See the *ACYF Child Welfare Case Manager Core Training Handbook for Legal Aspects in Child Protection*.

Revision History:

DES(07-2006)

Previous

21-1

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 21: Section 1

Providing Clinical and Administrative Supervision

Legal Basis

Policy: Clinical and administrative supervision shall occur on all cases open with the department to:

- monitor and support the quality of family engagement;
- monitor and support case activity at key decision points, at the time they occur to ensure that they embody critical thinking and family centered practice;
- monitor and support consistency of policy application;
- monitor and support service plan development to ensure the appropriateness of the interventions provided to the child and family and the implementation of services; and
- monitor and support the consistency of documentation and record keeping.

Implementation and Procedure Guide

Clinical supervision conferences between the CPS Specialist and supervisor shall occur:

- on all investigation cases ***within 21 days*** of case opening;
- ***at least quarterly*** on cases open for ongoing case management.

Clinical supervision shall occur **monthly** when the case involves the following:

- assigned to a CPS Specialist on original probation,
- a child with a family reunification permanency goal,
- a child who is placed in a residential treatment center or psychiatric hospital,
- a child at risk of placement disruption, or
- a child who has a permanency goal of adoption and no identified adoptive placement;
- an infant who has a permanency goal of adoption and no identified adoptive placement.

BEST PRACTICE TIP:
There is possibly nothing as fundamental to quality social work as strong and consistent supervision. The supervisor has the responsibility to assist the CPS Specialist in 1) ensuring that critical thinking is part of all decision making, 2) ensuring that the CPS Specialist's personal biases are not influencing permanency decisions, 3) ensuring that the CPS Specialist has the opportunity to think through possible permanency options other than those he/she has

decided, 4) helping the CPS Specialist to understand possible explanations/rationale for child and/or parent behavior and 5) assist in translating the needs identified in the assessment to the case plan. See Supervisors Guide to Implementing Family Centered Practice (Exhibit 35).

Critical components to strong supervision include the following:

- Controlled; non-random supervision
- Use a standardized process and criteria during consultative supervision
- Focus attention on the decision-making process of the CPS Specialist—what guided his/her thinking?
- Seek to reduce the influence of irrelevant information
- Know what you don't know
- Balance contradictory information and seek rationale
- Consider alternative explanations

Specific tasks as supervisors include:

§ To encourage and facilitate effective information collection that ultimately leads to child safety, permanency and well-being;
§ To help CPS Specialist analyze case information and correctly identify threats to child safety;
§ To assist in identifying difficulties in establishing sufficient safety/case plans;
§ To increase CPS Specialist competence; and
§ To locate and address a CPS Specialist's professional and personal characteristics associated with competence that limit effective child protective work.

During the clinical supervision conference, discuss case status and progress related to the following, as applicable to the case.

Key Areas of Supervision

Investigation/safety assessment issues such as:

§ the results of the current investigation/safety assessment, including information gathered during observations or interviews of children, family members, alleged perpetrators, non-offending parents; and others who have knowledge of the incident or knowledge of the family;
§ strengths and resources of the family that can assist in helping the child remain safe in their home;

BEST PRACTICE TIP:

CPS Specialists often express concern about how challenging it is to engage families during the safety assessment process. Supervisors need to assist CPS Specialists in finding ways to engage families while assessing for safety and risk. Supervisors should attend to the CPS Specialist's use of power, interviewing skills, judgment of families, helping the CPS Specialist differentiate the child protection role from the role of law enforcement.

§ indications of future risks to any child living in the home and ways that the family strengths and protective capacities might be able to mitigate the risk;

§ whether all current allegations and additional types of abuse or neglect not alleged in the report were identified and addressed;

§ whether the CPS Specialist has other concerns and whether those concerns were addressed and documented;

§ whether other persons need to be contacted and interviewed to ensure the completeness of the safety and risk assessment;

§ whether other professionals interviewed the children, and whether information obtained during those interviews was documented (i.e., Family Advocacy Centers, law enforcement);

§ whether there are current or past medical or law enforcement reports, and if so, what do the reports document;

§ whether substance abuse or domestic violence is present, and if so, how they are affecting the children's safety or risk of future harm, and whether the safety concerns or risks were addressed;

§ whether there is a history of reports, and if so, have the previous investigation/ assessment outcomes been reviewed to assess causes for repeated reports;

§ the need for intervention based on the current and prior investigations regardless of the investigation findings (including proposed substantiated and unsubstantiated allegations); and

§ whether unresolved risk factors or service needs are present that warrant voluntary or involuntary intervention and provision of services to support the family, including an in-home intervention or in-home dependency, regardless of the investigation findings.

BEST PRACTICE TIP

"It is the responsibility of the supervisor as a case consultant to the worker, to prevent the premature commitment to a position, point of view, judgment and prevent staff from becoming unwilling to consider alternative interpretations based on further information."

Gambrill, 1990

2) service planning issues such as:

§ whether the needs of the children, parents, and caregivers have been adequately identified and assessed;

§ the logical link between the needs identified during the assessment and the services being provided to the family;
§ the adequacy of services being provided to meet the needs of the children, parents, and caregivers;
§ efforts being taken to actively involve the child and family, caregiver (if the child is in care) in the identification of goals, needs, and progress; and
§ the educational, physical and mental health needs of the child and the adequacy of services being provided to meet those needs.

3) permanency planning issues such as:

§ whether the case meets the eligibility criteria for a Family Group Decision Making (FGDM) conference and whether a FGDM conference could facilitate safety, permanency and well-being outcomes for the child;
§ the appropriateness of the current permanency goal;
§ how long the permanency goal has been in place and unachieved;
§ whether services being provided are supporting the family in achieving their goal; and
§ for children with a goal of family reunification, the prognosis of reunification **within 12 months** of removal, and if poor, whether concurrent case planning has been initiated.

4) out-of-home placement issues such as:

§ the ongoing interaction between the child and their family;
§ the support for reunification provided by the caregiver;

BEST PRACTICE TIP:
The triangle of support between the CPS Specialist, the birth family and the resource family has a direct bearing on child outcomes. The more that the resource family supports the birth family and the more that the CPS Specialist and the birth family interact, the more likely that the child will return home and stay home. Supervisors need to ask specific questions about how the CPS Specialist is facilitating the relationship between the birth family and the resource family and help the CPS Specialist to remove any barriers to relationship building.

§ whether the child is placed with relatives and/or continual efforts to identify a relative caregiver are occurring;
§ how the positive aspects of the child's culture, values, religion, and other characteristics are being preserved while in out-of-home care;
§ the stability of the current placement;

§ whether siblings are placed together and any barriers to placing siblings together are being addressed;
§ the frequency and appropriateness of visitation between children and their parents and siblings; and
§ whether the child's educational, physical and mental health needs are being addressed.

5) adoption issues such as:

§ whether the child is free for adoption;
§ whether an adoptive home has been identified;
§ whether the child has been placed in an adoptive home;
§ steps necessary to finalize the permanent placement of the child; and
§ any barriers to achieving permanency through adoption.

6) factors affecting American Indian children such as:

§ whether the CPS Specialist has asked the child, the child's parents, extended family members, and anyone else who may have knowledge, if the child is or may be an American Indian child;
§ whether official tribal notification has occurred;
§ whether the child is placed in a placement according to Indian Child Welfare Act (ICWA) order of preference; and
§ the frequency and documentation of ongoing communication with, and involvement of, tribal social services.

Identify outcomes and tasks to address any unmet needs, barriers, or delays identified during the conference.

Review progress toward accomplishing these outcomes and tasks during the next clinical supervision case conference.

Review all investigation cases **prior to case closure or transfer to ongoing status**, using the Supervisory Case Record Review Guide - Investigation, (FW1810A), found in the Forms Registry.

Review all cases open for ongoing case management services at case transfer, case closure, and at least **once every six months**, using the Supervisory Case Record Review Guide - Ongoing, (FW-1810B), found in the Forms Registry.

Monitoring Case Activity Between Clinical Supervision And Record Reviews

§ Provide supervisory consultation as needed to provide guidance around key events and decisions.
§ Read all court minute entries and Foster Care Review Board Reports issued for cases assigned to the unit.
§ Read all reports, motions, and petitions submitted to the court for all cases assigned to the unit, and approve and sign the reports to the court if available in the required time frame.
§ Review the Child Safety Assessment and Safety Plan if appropriate for accuracy and thoroughness.
§ Review the Strengths and Risks Assessment for accuracy and thoroughness.
§ Review draft Case Plan and Case Plan Reassessment documents for accuracy and thoroughness, and sign the complete and accurate documents. See **Chapter 9** for completion of a family centered case plan.

Supervisors shall supplement clinical supervision conferences and monitor case activity by:

- reviewing the electronic (CHILDS) and hard copy record and completing the Supervisory Case Record Review Guide -- Investigation (FW1810A), or Supervisory Case Record Review Guide -- Ongoing (FW1810B), at the time of case transfer, closure, and at least once **every six months**;
- reading all court minute entries and Foster Care Review Board Reports issued for cases assigned to the unit;
- reading, and signing if available within required time frames, all reports to the court; and
- conducting additional quality assurance reviews of CHILDS data, according to district operating procedures.

DOCUMENTATION :

Document clinical supervision case conferences using the Case Notes window, Supervisor type, or by completing the Clinical Supervision Checklist - Investigation (FW-18300), Clinical Supervision Checklist - Ongoing/In-Home (FW-18400), or (FW-18500), Clinical Supervision Checklist - Ongoing/Out-of-Home, found in the Forms Registry.

Document electronic (CHILDS) and hard copy record reviews using the Supervisory Case Record Review Guide - Investigation, (FW-1810A) or Supervisory Case Record Review Guide -- Ongoing, (FW-1810B), found in the Forms Registry.

Document monitoring of case activity by signing complete and accurate Child Safety Assessments, safety plans, Strengths and Risks Assessments, case plans and reports to the court.

Document provision of supervisory consultation and guidance around key events and decisions using the Case Notes window, Supervisory type.

Revision History:
DES(07-2006)

22-1

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 22: Section 1

Working with Aging and Adult Services Administration

Legal Basis

Policy: ACYF shall refer to Adult Protective Services (APS):

- reports involving adults, 18 years or older, who are in danger of abuse, neglect or exploitation;
- reports of spousal abuse, when there are no children in the home;
- young adults who are in need of protection and who are no longer eligible for foster care due to graduation from high school or age; and
- parents of dependent children who are consented to the adoption of a child or upon whom a termination of parental rights petition has been filed, if the parents themselves are in danger of abuse, neglect or exploitation.

Central Intake Unit: All information regarding adults in need of protective services, 24-hours, are referred to the Adult Protective Services Hotline @ **1-877-767-2385** (SOS-ADULT).
If information is provided to Hotline staff that the reported individual is in imminent harm, the caller will be advised to call 9-1-1, or Hotline staff will place the call to ensure law enforcement receives the information.

Ongoing CPS Specialist:

Refer young adults who are preparing to leave foster care and require continued protection to Adult Protective Services at least six months before the termination of foster care services.

Provide APS with necessary documentation and participate in case conferences to plan for the transition of case management responsibilities.

If disagreements arise regarding case management responsibilities, conduct a case conference that includes:

- the ACYF CPS Specialist and Aging and Adult Administration (AAA) intake worker;
- their supervisors; and
- the ACYF Program Manager and AAA Program Supervisor, or designees.

The case conference may be conducted in person or by telephone.

If consensus is not reached, refer the situation to the ACYF and AAA Program Administrators for resolution within one working day.

DOCUMENTATION :

Document the case conference using the Case Notes window designated as Case Conference type.

Revision History:
DES(07-2006)

Next

22-2

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 22: Section 2

Working with the Division of Developmental Disabilities

Legal Basis

Policy: The Division of Developmental Disabilities (DDD) shall be responsible for case management for foster children who meet the eligibility criteria for DDD services. DDD responsibility includes permanency planning and pursuit of termination of parental rights or relinquishment, if appropriate.

To be eligible for DDD services, a child must be developmentally disabled by:

- autism, as diagnosed by a licensed psychiatrist or psychologist with appropriate expertise, as determined by DDD;
- cerebral palsy, as diagnosed by a licensed physician;
- epilepsy, as diagnosed by a licensed physician; or
- mental retardation, as determined by an individual qualified to provide psychological documentation utilizing culturally appropriate and valid tests.

A child must also meet the following criteria:

- have functional limitations in at least three of the seven major life activities as defined in ARS § 36-551; or
- be under age six and demonstrates a strong potential for becoming developmentally disabled as determined by appropriate tests; and
- be a resident of the State of Arizona.

A child age 0-6 shall meet at least one of the following criteria to be eligible for DDD services:

- has a diagnosis of cerebral palsy, epilepsy, autism or mental retardation:
- be at risk for becoming developmentally disabled based on an identified delay in one or more areas of development or if there is likelihood that without services the child will become developmentally delayed or disabled;
- demonstrates a significant developmental delay as determined in one or more areas of development as measured on a culturally appropriate and recognized developmental assessment tool; eligibility is exclusive of cultural and environmental factors.

Developmental delay must be determined by a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools and his/her informed clinical opinion. (6-61)

Any child with developmental disabilities who appears to meet the Division of Developmental Disabilities (DDD) eligibility criteria shall be referred to DDD.

DDD shall be responsible for the determination of eligibility for DDD services.

Implementation and Procedure Guide

To provide emergency child protective services to children with disabilities:

§ Follow procedures described in Providing Emergency Intervention (Chapter 3, Section 2).
§ If emergency placement is necessary, refer children with disabilities to DDD for residential placement. If DDD pays for the placement, document the placement using the Placement/Location Detail window. If DCYF pays for the placement, complete the Service Authorization Request and Provider Match processes.
§ Provide DDD with a written referral for emergency placement within one working day of the placement. Include the child's name, birthdate, and circumstances surrounding the need for placement.
§ If, after being placed by DDD on an emergency basis, the child is determined to be ineligible for DDD services, remove the child immediately upon request.

To provide voluntary or pre-adjudication services to children with disabilities:

§ Contact the DDD specialist for eligibility determination.
§ Contact DDD for consultation and/or assistance in coordinating necessary services. DDD Managed Care Operations may be involved to assist with technical training or identifying an appropriate placement for a child with special medical needs.
§ Keep the CPS case open while DDD is providing supportive services. Convene a case plan staffing with DDD prior to closure of the case.

To transfer a case to DDD, ensure that:

§ The child has been adjudicated dependent and determined eligible for DDD Services.
§ The case record and case plan are complete and current.
§ The record contains a transfer summary which includes the reason for the transfer and information listed in courtesy supervision.
§ The Educational Voucher is current.

§ There is no court hearing or Foster Care Review Board hearing scheduled within 30 days of the transfer.
§ The case plan staffing has been held jointly with DDD **within ten days** of adjudication.
§ Transfer of services from ACYF to DDD responsibility is arranged.

If a child with developmental disabilities and his or her sibling are in foster care:

§ Forward the relevant case information to DDD for an eligibility determination.
§ If the child is accepted by DDD, copy relevant information from the case record and send it to DDD.
§ Make efforts to keep the children in the same foster home if possible.
§ With the DDD specialist, jointly supervise the child with disabilities and plan for visits.
§ Copy the DDD specialist on all relevant correspondence and reports.
§ Prepare court reports, as necessary, on the non-disabled sibling; DDD will prepare court reports on the child with disabilities.

DOCUMENTATION :

The Case Notes window designated as Transfer Summary type is complete and documents the reason for transfer, future hearing dates and appointments, and other significant information including CPS Specialist's observations and opinions.

Document the referral for DDD Services using the Case Notes window designated as Collateral Contract type.

Document the closing case plan staffing using the Case Notes window designated as Staffing type.

Document the case conference in using the Case Notes window designated as Case Conference type.

Information available from the following windows are included in the hard copy record: Case-at-a-Glance; Case Directory; Case Participant Detail; Case Notes; Case Summary; CPS Report Summary; Custody Notices; Hearing Documentation; Legal Status; Participant Detail; Special Court Order; Case Plan, Child Safety Assessment and Family Strengths and Risks Assessment.

Revision History:
DES(07-2006)

Previous / Next

22-3

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 22: Section 3

Coordinating Services for Dually Adjudicated Youth

Working with the Department of Juvenile Corrections, and County Juvenile Probation Offices

Legal Basis

Policy:

ACYF shall work in cooperation with the Arizona Department of Juvenile Corrections (ADJC) and County Juvenile Probation (JPO) when a youth has been dually adjudicated.

The department shall participate in staffings jointly with ADJC, including the transition staffing conducted prior to the youth's discharge from a secured facility if the child is in the custody of DES or if filing a dependency petition.

Cases that include youth who are in the care, custody and control of the Department of Economic Security and are either detained or incarcerated must remain open.

Implementation and Procedure Guide

Notify ADJC in writing prior to filing a dependency petition. Notify the Assistant Program Manager or designee of the dependency petition.

In addition to the case management activities as described in Developing the Family Centered Case Plan (Chapter 9, Section 1), complete the following:

- Participate in any ADJC transition staffing or other meeting concerning the youth (this includes a youth who is incarcerated, in juvenile detention, in a community placement or placed with the parent or legal guardian).
- When participating in the ADJC transition staffing or any other meetings, discuss placement, education, therapeutic and medical needs and the transition plan. If a dependency is to be filed the CPS Specialist must attend the staffing.
- Include the ADJC representative and/or parole/probation officer in all CPS case plan staffings.
- In conjunction with the ADJC staff, develop a case plan for the youth's care in the

community prior to his/her discharge from a secured facility. Ensure that each agency's responsibilities are identified in the case plan.

- Monitor progress made towards the case plan permanency goal through regular communication with the assigned ADJC representative and/or parole/probation officer.

For children incarcerated or detained:

- Coordinate with ADJC or the detention facility to ensure that the youth's medical needs are met (medical appointments completed/conditions treated).
- If applicable, coordinate with ADJC or the detention facility for medication when a youth is detained.
- Ensure the ADJC representative, parole or probation officer and/or Juvenile Detention receives a copy of the youth's Medical Summary Report.
- Coordinate and communicate with ADJC, the detention facility, and/or the parole or probation officer the mental health needs and the assigned RBHA provider for the youth.
- Notify ADJC representative and/or parole or probation officer or Juvenile Detention of youth's medical condition and any need for medication.
- Sign for receipt of any medications for the youth upon release from secure care.

Notify ADJC staff of any surrogate parent.

When appropriate, attend all review of placement hearings including those related to the delinquency petition.

Attend IEP and other school meetings and appointments when necessary. Complete and send educational vouchers. Ensure IEP's are current, particularly during transition to a new placement. Ensure ADJC staff receives copy of the IEP.

Maintain contact with the child and provider according to Planning and Implementing Services and Supports Necessary to Achieve the Permanency Goal (Chapter 9, Section 4).

When communicating with the ADJC representative and/or parole/probation officer, include any observations regarding:

- the child and child's family;
- school attendance including progress or suspension;
- placement change recommendations;
- case plan progress, and;
- authorized contacts with child including sibling visitation.

Ensure ADJC representative (parole) or probation officer receives copies of provider reports.

Assist in locating a community placement for the youth when appropriate and provide that placement with required information. If the child is released to CPS, assess the child's placement needs and make a placement according to Providing Out-of-Home Care Under a Dependency (Chapter 6, Section 3).

Engage the parent and all other pertinent family members in services such as Family Group Decision Making, in an effort to enable the family to care for the child without CPS involvement.

If the Dually Adjudicated Youth is 16 years of age or older, determine if it is appropriate to provide Independent Living Services as described in **Independent Living Services and Supports**, (Chapter 16, Section 1).

DOCUMENTATION :

File a copy of the written notification to ADJC regarding the filing of a petition in the hard copy record.

Revision History:
DES(07-2006)

Previous

23-1

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 23: Section 1

Quality Assurance Processes

Legal Basis

Policy: The department shall maintain quality assurance and continuous quality improvement mechanisms to evaluate services, identify strengths and weaknesses, and, when necessary, ensure that corrective actions are taken.

Quality assurance and continuous quality improvement (CQI) are the shared responsibility of supervisors, district administrators, the Reports and Statistics Unit, the Practice Improvement Unit and ACYF/DCYF administrators.

The department shall assure quality and continuous quality improvement through:

- clinical and administrative case supervision,
- practice improvement case reviews, and
- the continuous quality improvement process.

Practice Improvement Units:

Each district will complete a practice improvement review at least annually.

Continuous Quality Improvement:

Quarterly, following the DCYF Continuous Quality Improvement Handbook, conduct CQI meetings and implement the Action Plans derived from the meetings.

Program Managers:

Provide the ACYF Program Administrator with quarterly reports identifying:

- innovative performance and/or excellence in service delivery;
- issues and concerns raised by supervisors and other staff;
- corrective actions initiated;
- barriers to improved performance; and
- recommendations regarding corrective actions needed**.**

Revision History:
DES(07-2006)

Next

23-2

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 23: Section 2

Special Circumstances: *High Profile Cases*

Legal Basis

Policy: Special procedures for high profile cases are intended to facilitate agency coordination, communication and decision making as well as to provide support for department personnel in situations that generate a high level of public visibility.

High profile procedures shall be used under the following circumstances:

- § situations that generate an unusually high number of complaints, despite efforts to solve problems at the local level;
- § situations in which an individual or group engages in a pattern of harassment of department personnel;
- § situations that generate a significant number of inquiries by legislators, the media or other advocates; or
- § other situations designated by ACYF management.

All contacts from the media related to ACYF cases, policies, or practices shall be referred to the department's Public Information Officer, Site Code 050 Z-1, (602) 542-4296.

All contacts by legislators shall be referred to Legislature Services, Site Code 050 A, (602) 542-4669.

The department will provide support for personnel involved in high profile procedures. This may include temporary reassignment of cases, referral to the Employee Assistant Program, and/or use of debriefing sessions provided through the Employee Assistance Program.

Implementation and Procedures Guide

Use the following procedures for high profile cases:

Notification:

1. Local Office Level – **Within two (2) hours** of identifying a situation as a potential high profile situation, the highest level local staff will notify the District Program Manager or designee of the situation.
2. District Office Level – **Within two (2) hours** of identifying a situation as a potential high profile situation, the District Program Manager or designee will notify the ACYF

Program Administrator or Crisis Response Manager by telephone and electronic mail.

3. The ACYF Program Administrator or Crisis Response Manager will be responsible for notifying the DCYF Deputy Assistant Director and DCYF Deputy Director. Depending on the urgency of the situation, the notification may be made via email or verbally.

Preparation:

The Assistant Program Manager responsible for the current case or most recent case shall send pertinent hard copy case information to the Crisis Response Manager **within 24 hours** of the determination that a high profile situation exists, excluding weekends or holidays.

High Profile Case Summary:

The ACYF Program Manager or Crisis Response Manager will determine if a High Profile Case Summary is required. If notified that the High Profile Case Summary is required, the District Office has **five (5) working days** unless otherwise requested by the Crisis Response Manager or designee, to complete the High Profile Summary.

High Profile Assessment:

If the ACYF Program Administrator or designee designates the case as high profile, the Crisis Response Manager shall coordinate a case conference, either in person or by conference call. At a minimum, participants should include:

- the CPS Specialist or other ACYF staff;
- the CPS Specialist's supervisor;
- Program Manager or designee;
- Program Administrator or designee;
- Assistant Director or designee; and
- Assistant Attorney General (optional).

If the ACYF Program Administrator does not determine the case to be high profile, follow normal conflict resolution procedures**.**

DOCUMENTATION :

Document referral to the department's Public Information Officer or Legislative Services using the Case Notes window designated as Key Issues type.

Revision History:
DES(07-2006)

Previous / Next

23-3

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 23: Section 3

Special Circumstances: *Unusual Incidents*

Legal Basis

Policy: ACYF and contracted staff are required to follow the procedures specified in DES 1-07-02A and 1-07-02B to report and record unusual incidents.

DES 1-07-02A defines an unusual incident as any incident that pertains to all department employees while in the performance of official duties.

Unusual incidents may include:

1. death, injury of illness of any employee that is work related;
2. hospitalization of an employee that is work related;
3. damage to a department or State asset;
4. theft of state or personal property where the theft of personal property occurred on state property;
5. vandalism to state or personal property where the vandalism to personal property occurred on state property;
6. physical or verbal threats or acts against employees or state property; and
7. incidents considered newsworthy or incur liability to the department or State of Arizona.

DES 1-07-02B defines an unusual incident as any incident that pertains to all clients that are in the care, custody, and control of the department and/or are participating in state operated group homes. This policy also applies to those incidents that occur to clients or the general public while on state property (owned or leased). Excluded are clients who receive services from the department and are not in the custody and control of the department.

Unusual incidents may include:

1. death, injury or unexplained illness of a client in the care, custody, and control of the department;
2. unexplained hospitalization of a client n the care, custody, and control of the department;

3. damage to a DES or State asset;

4. injury to a client or individual of the general public while on state property (owned or leased);

5. theft of client property where the theft of the client property occurred on state property (owned or leased);

6. vandalism to client property where the vandalism to client property occurred on state property (owned or leased);

7. theft or vandalism of client property where the client is in the care, custody, and control of the department;

8. physical or verbal threats or acts against clients or by clients; and

9. incidents considered newsworthy or would give rise to a liability claim against the department or the state.

If an unusual incident occurs, follow procedures specified in Unusual Incident Reporting (Exhibit 36) (DES 1-07-02A and 1-07-02B).

DOCUMENTATION :

Complete the Fatality Documentation Detail window and Fatality Closure Summary window.

In addition to the procedures specified, the following apply to ACYF staff:

- The Program Manager shall forward a copy of the completed Unusual Incident Report, J-309, to the ACYF Executive Staff Assistant or designee, Site Code 940-A, **within 24 hours** of receipt of the report.

- If the incident involves a child who is under review of the Foster Care Review Board, the Evaluation and Statistics Unit shall forward a copy of the Unusual Incident Report, J-309, to the Foster Care Review Board **within 24 hours** after receiving the report.

- If the incident involves the death of a child who is in the care, custody and control of the department, or placed in a facility licensed by the department, or in a placement under contract to or paid by the department, the CPS Specialist shall notify the Foster Care Review Board **immediately** by telephone.

Document the Unusual Incident by following procedures specified in Exhibit 13, DES 1-07-02A and DES 1-07-02B.

If an employee is injured, employee workers' compensation claims require reporting on the IR-

050 with copies sent to DES ORM at site code 842C and to ADOA Workers' Compensation at 100 N 15th Avenue, #301, Phoenix, AZ 85007 – fax (602) 542-2021.

Document any damage to State Property or Assets by completing the J-939 Property Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/Property and Liability at 100 N 15th Avenue, #301, Phoenix, AZ 85007 – fax (602) 542-1490.

Document any damage to a State Vehicle by completing the J-940 Automobile Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/Property and Liability at 100 N 15th Avenue, #301, Phoenix, AZ 85007 – fax (602) 542-1490.

Revision History:
DES(07-2006)

Previous / Next

23-4

Legal Basis: Not applicable

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 23: Section 4

Resolving Conflict

Legal Basis

Policy: The department shall approach disagreements among clients, out-of-home care providers, service providers and department staff in a cooperative and professional manner.

Clients, including children age 12 and older, out-of-home care providers, and service providers have the right to express dissatisfaction with services and/or treatment received.

Individuals served who have a complaint, will be provided a copy of the department's written conflict resolution and grievance procedures and will be encouraged to raise the complaint informally with the supervisor for resolution. An individual may initiate a formal grievance request at any time during the process.

Conflicts shall be resolved at the lowest possible level.

Conflicts among department staff shall be resolved by utilizing the department supervisory structure.

Conflicts involving clients, out-of-home care providers, and service providers may be resolved using the framework described below, except in the following circumstances:

- denial or revocation of a license or certification (see rules for Appeal and Hearings, R6-5-2401, R6-5-5806 and R6-5-75);
- issues concerning contract providers, where the Procurement Code applies (ARS §41-2501, Chapter 23);
- challenge the findings of a CPS investigation;
- court orders and/or information provided to the court;
- removal of children from a parent, guardian or custodian;
- mediation outcomes;
- results of an evaluation such as a psychological, psychiatric, substance abuse, medical, etc.;

- complaints previously reviewed or currently being reviewed by the Office of the Ombudsman-Citizens Aide; and

- any issue previously grieved when there are no new circumstances.

Implementation and Procedure Guide

To resolve conflicts with clients, out-of-home care providers, and service providers, follow these steps:

Informal Discussion: Informal discussions are initiated by the CPS Specialist in response to an individual who has raised concerns as part of the CPS Specialist's day-to-day case activities. These discussions involve the individual and the CPS Specialist or Licensing/Certification Specialist. If the issue is not resolved, inform the individual that he or she may request a Conflict Resolution Conference with the supervisor of the CPS Specialist or Licensing/Certification Specialist.

If the individual is not willing to participate in a Conflict Resolution Conference or a Conflict Resolution Conference would not resolve the issue, provide the individual with the Client Complaint/Grievance, ACY-1095A. Assist the individual in completing the ACY-1095A.

Conflict Resolution Conference: The conference may be held in person or by telephone at a time and place mutually agreed upon, **no more than 10 working days** after the request is made. At minimum, the individual raising the issue, the CPS Specialist or Licensing/Certification Specialist and the supervisor must participate in the conference. As needed, the Assistant Program Manager may participate in the conference. Other parties may be invited to attend all or part of the conference; however, they must agree to maintain confidentiality and sign a Confidentiality Agreement, FW-254. If a party refuses to waive his or her right to confidentiality, outside parties may not take part in the conference.

Formal Grievance Process:

Level I: An individual may initiate a formal grievance request by completing the Client Complaint/Grievance, ACY-1095A. If requested, the CPS Specialist is to provide the client with the three page ACY-1095A. The CPS Specialist is also to assist the client (or other person filing a grievance) in completing the form, if needed the CPS Specialist or CPS Specialist's or licensing/ certification specialist's supervisor will instruct the client to mail the completed ACY-1095A to the Central Office staff, according to the instructions on the form.

After receipt of the ACY-1095A, the Family Advocate or designee, in consultation with others

if necessary, will determine if the Level I complaint is eligible for the Formal Grievance process.

If the complaint is not eligible for Formal Grievance, the Family Advocate or designee will notify the client.

If the complaint is eligible for Formal Grievance, the Family Advocate or designee shall consult with the District Program Manager to decide who should most appropriately attempt to resolve the Formal Grievance. This person shall be referred to as the Resolution Designee.

The Resolution Designee will determine:

- The nature of the complaint and collect background information from the CPS Specialist, licensing/certification specialist or supervisors; including any action taken during the Informal Conflict Resolution Process.
- Contact the person filing the grievance and attempt to resolve the issue, in consultation with the District Program Manager.
- **Within ten (10) days**, provide a written response to the client via mail (certified return receipt requested) and include the Level II Client Grievance form (ACY-1095B) so that if the Level I response is not acceptable to the client, the client can appeal to Level II. Additionally the Resolution Designee is to email a copy of the response to all the appropriate parties, including the District Program Manager, the Family Advocate or designee, the CPS Specialist's supervisor and the CPS Specialist.

If the complaint is valid, District Program Manager or designee will take steps necessary to correct the situation. Whenever possible, meet with the individual personally to discuss the complaint and resolution.

The Assistant Program Manager or designee will address the complaint with staff involved and monitor the situation closely to ensure resolution.

Level II: If the individual is not satisfied with the department's response, he or she may elevate the grievance to the Program Administrator of the Administration for Children, Youth and Families, by completing the Client Grievance, Level II, ACY-1095B, and documenting the reason for the request. The Program Administrator must respond to the individual in writing **within 10 working days** of receipt of the request.

If the individual is not satisfied with the Program Administrator's written response, the individual may elevate the grievance to Level III by completing the Client Grievance, Level III, ACY-1095C.

Level III: Upon receipt of the written request for a Level III review, the DCYF Deputy Director will respond in writing to the individual **within 10 working days**.

DOCUMENTATION :

Document the conflict resolution process as follows:

Informal Discussion: Record results of the discussion using the Case Notes window designated as Key Issues type.

Conflict Resolution Conference: Take minutes of the conference. Give a copy to all involved non-DCYF parties within two working days. Keep a copy in the licensing record. The meeting may be tape recorded if all parties agree. File the tape in the hard copy record.

Document the request to initiate a grievance, submission of the Client Grievance, ACY-1095A/B/C for resolution, and contacts and meetings with the individual using the Case Notes window designated as Key Issues type.

File a copy of the Complaint/Grievance, ACY-1095A/B/C in the case record.

Revision History:
DES(07-2006)

Previous / Next

23-5

Legal Basis: ARS §8-809 establishes the Child Welfare Mediation Program.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 23: Section 5

Using Mediation

Legal Basis

Policy: Conflicts between the department and families which involve the provision of child protective services may be referred to the Child Welfare Mediation Program within the office of the Attorney General. (ARS §8-809)

The purpose of the Child Welfare Mediation Program is to facilitate the resolution of disputes. It does not supersede the authority of other agencies involved.

To determine if mediation is appropriate, consider these questions:

- Have family members or CPS staff requested the mediation?
- Is the parent, guardian or caretaker competent to mediate or does he or she have an advocate who can negotiate on his/her behalf?
- Have all parties to the dispute agreed to participate?

Note that mediation is not appropriate:

- when the child is in immediate danger;
- to determine the risk of abuse or neglect to the child;
- to determine if a child should be removed or returned to the home;
- to challenge the findings of a CPS investigation; or
- to challenge court orders.

Implementation and Procedure Guide

To schedule mediation in Phoenix, Tucson or Flagstaff, contact the Child Welfare Mediation Program in that area.

Scheduling of mediation outside of these areas should be arranged by the Assistant Program Manager and the Child Welfare Mediation Program Coordinator, Site Code 040A.

Revision History:
DES(07-2006)

Previous

24-1

Legal Basis: Responsibility for revenue generation is addressed in ARS §41-1954 and in state plans that are filed with the U.S. Department of Health and Human Services.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 1

Responsibility for Revenue Generation

Legal Basis

Policy: ACYF will seek to maximize its use of federal revenue sources in order to fund services to clients.

Because effective generation of federal funds benefits all ACYF clients, all ACYF staff share responsibility for revenue generation.

Revision History:

DES(07-2006)

Next

24-2

Legal Basis: The Arizona Random Moment Sample Survey (ARMSS) is a federally-approved cost allocation procedure.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 2

Arizona Random Moment Sample Survey (ARMSS)

Legal Basis

Policy: The department shall utilize the Arizona Random Moment Sample Survey (ARMSS) to allocate the labor costs of direct service staff to appropriate federal and state funding sources.

The ARMSS Unit shall be responsible for randomly contacting and interviewing CPS Specialists. The ARMSS Unit shall allocate the CPS Specialist's time to appropriate categories based on the information provided by the CPS Specialist regarding their activity being conducted at the time of the call.

Implementation and Procedures Guide

ARMSS calls are necessary to allocate staff activity to specific categories associated with different funding sources.

When a CPS Specialist is contacted by the ARMSS Unit by phone or e-mail, (s)he should provide any requested information. If the CPS Specialist is unavailable at the time of the ARMSS call, the CPS Specialist should return the call to the ARMSS unit promptly to ensure reliability of the random sample. If the CPS Specialist will be unavailable for the remainder of the month in which the ARMSS call occurred, the unit supervisor or other representative should return the call to the ARMSS unit on behalf of the CPS Specialist.

The answers to the ARMSS questions will determine which of the following categories best fit the activity performed by the CPS Specialist at the original time of the call:

- child protective services investigation;
- case management for an in-home case and there is NO case plan that indicates that effective services must be provided to prevent an otherwise imminent risk of removal of the child from the home;
- case management for an in-home case and there is a case plan that indicates that effective services must be provided to prevent an otherwise imminent risk of removal of the child from the home;
- case management for an out-of-home foster care case (whether removal is

voluntary or court ordered);

- § case management for adoption case; and
- § general administration and/or activity that is not related to a particular case.

It is important to note that the ARMSS categories are based on activity, not on job description or function. If a CPS investigator is performing an on-going case management activity at the time of the call, the activity should fall into one of the case management categories. If an on-going CPS Specialist is assisting in an investigation at the time of the ARMSS call, the activity should fall into the investigation category.

For More Information: On the ARMSS program and activity categories, see Exhibit 43, ARMSS Activity Codes.

Revision History:

DES(07-2006)

Previous / Next

24-3

Legal Basis: Title IV-B of the Social Security Act, as amended by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and the Adoption and Safe Families Act of 1997 (P.L. 105-89) provides federal funds for child welfare services.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 3

Title IV-B

Legal Basis

Policy: As required by the provisions of Title IV-B of the Social Security Act, ACYF has a comprehensive state plan that describes its continuum of services for children and families.

ACYF shall ensure that children in out-of-home care receive all protections specified in Title IV-B. These protections include but are not limited to:

- a case plan that is developed **within 60 days** of removal from home;
- a periodic review of the child's status that occurs at least once every six months, and
- a permanency hearing held according to the following time frames:

1. **within 30 days** of a court determination that reasonable efforts with respect to a parent are not required, or
2. **within 12 months** of the date the child is considered to have entered foster care when reasonable efforts to reunify families are required and annually thereafter.

Revision History:

DES(07-2006)

Previous / Next

24-4

Legal Basis: Title XX funding is provided to states through the federal Social Services Block Grant. States may fund local agencies to provide or purchase a broad range of social services.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 4

Title XX Social Services

Legal Basis

Policy: ACYF shall refer families to Title XX providers when such services are appropriate to meet families' needs.

Implementation and Procedures Guide

CPS Specialists should inform low income families of services that are available through local agencies funded under Title XX. These agencies could include services such as housing subsidy, counseling, aging assistance and community development.

Revision History:

DES(07-2006)

Previous / Next

24-5

Legal Basis: Title IV-E is part of the federal Social Security Act, as amended by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and by the Adoption and Safe Families Act of 1997 (P.L. 105-89). Title IV-E Foster Care is an entitlement program designed to provide federal monies to states to support the out-of-home placement of children who are removed from families that meet July 16, 1996 eligibility criteria for Aid to Families with Dependent Children (AFDC).

Rules: 45CFR 1356 describes Title IV-E eligibility criteria.

Revision History:
DES(07-2006)

Chapter 24: Section 5

Title IV-E

Legal Basis

Policy: ACYF shall maximize utilization of federal Title IV-E Foster Care funds by establishing eligibility for all qualifying children.

As provided for in federal law, ACYF will utilize Title IV-E funds to assist with the allowable cost of training, administration and foster care maintenance.

CPS Specialists shall provide the DCYF Eligibility Unit with information necessary to make a determination regarding a child's eligibility for Title IV-E funding.

The DCYF Eligibility Unit shall determine a child's initial Title IV-E eligibility upon receipt of eligibility information from the CPS Specialist and shall re-determine eligibility every six months thereafter.

Eligibility Criteria: A child is eligible for Title IV-E funds on the first day of any month in which all of the following criteria are met:

- The child was removed pursuant to:
  - a voluntary placement agreement entered into by a parent or specified relative which leads to a removal of the child from the home; or
  - a judicial order for removal from a parent or specified relative, including the following findings:

(A) a judicial finding in the first court ruling sanctioning the child's removal that continuation in the home would be contrary to the welfare, or that placement would be in the best interest, of the child, and

(B) a judicial finding **no later than 60 days** from the date of removal that reasonable efforts were made by the department to prevent removal of the child from the home, or reasonable efforts to prevent a child's removal are not required due to aggravated or extenuating circumstances.

- Legal custody of the child was removed from a parent or specified relative with whom the child resided at the time of physical removal or within the six months preceding the physical removal.

- The child met the AFDC financial eligibility criteria according to the rules in effect on July 16, 1996 at the time of removal based upon the composition of the household of removal.

- The child is deprived of parental support (through continued absence, death or disability of a parent), based upon the AFDC rules in effect on July 16, 1996.

- The child is a U.S. citizen or a qualified alien.

For a child to retain Title IV-E eligibility during his/her stay in foster care, the following criteria must be met:

- A judicial finding must be made **within 12 months** of the date the child entered foster care, and **at least once every 12 months thereafter**, that the department has made reasonable efforts to finalize the permanency plan in effect at the time of the ruling.
- The child continues to meet financial eligibility criteria (This determination is based on the child's income only).
- The child continues to be deprived of parental support.

A child who meets all the above criteria is Title IV-E eligible while he/she is placed in a licensed foster home, licensed group home, licensed private residential facility or public group facility licensed for no more than 25 children.

A return to out-of-home placement following a trial home placement exceeding six months duration without extension by court order shall be considered a new episode of foster care placement, requiring a new initial Title IV-E eligibility determination.

Title IV-E eligibility criteria apply whether the child remains placed within Arizona or moves to out-of-home placement in another state.

ACYF shall refer all Title IV-E cases to the Division of Child Support Enforcement (DCSE) for pursuit of child support assignment and collection when such a referral will not pose a

hindrance to a case plan goal of reunification.

Implementation and Procedures Guide

For every child who is placed in out-of-home care (either voluntarily or by court order) and is expected to remain in out-of-home care for **at least 72 hours**, the CPS Specialist should complete the following CHILDS windows **within 72 hours**, or as soon as the information becomes known:

- For each of the parent(s)/caretaker(s) in the household of removal, the Person Detail window and the Case Participant Detail window (including marital status information);

- For all adults and children residing in the household of removal at the time of removal, the Household of Removal window (note: If parents or siblings were not living in the household of removal at the time of removal, their names are not included in this window. If the child was not living in this home at the time legal custody was removed, the child's name should be included with an end-date for the last date he/she resided in this household.);

- The Family Relationships window, listing each person involved with the family (parent, guardian, step-parent, sibling, and significantly involved extended family member) and their relationships to each other (note: all involved family members are included in this window, even if they were not living in the household of removal.);

- For each parent and/or guardian involved with the child, and for any additional adults living in the household of removal, the Employment History window and the Income Detail window;

- For each parent and/or guardian involved with the child, the Medical/ Dental Condition Detail window, and the Psych/Behavioral Condition Detail window;

- The Deprivation Factors window, indicating whether or not any of the following conditions exist: a biological and/or adoptive parent is deceased, absent from the home or incapacitated (physically or mentally), or the family's principal wage earner is unemployed, (Note: This window should be updated any time relevant circumstances change.); and

- ü The Reasonable Efforts Findings window.

The completion of these CHILDS windows enables the Eligibility Unit to determine the child's IV-E eligibility. The results of the Title IV-E eligibility determination may be found in the Eligibility Directory window. The results may be interpreted as follows:

- § A indicates "approved"
- § D indicates "denied"
- § R indicates "re-determination" is due
- § N indicates "no current Title IV-E eligibility determination"

If a CPS Specialist is contacted by the DCYF Eligibility Unit, s/he should promptly provide any requested information.

Division of Child Support Enforcement (DCSE)

After a child is determined to be IV-E eligible and **60 days after removal**, the CPS Specialist will receive a notice via the IV-E Referral message in the Missing Mandatory Data window. The notice will instruct the CPS Specialist to determine if a referral to the Division of Child Support Enforcement (DCSE) would be appropriate. If a referral to DCSE would be appropriate, the CPS Specialist should complete the DCSE IV-E Referral window, and indicate which parents or alleged fathers should be referred to DCSE. If a referral to DCSE would *not* be appropriate, the CPS Specialist will not need to take any action. The message on the Missing Mandatory Data window will automatically clear **in eight days**.

DCSE may contact CPS Specialists to request information on an individual or a family, or to provide information. If DCSE identifies alleged fathers not already known to the DCYF case, or excludes alleged fathers through genetic testing, DCSE will provide that information to the CPS Specialist. The CPS Specialist should document any contact with DCSE using the case notes window.

To determine if a case is appropriate for referral to DCSE, consider the best interests of the child and the circumstances of the family. Questions to consider in making your decision may include:

- § Is the parent working toward a case plan goal of reunification with the child?
- § Would a referral to DCSE impede the parent's ability to reunify with the child?

- Is the parent routinely providing financial support to the child in other ways, such as purchasing clothes, paying a reasonable Court-ordered parental assessment, etc.?

For More Information: Regarding Title IV-E eligibility determination, or to verify eligibility for a child, contact the DCYF Eligibility Unit at (602)-235-9358.

For More Information: Regarding DCSE involvement in specific cases, contact DCSE at (602) 252-4045 in Maricopa County, or 1-800-882-4151 for all other counties.

Revision History:

DES(07-2006)

Previous / Next

24-6

Legal Basis: Title XIX of the Social Security Act provides federal funding for the Medicaid program. Title XIX is an entitlement program, with funding contingent on establishing individual financial eligibility determination for children in out-of-home placement.

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program.

Rules: Rules concerning AHCCCS are in Section R9-22 of the Arizona Administrative Code.

Revision History:
DES(07-2006)

Chapter 24: Section 6
Title XIX Medical Services

Legal Basis

Policy: ACYF shall seek to maximize its use of federal Title XIX funds to provide health care services for children in out-of-home placement by establishing eligibility for all qualifying children.

Any child in out-of-home placement is eligible for Title XIX if the child is a legal resident and is determined to be eligible for either Title IV-E or Supplemental Security Income (SSI). Illegal aliens are not eligible for Title XIX.

If the child has not been determined to be eligible for either Title IV-E or SSI, the child may still be eligible for Title XIX without eligibility for Title IV-E or SSI if the child meets all of the following criteria:

- has income and resources that do not exceed the maximum allowable for a household of one member;
- has a social security number (or an application has been made for one); and
- is a citizen of the United States.

CPS Specialists are responsible for providing the Title XIX Eligibility Unit with information necessary to make a prompt determination regarding a child's eligibility for Title XIX.

The Title XIX Eligibility Unit is responsible for determining whether a child is Title XIX eligible upon receipt of eligibility information from the CPS Specialist, and for reviewing eligibility **every six months thereafter**.

Implementation and Procedures Guide

In most cases, the same information is used to determine eligibility for both Title IV-E and Title XIX. Completion of the necessary CHILDS windows enables the Eligibility Unit to determine the child's Title XIX eligibility. For each child, a CHILDS Health Coverage Detail window is necessary for Title XIX eligibility determination. If the Title XIX Eligibility Unit requests any additional information, CPS Specialists should provide information promptly.

The results of the Title XIX eligibility determination are located in the Eligibility Directory window. The results may be interpreted as follows:

- A indicates “approved”
- D indicates “denied”
- R indicates “re-determination” is due
- N indicates “no current Title IV-E eligibility determination”

If the Eligibility Directory window does not reflect a Title XIX eligibility determination, the CPS Specialist may contact the Title XIX Eligibility Unit directly.

For more information: on the process of eligibility determination for Title XIX, the CPS Specialist should contact the Title XIX Eligibility Determination Unit.

Revision History:

DES(07-2006)

Previous / Next

24-7

Legal Basis: Temporary Assistance to Needy Families (TANF), established through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) provides block grant federal funding to states. TANF replaces the Title IV-A Emergency Assistance Program.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 7

Temporary Assistance for Needy Families (TANF)

Legal Basis

Policy: ACYF uses TANF funding for services for children in out-of-home placement who are not eligible for Title IV-E.

TANF funds may provide services for out-of-home care, child care and family support assistance.

A child may be eligible for TANF if all of the following conditions are met:

- an emergency exists which requires child welfare intervention due to an allegation of child maltreatment (abuse, neglect, exploitation or abandonment), or due to a judicial determination of dependency;
- the child is under age 18;
- the child is a U.S. citizen or legal alien (an alien lawfully admitted to the United States for permanent residence);
- the child is placed in out-of-home care; and
- the child is not Title IV-E eligible.

The DCYF Eligibility Unit is responsible for determining a child's eligibility for TANF, using information already recorded in CHILDS.

Implementation and Procedures Guide

The results of the TANF eligibility determination are located in the Eligibility Directory window. The results may be interpreted as follows:

- A indicates “approved”
- D indicates “denied”

- R indicates “re-determination” is due
- N indicates “no current Title IV-E eligibility determination”

If a CPS Specialist is contacted by the DCYF Eligibility Unit, s/he should provide any requested information promptly.

For More Information: For more information on the process of eligibility determination for TANF, contact the DCYF eligibility unit.

Revision History:

DES(07-2006)

Previous / Next

24-8

Legal Basis: The Social Security Administration provides Supplemental Security Income (SSI) as specified under Title XVI of the Social Security Act. SSI is a monthly income for qualifying children who are physically, mentally or functionally impaired or disabled. The SSI program is based on financial need and takes into consideration the income and resources of parents living in the household. The program also permits certain income and resources to be disregarded, so families with moderate income and resources may still be eligible to receive a reduced SSI benefit on behalf of a child.

The Social Security Administration provides Old Age Survivors and Disability Income (OASDI) as specified under Title II of the Social Security Act. A child may qualify for OASDI monthly cash benefits (sometimes called SSA benefits) if the child's parent is deceased or receiving Social Security retirement or disability benefits.

ARS §41-1954 authorized DES to be representative payee for Social Security funds for children in the care, custody and control of the department.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 8

Social Security (SSI and OASDI)

Legal Basis

Policy: ACYF shall maximize social security funding by applying for benefits on behalf of all qualifying children. The CPS Specialist is responsible for initiating an application to SSA for any available funding, and for providing or securing information from other individuals, as requested by SSA.

For children who are in out-of-home care in a licensed placement, DES will be named the payee for social security benefits. For children who are in out-of-home care with unlicensed caregivers, the caregiver will be named the payee. For children who are living at home, the custodial parent will be named the payee.

Social Security Income (SSI)

The Social Security Administration (SSA) is responsible for determining SSI eligibility, using medical and non-medical information provided by the CPS Specialist, medical providers, teachers, caregivers and others.

Children who receive SSI benefits are categorically eligible for Title XIX medical benefits through the Arizona Health Care Cost Containment System (AHCCCS).

Implementation and Procedures Guide

To apply for new SSI benefits for a child in licensed out-of-home placement:

The CPS Specialist should contact the Social Security Administration at 1-800-SSA-1213, and provide any information as requested. In addition to identifying information, the CPS Specialist should be prepared to provide:

- the child's social security number;
- the nature of the child's disability;
- the DES' federal employer identification number (1-866004791-A9); and
- the funding category for the child ("state funded").

If requested, the CPS Specialist should participate in an additional in-depth telephone interview. The CPS Specialist should also complete and submit forms as required to the Social Security Administration.

If SSI is denied, the CPS Specialist should request that the Social Security Administration review the claim.

To apply for OASDI (SSA) benefits for a child in licensed out-of-home placement:

If a child's parent is deceased or receiving retirement or disability benefits through the Social Security Administration, and the child is in a licensed out-of-home placement, the CPS Specialist should contact the Social Security Administration at 1-800-SSA-1213 and provide any information as requested.

In most cases, the CPS Specialist will be requested by the Social Security Administration to complete the "Application for Child's Insurance Benefits," under Title II of the Social Security Act, SSA-4-BK.

To apply for social security benefits (SSI or OASDI/SSA) for a child still in the home:

If a child is still in the home, the CPS Specialist may assist the parent or other caregiver to apply for benefits. The CPS Specialist may help the parent or caregiver call the Social Security Administration and fill out any required forms.

If benefits are denied, the CPS Specialist may help the parent or caregiver request that the Social Security Administration review the claim.

To apply for a Change of Payee for existing benefits:

When a child is in out-of-home care, and is expected to remain in care for at least 30 days, if the child is receiving social security benefits, the CPS Specialist should complete the "Request to be Selected as Payee," Form SSA-11, as follows:

- If the out-of-home care provider is licensed, the form should request for DES to be the payee. The CPS Specialist should use the following mailing address for the benefits check:

CPS/DES Office of Human Service Collections, 833C
PO Box 60
Phoenix, AZ 85001
(602) 252-0024

§ If the out-of-home care provider is not licensed, the form should request for the provider to be the payee.

The CPS Specialist should submit this form to the Social Security Administration along with a copy of a dependency court order indicating the child is in the care, custody and control of the department.

To communicate changes when DES is the payee of the social security benefits:

When the child returns home, **within 10 days** of the change of physical custody, the CPS Specialist should request a change of payee, making the parent the payee. The CPS Specialist should use the "Request to be Selected as Payee," Form SSA-11.

When the child transfers out of the custody of DES to another permanent placement, **within 10 days** of the finalized permanency arrangement, the CPS Specialist should request a change of payee. The CPS Specialist should select the most appropriate person from the new permanent placement as the payee. The CPS Specialist should use the "Request to be Selected as Payee," Form SSA-11.

When the youth turns 18, the CPS Specialist should assist the youth in contacting SSA at 1-800-772-1213 to arrange for the youth's continued benefits.

The CPS Specialist should file a copy of all forms submitted to the Social Security Administration in the child's hard copy case record.

For More Information: About SSI benefits contact the Social Security Administration at 1-800-SSA-1213.

Revision History:

DES(07-2006)

Previous / Next

24-9

Legal Basis: Title IV-E Adoption Assistance is an entitlement program designed to provide federal monies to facilitate the adoption of children with special needs. This assistance is available for children who meet one of the following criteria:

- The child was eligible for Supplemental Security Income (SSI);
- The child was eligible Title IV-E foster care; or
- The child met the July 16, 1996 eligibility criteria for Aid to Families with Dependent Children at the time of their adoption and is being adopted by a specified relative.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) requires health care to be provided for children for whom there is an adoption subsidy agreement.

Children who are both eligible for Title IV-E and legal residents of the United States are categorically eligible for Title XIX medical services. Children eligible under a state funded adoption subsidy agreement may be eligible for Title XIX medical services (ARS §36-2901.4 (b) (v)).

ARS §8-142(C) requires the department to apply for all existing federal eligibility categories under the Title IV-E program before considering an applicant for a state funded adoption subsidy.

Rules: Not applicable

Revision History:
DES(07-2006)

Chapter 24: Section 9

Adoption Assistance

Legal Basis

Policy: ACYF shall maximize utilization of federal funds by establishing eligibility for all qualifying children through Title IV-E Adoption Assistance and Title XIX (to provide health care services to children with adoption assistance agreements).

As provided for in federal law, ACYF will utilize Title IV-E funds to assist with the cost of adoption subsidy payments, administrative expenditures and training expenses.

Adoption CPS Specialists are responsible for supplying the DCYF Eligibility Unit with information necessary to make a prompt determination regarding a child's eligibility for Title IV-E funding as early as possible in the adoption process.

The DCYF Eligibility Unit shall re-determine eligibility for both Title IV-E Adoption Assistance and Title XIX annually.

A child who is eligible for Title IV-E Adoption Assistance retains eligibility for Title IV-E Adoption Assistance in subsequent adoptions, if the initial adoption dissolves, or if the child becomes eligible for adoption again due to the death of the adoptive parents.

Termination of Title IV-E Adoption Assistance:

Eligibility for Title IV-E Adoption Assistance terminates when:

- a child turns 18; or
- the family is no longer legally and financially responsible for the child.

Families have the right to appeal the termination of Title IV-E Adoption Assistance **within 10 days** of receipt of the termination notice. (ARS §8-145)

For more information on: applying for Title IV-E Adoption Assistance, see Chapter 14, Adoption Subsidy.

For more information on: determining eligibility for Title IV-E Adoption Assistance and Title XIX medical services for adopted children, contact the DCYF Eligibility Unit.

Revision History:

DES(07-2006)

Previous / Next

24-10

Legal Basis: ARS §46-138.01 established the Public Assistance and Administration Revolving (PAAR) Fund.

Rules: Not applicable.

Revision History:
DES(07-2006)

Chapter 24: Section 10

Public Assistance and Administration Revolving (PAAR) Fund

Legal Basis

Policy: DCYF staff shall use the PAAR Fund in emergency situations only, when neither CHILDS nor the Financial Management Control System (FMCS) payment processes are sufficient. DCYF shall use the PAAR Fund as a last resort only, and not for convenience.

Emergencies are defined as situations that require a service be provided and paid for within two working days.

If a PAAR Fund request for a service is not located in the following list, or if the amount exceeds the maximum amount indicated in the list, the PAAR Fund request must be first reviewed by the District Program Manager (or designee) and then approved by the Finance and Business Operations Administration (FBOA) Budget Unit Manager (or designee).

In an emergency, services which may be paid through the PAAR Fund include:

- § out-of-state birth or death certificates (maximum $25);
- § bus transportation (maximum $300);
- § emergency clothing allowance (maximum $150 per child) (Note: For emergency clothing funds, complete a clothing inventory before submitting the PAAR Fund request.);
- § special diaper allowance (maximum $75 per child) (Note: For a special diaper allowance, obtain documentation of the condition necessitating the allowance before submitting the PAAR Fund request.);
- § books and education allowance (maximum $85 per child);
- § first month's Housing Assistance for rent or utilities (maximum $1800);
- § first month's Independent Living Subsidy (for start up) and maintenance (maximum $558);
- § CPS meal reimbursement;
- § work uniforms for children in the Independent Living Program;
- § state identification for clients issued through the Department of

Transportation, Motor Vehicle Division; and

- CPS Donation Fund.

In districts where the PAAR Fund is administered by DCYF, designated DCYF staff shall be authorized to issue checks using the PAAR Fund. To authorize a DCYF staff person to issue PAAR checks, the district Program Manager (or designee) shall submit the PAAR Fund Signature Authorization, AS-150, to the DCYF Assistant Director. The district Program Manager must also submit the AS-150 when there is a change in personnel authorized to sign PAAR Fund checks. PAAR Fund check signers shall be different employees than those who prepare the checks.

In districts where the PAAR Fund is administered by the Family Assistance Administration (FAA), DCYF shall designate staff who are authorized to approve use of the PAAR Fund and sign the PAAR Payment Authorization, FA-417. The district Program Manager or designee shall provide the names of the designated staff to the district or local FAA staff responsible for the PAAR Fund.

The individual approving the PAAR Payment Authorization shall not be the payee of the PAAR check. Clients shall not be the payee of a PAAR check without approval of designated district staff. Employees shall not be the payee of a PAAR check without approval of designated district staff, except when the PAAR check is for purchase of a child client's meal.

DCYF staff who request a PAAR Fund check shall retain receipts for all expenditures.

ACYF district Program Managers (or designees) shall ensure that all client service PAAR expenditures are entered into CHILDS. The FBOA Budget Unit shall monitor the PAAR Fund expenditures.

Implementation and Procedures Guide

When the CPS Specialist has an emergent need that meets criteria for a PAAR Fund request, the CPS Specialist should review the above list of pre-approved PAAR Fund expenditures and their maximum limits. If the PAAR check is needed for an expense that is not pre-approved according to the list, the CPS Specialist should obtain approval for the request from the district Program Manager (or designee) and the FBOA Budget Unit Manager (or designee).

To request a PAAR check, the CPS Specialist should complete the PAAR Payment Authorization, FA-417, obtain required approval signatures, and attach any required documents, according to district operating procedures. The following data fields must be completed on the FA-417:

- payee's name (name of the person or organization to whom the check will be issued);
- case number (CHILDS case number);
- Social Security Number (Social Security Number for the client);
- case name (name of primary client in the case);
- disposition of check (Specify method of delivery. Mailing address may be site code, P.O. box, rural route, or street);
- PAAR amount requested;
- reason for request/comments (The CPS Specialist should describe the emergency requiring issuance of a PAAR check. Include the client's name, CHILDS participant ID, birth date and Social Security number);
- CPS Specialist's signature, title, and site code; and
- authorization (Signature of authorized individual, including their title, the amount authorized and the date)

The CPS Specialist should forward the completed FA-417 and attachments to the staff authorized to issue PAAR Fund checks, per district operating procedures.

Ensure the district DCYF staff responsible for tracking use of the PAAR Fund receives the original PAAR Payment Authorization form, and the original receipts of expenditures, per district operating procedures.

To use money from a CPS Donation Fund, the CPS Specialist should do the following:

- Request the donation check be made payable to DES and mailed to the district office.
- From the district office, forward the donation check to the FBOA Budget Unit Manager for deposit in the district's account set up for this purpose.
- Submit an FA-417, PAAR Fund Authorization, per district operating procedure, when requesting funds from this account.

When use of the PAAR Fund is case related, the CPS Specialist should do the following:

- Document the emergency necessitating use of the PAAR Fund using the Case Notes window.
- Document the provision of the PAAR check to the payee using the Case

Notes window.

§ Document the case name, the client's name, and the client's participant ID number on expenditure receipts.

§ File a copy of the completed and signed FA-417, PAAR Payment Authorization, the PAAR check, and receipts, in the hard copy case record.

§ Ensure the district DCYF staff responsible for tracking use of the PAAR Fund receives the original PAAR Payment Authorization form, and the original receipts of expenditures.

For CPS Donation Fund:

At the district or each local office, the CPS Specialist should document each check written using the donated funds and the amount of each check deposited to the district account.

Program Manager and FBOA Budget Unit Manager or designees:

Approval or denial of any PAAR request that is not included in the list of pre-approved services or that exceeds the maximum for a particular service should be documented in the Case Notes window, Management Contact type.

For More Information: See DES 1-47-03 for more information on the PAAR Fund

Revision History:

DES(07-2006)

Previous

Exhibit 1

CHILD ABUSE HOTLINE
QUESTIONS TO SUPPORT THE INTERVIEW PROCESS

PRE-SCREENING:

1. Is your concern about a child (person under age 18)?
2. What is your concern about the child?
2. Who do you believe is maltreating the child (parent, guardian or custodian)?

FAMILY COMPOSITION AND DEMOGRAPHIC DATA:

1. What is the family's home address? Include the name of the apartment complex or trailer park, apartment or space number and directions, if needed. What is the phone number?
2. Does the child live there: If not, where can we locate the child such as school, day care, relative's home, etc.? include attendance times, if applicable.
3. Who is living in the home, including family members and others? Are there other children who do not live in the home?
   Do you happen to know the dates of birth or ages, and the social security numbers of family members?
4. If the parents are divorced, do you know the marital, custodial and visitation arrangements?
5. Do you know the ethnicity of the family? If family members are Native American, do you know the tribal affiliation?
6. What is the primary language of family members or others in the home? Is English also spoken or understood?

Kin Identification

7. Do you know of any relatives or adults who care about the child and are involved in the life of the child? If so do you know where they live and how to get in contact with them?

ABUSE

Physical Abuse

1. Did the child report abuse to you or to someone else?

   What were the child's statements about the injury or how it occurred?

2. Who is it that has harmed the child?? Did you witness the incident? If not, were there any witnesses? If so, who?
3. When and where did the incident occur? Are you aware if incidents like this have occurred before? Do you know how often these kinds of incidents occur?
4. Can you describe the injury, including the location, size, shape and color?
5. Has the injury been treated? If so, do you know how and by whom? Do you know if the child has seen a doctor for the injury? If so, do you know the doctor's name and phone number?

   If the source is a doctor: ask the physician why he/she does not believe that the injury is inconsistent with the explanation given by the caregivers?

Sexual Abuse:

1. Has the child reported sexual abuse to you or others? If so, who and when? What are the child's statements?
2. Why do you think the child has been sexually abused or is at risk of abuse (activities, physical signs or behaviors)?
3. Did you see these activities, signs or behaviors? If not, were there any witnesses to the incident? If so, who?
4. Do you know when and where the last incident or other incidents occurred?
5. Do you know what contact the alleged perpetrator has with the child now?
6. Do you know if the child has seen a medical doctor? If so, do you know the doctor's name and phone number?

NEGLECT

Food:

1. What makes you believe the child is not getting enough food?

   Has the child told you or others that he/she is hungry or not being fed?
2. Do you know what the parent is feeding the child, or if someone else is feeding the child? If so, who?
3. Are you aware of any factors or reasons why the child is not being fed appropriately?
4. When was the last time you saw the child? Can you describe the physical condition of the child?
5. Are there other witnesses to these concerns?
6. Have you been in the home? If so, when and can you describe the food you saw?
7. Has the caregiver indicated to you that he/she is not able to feed the children?
8. Do you know if the child has seen a medical doctor and whether there is a diagnosis that the child is malnourished/failure to thrive? If so, do you know the doctor's name and phone number?

Clothing:

1. Do the child s clothes generally match the weather conditions? If not, please describe. Are the clothes clean and do they fit?
2. Are the clothes that the child wears clean, and do they generally fit the child?
3. What effect is the lack of clothing having on the child? How do you know?
4. Are there any reasons or factors why the child is not being dressed appropriately? Has the caregiver indicated to you that he/she is unable to acquire clothing for the child?

Shelter:

1. What are your concerns about the child s living environment? Please describe any health or safety hazards where they live.
2. Do you know how long these conditions have existed?

   Are there other witnesses to these conditions?
3. When was the last time you saw the child or the home condition?
4. What effect do you believe these conditions have on the child?
5. Are there reasons or factors which contribute to the family living like this? Has the caregiver indicated to you any need for assistance in maintaining the home?

Supervision:

1. How old is the child?

   Are you concerned about the child right now?
2. **Is the child alone now?**
   How long has the child been alone?

   Does the child know how to contact emergency personnel?
   Where is the person who should be watching them and when will they return?
   Have you called police?
3. **If the child is not alone now:**
   Who is taking care of the child?
   Can the child remain with this caregiver or is intervention needed now?
   How often is the child is left alone and when does this usually happen?
   Does someone check on the child when alone? Who and how can we contact them?
   Does the child know how to contact a parent or emergency personnel?
4. Is the child able to take care of him/her self when alone or unsupervised?

5. Does the child have behavioral, emotional, developmental or physical limitations that require supervision?
6. Do you know if the child ever been injured when left alone or inadequately supervised? Describe the incident or injury and when did it occur?
7. Are there reasons or factors which contribute to the parent's lack of supervision? Does the parent work?

   Has the parent ever indicated to you that they were worried about having to leave the child due to employment?

Medical/Dental Care:

1. Could you describe your concern regarding the child s medical condition?

   Do you know when the concerns became known and what was the cause?

2. How are these concerns affecting the child?
3. Is the parent, guardian or custodian aware of the problem? Have they taken any action to resolve the concern? Have they talked to you about the problem?
4. Do you know if or when the child last saw a medical doctor? If so, why? Do you know the doctor's name and phone number?
5. Do you know why the caregiver is not getting medical care for the child? Have they shared with you a language barrier, a financial concern, a transportation problem?

If the reporting source is a medical doctor or representative, ask the following:

1. What is the medical or psychiatric condition or diagnosis of this child and when did it begin?
2. What medical care and/or medication (including psychiatric) is needed?
3. What will happen if the child does not receive the medical care or medication (including psychiatric)?
4. Did you talk to the caregiver about your concerns? What was their response?

Substance Exposed Newborn (SEN):

1. Has the child or mother been tested and what are the results?
2. What is the reported history of drug use, including the extent of use during the pregnancy? What type of drug was used and when was the last use?
3. What is the age of the mother? Does she seem to understand the danger that substance abuse has caused to her baby?
4. Has mother ever received drug treatment? Do others in the home use drugs?

5. What is the medical and physical condition of the child? Has a doctor diagnosed or noted withdrawal symptoms or is the child considered medically fragile?

   If so, what are the medical concerns and what treatment or care is needed?
6. What is the child's birth weight, gestational age, and Apgar score?

7. What prenatal care was received?
8. Who is the medical doctor and what is the name and location of the hospital where the child was born?
9. Does the mother show signs of attachment and bonding? Does she want to hold the child; talk to the child; want the child in her room?

10. Is a support system available to the mother?
11. Are you aware if the mother has made preparations for the child in the home? Is there a crib or someplace safe for the child to sleep? Does she have any new born baby clothes/

Methamphetamine Labs:

1. Where was the parent, guardian or custodian "cooking" the drug? If not in the home, where were they cooking and what is the proximity to the home?
2. Where were the fumes being vented?
3. Was the child in the home or area where cooking or venting occurred?
4. Where are the chemicals stored? What is the proximity to the children and do they have access?
5. Does the child exhibit symptoms of drug exposure such as a skin rash, agitated or lethargic behavior or other symptoms? Did you observe this behavior in the child? If not, has someone else observed this behavior in the child?
6. Is drug or chemical residue present? If yes, where?
7. What is the general condition of the home?
8. Did the caregiver have a place for the child to go when he/she was cooking or using the drug?

Abandonment:

1. Do you know where the child s parent is now?
2. Do you know when the parent had last contact with the child?
3. Do you have any information about when the child s parent is coming back?
4. Do you know what arrangements the parent make for care of this child?
5. How long are you able or willing to care for the child? Are relatives or friends of the family available?

   If so, what are their names, and how can we contact them?

6. Are the parents willing to make other arrangements for the child?

If the parent is the source and wants the child removed from the home, ask them:

1. What assistance have you asked for in order to be able to care for you child, such as counseling, medical or psychiatric assessment, or assistance from the school or law enforcement?
2. Is there anyone with whom your child could live such as relatives or family friends while you obtain assistance?
3. Have you considered professional placement, such as a teen shelter?
4. Are you willing to work with CPS to make arrangements other than CPS placement for the care of your child?

Safe Haven Newborn:

1. Is the parent or agent who delivered the newborn still present?
2. Did the parent express intent to return for the newborn infant?
3. Does the child appear to be a newborn infant? (under 72 hours hold)
4. What is the newborn's condition?
5. Does the infant need immediate medical attention? If so, have you called 9-1-1?
6. Did the parent or agent offer any information about themselves or the newborn?
7. Did the parent or agent say why they brought the newborn to a Safe haven?

EXPLOITATION

Non-sexual Exploitation:

1. Describe how the child is being exploited. Do you know when and where the last incident or other incidents occurred? Did you witness the exploitation? If not were there others who did?
2. What did the caregiver indicate was the reason for the exploitation of the child?
3. How long as this been going on?

POTENTIAL ABUSE AND NEGLECT

Describe behaviors of the parent, guardian, custodian or child that give you reason to believe that abuse or neglect may occur.

1. What effect have these behaviors or conditions had on the child? Have you observed the child with these behaviors or conditions? If not, has someone else witnessed the behavior or condition? If so, who? How might we contact them?

2. Are you aware if any abuse or neglect has occurred before? If so, when and where? Did you witness the abuse or neglect? If not, did someone else witness the abuse or neglect? If so, who? How might we contact them?
3. Has the parent, guardian or custodian expressed concerns or fears about the possibility that they might hurt or not being able to care for the child? Did they express financial concerns? Employment concerns?

FOR LICENSED OR CERTIFIED FOSTER HOMES OR FACILITIES, ask the following in addition to specific cue questions regarding the incident (as listed above):

Physical Abuse:

1. Did the injury occur as a result of a physical restraint?
2. What kind of restraint was used?
3. Why was the child restrained?
4. Will the staff person have contact with this child or other children in the facility?
5. Do you know the name of the licensing agency or specialist, or the child's CPS social worker? If so, what is the name and phone number?

Neglect:

1. What supervision was being provided to the child at the time of injury?
2. Was the injury a result of conduct between children?
3. Was the foster parent or facility staff aware that a child might physically or sexually assault another child?
4. What steps were or are now being taken to restrict contact between the child and other children?
5. Do you know the licensing agency or specialist or child's CPS social worker? If so, what is the name and phone number?

QUESTIONS TO ASK AS YOU END THE CALL

Consider the child's vulnerability:

1. To what extent is the child able to protect him/her self?
2. Has the child expressed concern about going home? If so, what?

3. Does the child have any mental, emotional, intellectual or physical impairment?
4. Does the child have difficult behaviors or other special needs that may contribute to parental stress?
5. Is the child able to identify another adult who they feel comfortable with? Do they know the adult s phone number or address?

Consider parent/caregiver characteristics:

1. Does the parent/caregiver expressed love and concern for the child?
2. Are you aware if the parent/caregiver has any mental, emotional, intellectual or physical impairment? (bizarre, angry or volatile behavior, developmental impairment or illness)
3. Have you observed the way that the parent interacts with the child on a day to day basis? Do they laugh with the child, or listen as the child talks to them?
4. Based on your interaction with the parent/caregiver does it seem that they understand the needs of the child? Does it seem to you that the parent/caregiver expects too much from the child given the child s age?
5. Does either parent recognize the problem, protect the child from the alleged perpetrator, or cooperate with intervention offered by others?
6. Are you aware if there is a history of CA/N as a child or of violence toward peers and/or children?

Consider family, social and economic factors:

1. Substance Abuse:
   Are you aware if anyone in the home abuse drugs or alcohol?
   If so, who, what drugs, how often:

   Do you suspect drug sales or manufacture in the home? If so, why?
2. Domestic Violence:
   Are you aware if there is any domestic violence in the home? If so:
   Do you know who is the abuser?
   The victim?
   Does either parent actively protect the children?
   Where are the children when incidents occur?
   Have there been injuries to adults and/or children? If yes, describe.
   How often does violence occur? When was the last incident?
   Were police called? What was the outcome?
3. Family Income/Making Ends Meet:
   Is the parent/caregiver employed or how do they support the family?
   Is there a parent or caregiver who accesses community services such as food banks to provide for their children?

   Are you aware if family members provide help to the family to help them make ends meet?

4. Social worker Safety:
   Are you aware if there any safety concerns, such as pets, weapons, conditions, violence or illegal activity that may threaten a social worker's safety if they were to visit the home?

Other Agency involvement:

1. Are you aware if the family has ever received services from other community agencies (including CPS)?
2. If so, which agency and who can we contact from that agency?
3. Are you aware if law enforcement has been notified of the current concern? Are you aware if law enforcement has been involved with the family before?

A.R.S. 41-1010 - According to this State law, we must inform you that you are required to provide your name. Under existing CPS confidentiality statutes (ARS 8-807), we will keep your name confidential unless this law should take precedence over CPS laws in the future. If so, your name would become public record unless we can show that substantial harm would result to you, someone else or the public. While we do not anticipate that happening, we would like to record any concerns you may have in regards to substantial harm.

1. Is there any concern that substantial harm will result if your name were disclosed? If so, what is the substantial harm? Request Specific reasons, if known
2. May we document your name and phone number as the source of this report?

Exhibit 2

Tracking Characteristics

Does not require an investigation, but may require an action

TB	Notice that a family or alleged abusive person known to another state CPS is residing in or believed to be relocating to Arizona
TD	Request for courtesy assessment from another state CPS to ensure safety of a child.
TE	Runaways from other states or shelter due to out-of-state request or courtesy ICPC shelter
TF	Court ordered pick up (domestic relations)
TG	Mental health treat needed, but cannot be obtained without CPS intervention
PI	Physical Injury Between Children
SX	Sexual Conduct Between Children

Tracking Characteristics: Requires An Investigation And Must Include At Least One (1) Report Allegation

AB	Child Abandonment
DV	Domestic Violence
FR	False Report Indicated
NF	Near Fatality - an act certified by a physician, placed the child in serious or critical condition (Federal definition)
SEN	Substance Exposed Newborn
TH	Child in care, custody and control of DES via court order or Voluntary Foster Placement Agreement
TJ	Administrative ordered investigation
TK	Court ordered investigation
TL	Private dependency petition
TM	Substance abuse contributes to the maltreatment
TN	DES certified child care home
TO	Family resides on Indian Reservation or Military Base
TP	Family Assistance Administration (AFDC teenage parent recipient) report.
TSH	Safe haven Newborn.
TSX	Sexual Conduct Between Children.
TPI	Physical Injury Between Children

Exhibit 3

Aggravating and Mitigating Factors

AGGRAVATING FACTORS
(Requires documentation in the case record by the supervisor)

A1 Child victim placed in temporary custody by law enforcement or court order

A2 Parent, guardian or custodian is described as volatile or dangerous

A3 Ability to locate child victim is time limited

A4 Family in crisis NOW

A5 Chronicity including previous validated or undetermined investigated reports

A6 Special needs of child victim place child victim at greater risk

A7 Child victim in care, custody and control of DES via court order or Voluntary Foster Placement Agreement

A8 Administrative directive for quicker response time

A9 Child victim expressing fear of maltreatment if going home

MITIGATING FACTORS
(Requires documentation in the case record by the supervisor)

M1 No perpetrator access to child victim during the determined response time

M2 Child victim hospitalized or in other safe environment and will remain there during the determined response time

M3 Maltreatment occurred thirty (30) days or longer prior to report for child victim age one (1) or older

M4 Family receiving treatment related to report allegation and, in the opinion of the treatment provider, the child victim will be safe during the determined response time

M5 Law enforcement report and no contact with CPS by phone at time of law enforcement response; may mitigate up to Potential Risk Standard Response Time

An SEN report may be mitigated if one or more of the following factors are present:

M7 The Mother is currently living with non-substance using partner or extended family.

M8 The mother's drub usage was limited to marijuana.

M9 The child will remain hospitalized for 24 hours or longer.

Exhibit 4

CULTURAL COMPETENCE CONTINUUM

CULTURAL DESTRUCTIVENESS is represented by attitudes, policies, and practices that are destructive to cultures and, consequently, to the individuals within the culture. There are assumptions that one's own race or culture is superior to another and that "lesser" cultures should be eradicated because of their perceived subhuman position. Bigotry coupled with vast power differentials allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority populations.

CULTURAL INCAPACITY is seen in individuals and organizations that lack the capacity to help individuals, families, or communities of color. Extreme bias, a relief in racial superiority of the dominant group, and a paternal posture are evident. Resources may be disproportionately applied; discrimination and practices, subtle messages to people of color that they are not welcome or valued, and lower expectations of minority clients are seen.

CULTURAL BLINDNESS ignores cultural differences, holding an expressed philosophy of being unbiased, and perceiving all people as the same. The belief that helping approaches traditionally used by the dominant culture are universally applicable is characteristic, and cultural strengths are ignored. Assimilation is encouraged; and a "blaming the victim" model or a cultural deprivation model, which asserts that problems are the result of inadequate cultural resources, prevails. Institutional racism continues despite participation in special projects for clients of color when funds are available. These projects may take a " rescuing approach" that does not include community guidance and that may be canceled when funds run out.

CULTURAL PRECOMPETENCE is demonstrated when individuals and organizations recognize their weaknesses in serving people of color and attempt to improve some aspects of their services to a particular population. There is a desire to deliver high-quality services and a commitment to civil rights. Organizations may hire people of color; staff may be trained in cultural sensitivity; and people of color may be recruited for agency boards or advisory committees. Yet tokenism may prevail and, if an activity or program is undertaken and fails, there may be a reluctance to try again; or the initiation of one program or activity to serve the community may be seen as fulfilling the obligation to the community.

CULTURAL COMPETENCE respects differences, involves continuing self-assessment

regarding culture, is attentive to the dynamics of difference, seeks continuous expansion of cultural knowledge and resources, and offers a variety of adaptations to service models to meet the needs of people of color who receive services.

CULTURAL PROFICIENCY is demonstrated when individuals and organizations seek to add to the knowledge base of culturally competent service delivery through research, development of new approaches based on culture, publishing and disseminating results of demonstration projects, and by becoming specialists in and advocates for cultural competence and improved relations between cultures.

Adapted from Cross, Terry L.; Brazen, Barbara J.; Dennis, Karl W.; Isaacs, Mareasa R., *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. CASSP Technical Assistance Center, Georgetown University, 1989, by Drenda Lakin, National Resource Center for Special Needs Adoption, 1990; revised, 1993.)

Exhibit 5

CHILD SAFETY ASSESSMENT PROTOCOL

REQUIREMENTS FOR USE OF THE CHILD SAFETY ASSESSMENT PROTOCOL

The Child Safety Assessment (CSA) Protocol is used within the larger protocols of child protection and child welfare practice. It is a "Life of the Case" protocol designed to provide CPS Specialists with a mechanism for assessing the potential for present and/or foreseeable danger of serious harm to children, and for taking quick action to protect children. CPS Specialists will use the protocol to help focus decision making to determine whether a child is safe or unsafe and, if unsafe, what actions must be taken to ensure the safety of the child. The major steps required to apply the protocol include an assessment and analysis of the safety factors, completion of the CSA, and implementing and monitoring the safety plan when necessary.

CPS staff is required to utilize the Child Safety Assessment Protocol (Exhibit 7, Child Safety Assessment, PS05400 and Child Safety Assessment Summary) and complete the CSA at the specified case milestones and, at any other time, when the CPS Specialist suspects or believes that a child may be unsafe. The CSA helps document child safety assessments and safety plan decisions shared by the CPS Specialist and the Supervisor. Document the outcome of the safety assessment using the Child Safety Assessment Summary window.

DEFINITIONS:

Degree of Harm means the severity of harm which could range from minor to moderate to severe.

Foreseeable Danger refers to a family situation or a behavior, emotion, motive, perception or capacity of a household member that is determined to be out-of-control and will likely result in serious harm to a child within the near future.

Near Future means within the next several days to a few weeks.

Present Danger refers to an immediate, significant and clearly observable family condition occurring in the present which will likely result in serious harm to a child requiring a prompt CPS response.

Prompt means the same day.

Risk Determination means the likelihood of any degree of long-term future harm or maltreatment.

Safety Decision means a child is considered to be safe when an assessment of available information supports the conclusion that a child in a household or in custodial care is not in

danger of serious harm.

Serious Harm means threat of danger to a child's life or health, impairment to his or her physical or mental well-being, or disfigurement.

CHILD SAFETY ASSESSMENT PROTOCOL

The Safety Assessment Protocol is a process whose purpose is to identify the potential for present and/or foreseeable danger of serious harm (i.e. safety concerns) to a child. When the potential for present and/or foreseeable danger of serious harm to a child is identified, the protocol requires the implementation of a safety plan to control or immediately resolve or reduce the potential. These safety concerns and the safety plan to control them must be documented on the CSA. The Child Safety Assessment Protocol is NOT unique to just one stage of a case, but is to be adhered to throughout the life of an open case from the initial investigation through services to case closure. This protocol must be integrated with the department's ongoing determination of risk of harm which is currently documented on the Reassessment and Reassessment Detail windows, and which serves as a basis for client service planning efforts to resolve long term risk issues.

1. **Safety and Risk**

Safety is best understood when it is compared to risk. Safety and risk of children are determined by the consideration of behavior, condition and accessibility of the child and the persons who have contact with the child. Safety is a subset of the broader concept of risk; therefore, all factors which apply to safety also apply to risk. However, not all risk factors apply to safety because safety is a form of risk that is concerned about conditions that meet the danger threshold and require a protective action.

Safety concerns are restricted to the essential criteria of "immediacy and degree of harm". The purpose of the broader area of risk is not control, but rather to decrease the risk of future harm and resolve problems that cause risk. Safety factors are to be controlled and risk factors are to be resolved or reduced. Unresolved risk factors may result in immediate safety concerns.

2. **Similarities Between Safety and Risk**

Safety and risk are similar in some very important ways, one being the prediction of harm. In the case of both safety and risk, there is a concern about the potential for future harm. Past harm and threat of future harm may describe both an immediate and long-term concern regarding a child's safety. Past harm and threat of future harm are common to safety and risk.

Safety and risk both relate to the conditions of the home environment, or the behavior or the physical/mental condition of a family member or an interaction in the family. These conditions may predict immediate or short-term potential for harm (safety) or longer-term potential for

harm (risk). Safety and risk elements can change quickly. Often they can be controlled or reduced by utilizing family strengths or other mitigating strengths and circumstances. In some cases, it may be necessary to address the problems with specific interventions designed to protect the child.

3. Differences Between Safety and Risk

The time element is the major difference between safety and risk. Safety means now or in the very near future and risk means longer-term. Safety and risk also differ by the degree of harm or the severity of the potential harm. Primarily, safety concerns itself with the potential for immediate moderate to severe harm, but risk is concerned with a full range of severity of harm, from minor to severe.

The primary purpose of safety is to control the situation to prevent harm from occurring in the short-term, while the primary purpose of risk is to reduce or resolve the problems that lead to risk. Safety and risk both require intervention in order to prevent harm, but safety must always be assessed quickly, while risk may be assessed over a longer period of time.

INSTRUCTIONS FOR COMPLETING THE CHILD SAFETY ASSESSMENT FORM

Part 1. Complete a Child Safety Assessment When

Identifying Information: Enter the case name, the CHILDS case ID number and date of the current assessment.

A. For Child Protective Investigation Cases (check the appropriate box)

1. Within 24 hours after the investigator SEES the alleged child victim(s). If all alleged child victims are not together at the same time as the initial safety assessment is being conducted, and the CPS Specialist cannot complete the safety assessment within 24 hours for all children, complete the assessment on those children who are present. Another CSA shall be completed as soon as possible for those alleged child victims who were not present. If other non-involved children are present, the Case Manager shall include them in the initial safety assessment.
2. Whenever evidence or circumstances suggest that a child's safety may be in danger including a new report.
3. At the conclusion of the investigation. All children in the home, alleged victims and non-involved children must be included.

B. For In-Home Cases (check the appropriate box)

1. Prior to supervisory approval when considering whether to close a case.
2. Whenever evidence or circumstances suggest that the child's safety may be

in danger including a new report.

C. For Out-of-Home Cases (check the appropriate box)

1. When considering the commencement of unsupervised visits in the home with the parent or guardian.
2. Within 24 hours prior to returning a child home. Assess safety in the child's return home environment.
3. Prior to supervisory approval when considering whether to close a case.
4. Whenever evidence or circumstances suggest that the child's safety may be in danger in the home of the out-of-home caregiver including a report concerning the out-of-home caregiver or non-custodial parent.

Clarifications as to when the CSA is conducted:

- **Out of Home Caregivers** this includes foster, relatives or adoptive homes, unless the caregiver or any member of the household, non-custodial parent is identified as an alleged perpetrator in a new report.
- **YAP Cases CSA s are completed:**
  - When considering commencement of unsupervised visits in the home with the parent or guardian;
  - Within 24 hours prior to returning a child home. Assess safety in the child s home environment;
  - Prior to supervisory approval when considering whether to close a case;
  - Whenever evidence or circumstances suggest that the child s safety may be in danger in the home of the out of home caregiver including a report concerning the out of home caregiver.
  - When a teen parent has custody of his/her child, complete the CSA on the teen parent s child in accordance with CSA protocols.
- **Action Requests** CSA s are not required.
- **Alternative Investigations** CSA s should not be completed unless the child has been seen by the CPS Specialist.

Part 2. Assessment

Identify the case name, CHILDS case ID number, and the type of assessment, and the date and time of the assessment. The type of assessment corresponds to the case milestones specified in Part 1.

List all adults and children living in or frequenting the home and whether or not each person was interviewed or observed. Complete the current whereabouts or location of family members not present at the time of the assessment. Identify the relationship of each person to the primary caregiver. List all children and adults not assessed, the reason the person was not assessed and a plan/time frame for completing the assessment.

Clarifications Regarding Who Is Included in the Safety Assessment

At the initial safety assessment conducted during an investigation of a report of child abuse or neglect, all alleged child victims must be seen and, if verbal, interviewed out of the presence of the caregiver and alleged perpetrator, if possible. All other children residing in the home must be seen prior to the conclusion of the investigation, and, if verbal, interviewed out of the presence of the caregiver and alleged perpetrator, if possible. Non-involved children who are present during the initial safety assessment are to be included in the assessment. If any of the children are not home at the time of an initial assessment, the assessment shall still be completed with a new assessment completed when the children who were not present are seen.*

For all other safety assessments, all children residing in the home are to be included in the assessment and, if verbal, interviewed out of the presence of the caregiver and alleged perpetrator, if possible.*

All adult members of the household or others who are frequently part of the household are to be included in the safety assessment to consider what effects they have on the child's safety.*

*When household members not present at an assessment are eventually seen, a new assessment is only required when a change has taken place in the assessment. If no change has occurred, indicate in Part 4, Safety Decision that no change has occurred due to the assessment of the additional household members.

Child in the Hospital, Incarcerated/Detained

While a child victim may be safe due to hospitalization, incarceration or detention, the safety assessment must be conducted based on the child s return home environment.

Part 3. Safety Factor Identification

The following list of factors are behaviors or conditions that may be associated with a child being in present and/or foreseeable danger of serious harm. This list of Safety Factors is based on the reality that usually the obvious, present danger is known or revealed immediately, while foreseeable danger takes greater involvement and information collection. When assessing child safety, consider the effects that any adult or household member, who has access to the child, could have on his/her safety. The presence or absence of a Safety Factor must be based upon all available information obtained through direct observations, interviews with family members, relatives and others who have information about the family, contacts with collateral sources, and a review of prior or current records. Identify the presence of each factor by checking "YES", which is defined as "clear evidence or other cause for concern".

Remember that young children can not protect themselves. Also, older children who have mental, emotional and/or physical disabilities and children who have been repeatedly victimized often can not protect themselves. Finally, remember that a history of prior reports of child abuse

and neglect is strongly associated with new incidents of child abuse and neglect.

When no safety factor is checked "YES", the CPS Specialist must summarize the available information which indicates that no child is likely to be in present and/or foreseeable danger of serious harm in Part 4, Safety Decision.

Safety Factors and Descriptive Examples

1. ***Caregiver leaves child alone and child is not competent to care for self, or caregiver leaves child with persons unwilling or unable to provide adequate care, placing the child at substantial risk of harm.***
   - Caregiver leaves child alone (acceptable time period varies with age and developmental stage).
   - Caregiver makes inadequate and/or inappropriate baby-sitting or child care arrangements and/or demonstrates very poor planning for child's care.
   - Caregiver makes impulsive decisions and plans that may leave child in precarious situations such as unsupervised or supervised by an unreliable person.
   - Caregiver is/has been absent from the home for lengthy periods of time, no other adult is available to provide basic care.
   - Caregiver has abandoned the child.
   - Caregiver arranged for care by an adult, but caregiver's whereabouts is unknown, or caregiver has not returned according to plan, and child is with a caregiver who is unable or unwilling to care for the child now.
   - The child has been abandoned at an institution or with someone who does not know who the caregiver is.
   - Caregiver has left the child with someone, but the caregiver has not returned according to plans, or did not express plans to return, or has been gone longer than the person keeping the child expected or would be normally acceptable.
   - Caregiver's unexplained absence exceeds a few days.

2. ***Child is fearful of caregiver, other family members or other people living in or having access to the home.***
   - Child describes threats against him or her that seem reasonable and believable.
   - Child has reasonable fears of retribution or retaliation from caregiver.
   - Child demonstrates emotional and physical responses indicating fear of the home or people within the home (e.g., crying, jitters, inability to focus, withdrawal, nightmares, insomnia, etc.).
   - Child states fearfulness and describes people and circumstances that are reasonably threatening.
   - Child recounts previous experiences that form the basis for fear.
   - Child's fearful response escalates at the mention of home, people or circumstances associated with reported incidents.
   - Domestic violence situations involving physical and verbal assault on a caregiver in

the presence of a child and child is fearful for self and others.

3. ***The behavior of a child living in the home threatens immediate harm to himself or to others and the caregiver can not control the behavior. (Note: Any of the following examples apply only if the caregiver is not able to control the behavior.)***
   - Provocative behaviors (sexually or physically acting out, aggressive, whiny, etc.) that do not demonstrate the ability to self-protect.
   - Seeks out or stimulates physical aggression as a means of gaining attention.
   - Child threatens or attempts suicide.
   - Child talks about suicidal thoughts.
   - Child's emotional state is such that immediate mental health/medical care is needed and caregiver will not provide the care.
   - Child is capable of and likely to self-mutilate and caregiver is not equipped to handle it.
   - Child is a physical danger to others.
   - Child abuses substances; may overdose and caregiver has no strategy to deal with it.
   - Child is so withdrawn that basic needs are not being met.
   - Child exhibits severe anxiety or depression.

4. ***Caregiver is verbally hostile when talking to or about the child and/or the caregiver has extremely unrealistic expectations for the child's behavior.***
   - Caregiver's expectations of a child far exceed the child's capacity; thus, placing the child in harmful situations (e.g., allows young child to boil water, plug in appliances, etc.).
   - Caregiver's expectations of the child are totally unrealistic in view of the child's condition.
   - Caregiver expects a child to perform or act in a way that is improbable/impossible given the child's age (e.g., babies and young children expected not to cry; remain still for extended periods of time; not to soil themselves/be toilet trained; eat neatly; care for younger siblings; stay alone, etc.).
   - The child is seen as the devil, demon possessed, evil, bastard, product of rape, etc.
   - The child has taken on the same identity, as someone the caregiver hates, is hostile toward, fearful of, and caregiver transfers feelings and perceptions of the person to the child (e.g., mother who hates child's father, etc.).
   - The child is seen by the caregiver as deformed, ugly, deficient, embarrassing.
   - The child is considered by the caregiver to be punishing, torturing them.
   - One caregiver is jealous of the child and believes the child is a detriment or threat to the caregiver's relationship or stands in the way of the caregiver's best interest.
   - Caregiver sees child as an undesirable extension of self and this results in extremely harsh/dangerous treatment of child.
   - Child is blamed and held accountable for CPS involvement.

- Caregiver's unreasonably or in a hostile manner directly associate difficulties in their lives, limitations to their freedom or financial or other burdens to the child.
- Conflicts that caregiver's experience with others (e.g., family members, neighbors, friends, school, police, CPS, etc.) are considered to be the child's fault.
- Losses (e.
- g., job, relationships, etc.) the caregiver experiences are attributed to the child.
- Child is openly unwanted.

5. ***Caregiver's behavior is violent or out-of-control.***
   - Caregiver is impulsive, exhibiting physical aggression, temper outbursts, or unanticipated and harmful physical reactions such as throwing things, which causes danger to the child.
   - Caregiver's disorders reduce their ability to control their behavior in ways that threaten safety (e.g., extreme fears, phobias, etc.).
   - Threatens CPS Case Manager
   - Caregiver spends impulsively, resulting in a lack of basic necessities that then threaten safety.
   - Caregiver has addictive patterns/behavior that are uncontrolled and leaves child in threatening situations such as failing to supervise or provide other basic care; may include addiction to substances, gambling, computers, etc.
   - Caregiver uses brutal or bizarre punishment (e.g., scalding with hot water, burning with cigarettes, forced feeding, confinement, over-strenuous exercise, etc.).

6. ***Domestic violence among adults living in or having access to the home seriously impairs the necessary supervision or care and/or the physical safety of the child. (See Exhibit 47, Guide to Assessing Domestic Violence for more assistance.)***
   - Domestic violence in which assaults on a child occur.
   - Domestic violence perpetrator has had recent violent outbursts that resulted in injury or threat of injury to the child.
   - Domestic violence in which a child may be attempting to intervene.
   - Domestic violence in which a child could be inadvertently harmed even though he/she may not be the actual target of the violence.
   - Caregiver's own victimization (past or current) severely interferes with ability to parent or protect child.

7. ***Caregiver has caused serious harm to the child or has made a believable threat to cause serious harm to the child.***
   - Caregiver states he/she will harm the child.
   - Caregiver describes conditions and situations that stimulate him/her to think about harming the child.
   - Caregiver talks about being worried, fearful, preoccupied with abusing or neglecting the child.

- Caregiver identifies things that the child does that aggravate, annoy the caregiver in ways that the caregiver wants to attack the child.
- Caregiver describes incidents involving discipline that have gotten out-of-hand.
- Caregiver is distressed, "at the end of their rope" and is asking for some relief in either specific terms ("take the child") or general terms ("please help me before something awful happens").
- One caregiver is expressing a concern for what the other caregiver or someone in a caregiving role is capable of or may do.
- The incident was planned; had some element of premeditation.
- The nature of the incident or use of an instrument can be reasonable assumed to heighten the level of pain or injury (e.g., cigarette burns, etc.).
- Caregiver's motivation to teach or discipline seems secondary to inflicting pain and/or injury.
- Caregiver can reasonably be assumed to have had some awareness of what the result would be prior to incident.
- Caregiver's action was not impulsive; there was sufficient time and deliberation to assure that the actions hurt the child.
- Caregiver does not acknowledge any guilt or wrong doing and intended to hurt the child.
- Caregiver shows no empathy for the pain or trauma the child has experienced and intended to hurt the child.
- Caregiver may feel justified; may express that the child deserved it and intended to hurt the child.

8. ***Caregiver's explanation for the child's injury or physical condition is inconsistent with the observed or diagnosed injury or condition.***
   - The child has a credible account of the injury, which contradicts the explanation of the caregiver.
   - Caregiver acknowledges the presence of injuries and/or conditions, but does not explain them or seem concerned.
   - Caregiver acknowledges the presence of injuries and/or conditions, but plead ignorant as to how they came to be.
   - Caregiver may express concern for child's condition, but is unable to explain it.
   - Family appears to be totally competent and appropriate with the exception of the abuse or neglect and the lack of an explanation or an explanation that makes no sense.
   - "Battered Child Syndrome" case circumstances are present in which the family appear to be competent, but the child's symptoms do not match the family appearance and there is no explanation for the child's symptoms.
   - Caregiver's explanations are far-fetched.
   - Facts related to the conditions, the incident and injury, as observed by CPS and/or supported by other professionals, contradict explanations.
   - History and circumstantial information are incongruent with the caregiver's

explanation about the injuries and conditions.

- Caregiver's verbal expressions do not match emotional response and there is not a believable explanation.

9. ***Caregiver refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts can not be ascertained.***
   - Family is highly transient.
   - Family has little tangible attachments (e.g., job, home, property, extended family, etc.).
   - Caregiver is evasive, manipulative, no-shows, suspicious.
   - There is precedence for avoidance and flight.
   - There are or will be civil or criminal complications that family wants to avoid.
   - There are other circumstances prompting flight (e.g., warrants, false identities uncovered, criminal convictions, financial indebtedness, etc.).
   - Caregiver refuses to speak with CPS.
   - Caregiver is openly hostile and physically aggressive toward CPS.
   - Caregiver refuses access to the home.
   - Caregiver hides child; refuses access to child.
   - Caregiver avoids all contacts, fails to keep appointments, never shows up, is never home.
   - Caregiver constantly lies and deceives in respect to the child, the child's condition, home conditions, events and circumstances related to the report and CPS intervention.

10. ***Caregiver has not, can not or will not protect child from serious harm, including harm from other persons living in or having access to the home.***
    - Caregiver is unable to be objective about the threats to the child due to the relationship with the alleged perpetrator.
    - Caregiver sides with the alleged perpetrator and this places the child in danger.
    - Caregiver is totally dependent on the perpetrator for living accommodations and expenses.
    - Caregiver does not attend to the child; the need for care goes unnoticed or unmet (e.g., child wanders outdoors alone, plays with dangerous object, plays on unprotected window ledge, or is exposed to other serious hazards, etc.).
    - Caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.
    - Caregiver does not know or apply basic safety measures such as keeping medications, sharp objects, household cleaners, etc. out of reach.

11. ***Caregiver is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care placing the child at substantial risk of harm.***
    - Caregiver is or will be incarcerated, leaving the home without a responsible adult.

- Failure to be given prescribed medication endangers the child's life or causes illness.
- Child complains of extreme pain for which the caregiver does not seek medical attention.
- Unreasonable delay in obtaining medical or dental services that endangers the child's life or places child at risk of permanent disability.
- Caregiver refuses medical care for child's serious condition based on religious or social reasons.
- A lack of motivation results in caregiver abandoning their role to meet basic needs or failing to adequately perform the caregiver role which would meet the child's basic needs. The inability/unwillingness to meet basic needs creates a safety concern for the child.
- Lack of hygiene is so dramatic as to cause or potentially cause serious illness.
- Infant has not been fed for 12 hours.
- Food is not provided or only provided sporadically.
- Clothes are inadequate to protect child from the elements.
- Family has no money.
- Family has no food, clothing or shelter.
- Family finances are insufficient to support unusual need that, if unmet, could result in a threat of harm (e.g., medical needs, etc.).
- Family may be using resources for other than basic needs which leaves the family and children routinely without basic needs being met adequately (e.g., using resources for drugs, etc.).
- Because of unusual condition, the basic need of a child exceeds normal expectations and family is unable to adequately address (e.g., disabled child, etc.).
- Caregiver does not know what basic care is or how to provide it (e.g., how to feed, diaper, protect or supervise appropriate to child's age, etc.).
- Caregiver's skill in parenting is exceeded by special needs and demands that a child displays in ways that affect safety.
- Caregiver's knowledge and skill is adequate for some children's age and development, but not for others (e.g., can take care of an infant, but can not control a toddler, etc.).
- Caregiver does not want to be a caregiver and does not perform role, particularly in terms of basic needs.
- Caregiver has an aversion to parenting and does not attend to basic needs.
- Caregiver avoids the responsibilities concerned with parenting and basic care.
- Child has a physical or mental condition, that if untreated, serves as a threat of harm to the child's safety and caregiver can not or will not control/address it.
- Caregiver does not recognize condition.
- Caregiver views condition as less serious than it is.

12. ***Caregiver, paramour or other person living in or having access to the home***

previously harmed or endangered a child and circumstances indicate the person is a present danger to the child.

- Household member has past convictions regarding violent behaviors and acts toward others to include assault and battery, homicide, sexual assault or rape, or criminal acts involving weapons.
- Previous involuntary TPR.
- Previous death of a child due to abuse or neglect.
- Previous criminal conviction for child abuse or neglect.
- Known CPS history of severe child abuse or neglect.
- No steps were taken by the caregiver to protect the child from abuse or neglect by the current paramour or other person living in or having access to the home.

13. ***Child sexual abuse is suspected and circumstances suggest that continued sexual abuse is an immediate concern.***
    - Caregiver can not control sexual impulses.
    - Sexually abusive caregiver has unsupervised access to the child.
    - Sexual abuse has occurred in which: the child discloses; family circumstances including opportunity may or may not be consistent with sexual abuse; and the caregiver denies, blames the child or offers no explanation or an unbelievable explanation.
    - Child is prostitute/exploited.

14. ***Physical conditions in the home are hazardous and immediately threaten the child's safety.***
    - Housing is unsanitary, filthy, infested, a health hazard (e.g., human/animal feces, undisposed garbage, access to dangerous objects or harmful substances, etc.).
    - The physical structure of the house is decaying, falling down.
    - Wiring and plumbing in the house are substandard, exposed.
    - Furnishings or appliances are hazardous.
    - Heating, fireplaces, stoves, etc. are hazardous and accessible.
    - The home has easily accessible open windows, balconies, etc. in upper stories.

15. ***Drug and/or alcohol use by caregiver or others living in or having access to the home places the child in immediate danger. (For more assistance, see Exhibit 25, Substance Abuse Behavioral Indicator Checklist; Exhibit 35, Guide to Assessing Risk Factors for Substance Exposed Newborns; and Exhibit 36, Guide to Assessing Risk Factors for Substance Exposed Newborns Instructions.)***
    - Substance abuse prevents caregiver from protecting or providing for the child.
    - Other safety factors are directly related to the use of drugs or alcohol.
    - Caregiver has additions or periods of incapacitation due to substance abuse or other drug usage.
    - Drugs used in presence of children or paraphernalia left around and accessible to

children.

- Caregiver drives with child in vehicle when legally intoxicated or appearing to be incapacitated by substance abuse.

16. ***The caregiver's involvement in criminal activity or the criminal activity of any other person living in or having access to the home endangers the child.***
    - Caregiver's behavior outside of home (e.g., drugs, violence, aggressiveness, hostility, etc.) creates an environment within the home which threatens child safety (e. g., drug parties, gangs, drive-by shooting, etc.).
    - Adult uses child to sell or transport drugs.
    - Drug transactions occur in the home.

17. ***The physical or mental health or mental limitations of caregiver or other person living in or having access to the home places the child in immediate danger.***
    - Caregiver's disorders reduce their ability to control their behavior in ways that threaten safety.
    - Caregiver is emotionally immobilized (chronically or situationally) and can not control his/her behavior in ways that threaten safety.
    - Caregiver is delusional; experiencing hallucinations.
    - Caregiver can not control sexual impulses.
    - Caregiver is so depressed that he/she is not functionally able to meet basic needs of the child.
    - Caregiver's intellectual incapacity affects judgment/knowledge in ways that prevent providing adequate basic care.
    - Young or limited caregiver who has little or no knowledge of child's needs and capacity.

18. ***Other (specify). This Safety Factor may be used to record any unusual behavior or condition that creates a safety concern not identified in the previous 17 Safety Factors.***

Part 4. Safety Decision

In consultation with the Supervisor and based upon the assessment of all Safety Factors and any other information about this family that is available to you, identify the Safety Decision as Safe or Unsafe. Identify any Safety Factor checked "YES" and describe the specific persons, behaviors, conditions and circumstances associated with that particular factor. If no Safety Factor is checked "YES", summarize the available information that leads you to believe that no child is likely to be in present and/or foreseeable danger of serious harm.

Do not check Safe, if any Safety Factor is checked "YES". If at least one child is Unsafe, determine whether the Safety Plan involves in-home or out-of-home placement. When a decision is made that a child is "UNSAFE", a Safety Plan must be developed and implemented

to avoid immediate danger to the child.

Consider all alternatives to out-of-home placement before implementing a Safety Plan that requires temporary custody.

The completed Child Safety Assessment must be signed by the CPS Specialist and the Supervisor indicating supervisory approval of the Safety Decision and Plan.

Part 5. Safety Plan

In the column, Safety Factors, identify the Safety Factor number.

In the column, Name of Unsafe Child & Involved Adult, identify the name of the unsafe child and the adult who presents the behavior or condition that causes the child to be unsafe.

In the column, Specific Safety Action and Mitigating Circumstances, clearly identify what specific actions must be taken to protect the child in relation to the Safety Factor. Identify any family strengths or mitigating circumstances which may serve to control or manage the Safety Factor. Sometimes the presence of a Safety Factor can be partially or fully controlled or eliminated by a family strength or mitigating circumstance. Therefore, consider all of the factors known about the family strengths when developing the Safety Plan. Regular contact with a support person who can ensure the safety of the child shall be considered a family strength.

In the column, Implementation/Monitoring, specify exactly who is responsible for implementing the action to ensure child safety and how the plan will be monitored to ensure that all of the designated tasks are completed effectively.

When Developing and Implementing the Safety Plan

When the Safety Decision is that at least on child is Unsafe, a Safety Plan must be developed, implemented and monitored. The Safety Plan must address whether the child should be removed from the home or if there are mitigating factors that would permit the child to remain safely at home if a Safety Plan is developed and implemented. After the Safety Plan has been developed, it must be implemented to ensure that all of the designated tasks are completed effectively. The Safety Plan should contain a time frame for implementation and continued monitoring.

The Case Manager who is responsible for implementing the Safety Plan must explain the Plan to the family and, whenever the family has an active role in carrying out the Plan, obtain the family's commitment to cooperate and participate in carrying out the Plan. The CPS Specialist shall document the family's agreement and commitment in the case record. The CPS Specialist shall develop and document a backup plan whenever necessary, particularly when family members have an active role in carrying out the primary plan.

Safety plans are temporary, usually short-term measures designed to control serious and immediate threats to a child's safety. It is important that safety plans be crafted to control specific threats and that there is a mechanism for ending each Safety Plan. Under no circumstance is a Safety Plan to serve as the solution to a long-term problem. Every Safety Plan must specify the conditions under which the plan will terminate and an estimated time frame within which this can be expected to occur. Failure to agree to the Safety Plan or to carry out the Plan should result in a reassessment of the home and possible protective custody and/or consultation with the Attorney General's Office regarding the need to file a dependency petition.

The Safety Plan is to be used to control or immediately resolve or reduce the potential for present and/or foreseeable danger of serious harm to a child until a more stable/permanent change can take place. This step requires a written description of what actions will be taken to protect the child, who will be responsible for implementing the components of the Safety Plan and how/who will monitor the Plan.

The CPS Specialist who initiates a Safety Plan is continuously responsible for implementation of the Safety Plan and the safety of the child. If the case is transferred for ongoing services after a Safety Plan has been initiated, the CPS Specialist who initiated the Safety Plan will remain responsible for the Safety Plan until the responsibility for services to the child and family are transferred to another CPS Specialist. The CPS Specialist transferring the case shall discuss the case and the terms of the Safety Plan with the new CPS Specialist at the time of the case handoff.

NOTE: Safety Plans are not used when the child is assess to be safe. If a child is considered safe, but the CPS Specialist has concerns about potential risk factors that need to be addressed by the caregiver, the CPS Specialist may use the case planning process to address those concerns. The case plan may include outcomes and tasks to ensure the child's safety, identification of those persons the caregiver can call upon for support and identification of persons (such as other family members) the child can call upon (if old enough) if the child needs help. Other alternatives include CPS child care and unannounced monitoring visits.

Part 6: Signatures and Dates for Safety Plan

The completed CSA must be signed and dated by the CPS Specialist and Supervisor, the child's primary caregiver, the person most responsible for implementing the Safety Plan, if different than the primary caregiver, and any other person responsible for components of the Safety Plan.

A copy of the completed Plan shall be given to the parent/guardian/primary caregiver, and a copy to the person most responsible for implementing the Safety Plan, if other than the primary caregiver. The original shall be filed in the case record.

The Supervisor or designee shall sign the completed Safety Plan within 24 hours after the CPS Specialist has signed it. If the CPS Specialist has signed CSA on a weekend or holiday and

more than 24 hours will elapse before the Supervisor can sign the Plan, the CPS Specialist shall obtain the verbal approval of the Supervisor or designee by phone. The Supervisor shall then sign the Safety Plan on the next working day. In all other instances when the Supervisor who gave verbal approval will not be available to sign the Safety Plan due to a prolonged absence, another Supervisor may sign the Plan.

Document the outcome of the safety assessment using the Child Safety Assessment Summary window.

Exhibit 6

SUBSTANCE ABUSE BEHAVIORAL INDICATOR CHECKLIST

There are certain attributes that you may family members exhibiting. The following tool was developed to assist you in recognizing these characteristics that may be attributed to substance abuse.

Appearance/Body Odor

Physical Symptoms:

Appearance:

- Odor of alcohol on breath
- Body odor of alcohol
- Skin lesions such as abscesses or track marks consistent with injection drug users

Eyes:

- Constricted (pinpoint) pupils
- Dilated pupils (enlarged)

Psychomotor Impairment:

- Stumbling (Staggering)
- Swaying gait

Speech:

- Slurred
- Incoherent

Perinatal Indicators:

- Lack of prenatal care
- Previous deliver of a prenatally drug exposed infant

History, Conduct/Behavior:

History of Substance-Related Problems:

- Reports from employer, probation/parole related to positive drug screen/breathalyzer
- Pending DWI court case
- Loss of license for DWI
- Misdemeanor drug arrest/conviction
- Frequent automobile or other accidents
- Self-defeating behaviors (e.g. missed appointments absences from work, repeated lateness)

Conduct/Behavior:

- Loss of inhibitions with no apparent reason (i.e. yelling, cursing during interview)
- Failure to report for job interview (2 or more)
- Repeated missed appointments
- Personality changes and inconsistent behavior

Exhibit 7

Roles and Responsibilities in the Coordination of SEN Cases

CPS SPECIALIST	SUBSTANCE ABUSE TREATMENT PROVIDER	SHARED
• Responds to reports of alleged child maltreatment • Conducts safety assessment of children • Provides family intervention as necessary to assure safety of the children • Gather all substance abuse related information relating to SEN and mother • Referral to Arizona Families F.I.R.S.T. providing information related to substance abuse and any other information that may assist in the engagement and assessment process • Follow up and coordination with Arizona Families F.I.R.S.T. Did client agree to an assessment? • Files dependency petition with juvenile court when child is in imminent danger of maltreatment • Maintains care, custody and control of children as directed by the court • Identifies critical risk factors and family strengths to determine intervention when substance abuse is identified as risk factor • Ensures the provision of services to facilitate case plan goals • Coordinates with other team members to assess progress and identify service needs • Monitors the welfare of children in out-of-home placement, assuring needs are met • Provides information to the court to monitor and assess progress in addressing identified risk factors • Recommends alternative permanency goals for children as necessary	Receives the referral • Within 24 hours of receipt of referral make contact with the family to engage in services and complete a substance abuse screening • Obtains informed consent • Arrange for assessments within 5 working days of completion of screening • Schedule an assessment ASAP and provide feedback to the CPS Social worker • Will identify clinical issues and recommended approaches • Develops family centered service plan within 5 days of completion of assessment incorporating aspects of the Child Protective Services and treatment plan • Arranges for appropriate substance abuse and supportive services • Completes progress reports, gathers information from other service providers • Facilitates staffings to monitor progress • Completes case closure form	Utilizes best practices and a family-centered approach when working with families • Participates in multi-agency case planning • Ensures the provision of services to facilitate case plan or service plan goals • Coordinates with other team members to assess progress and identify service needs • Participates in regular communication with other team members • Participates in program evaluation
• Responds to reports of alleged child maltreatment • Conducts safety assessment of children • Provides family intervention as necessary to assure safety of the children • Gather all substance abuse related information relating to SEN and mother • Referral to Arizona Families F.I.R.S.T. providing information related to substance abuse and any other information that may assist in the engagement and assessment process • Follow up and coordination with Arizona Families F.I.R.S.T. Did client agree to an	Receives the referral • Within 24 hours of receipt of referral make contact with the family to engage in services and complete a substance abuse screening • Obtains informed consent • Arrange for assessments within 5 working days of completion of screening • Schedule an assessment ASAP and provide feedback	Utilizes best practices and a family-centered approach when working with families • Participates in multi-agency case planning • Ensures the provision of services to facilitate case plan or service plan goals • Coordinates with other team members to assess progress and identify service needs • Participates in regular communication with other team

assessment?

- Files dependency petition with juvenile court when child is in imminent danger of maltreatment
- Maintains care, custody and control of children as directed by the court
- Identifies critical risk factors and family strengths to determine intervention when substance abuse is identified as risk factor
- Ensures the provision of services to facilitate case plan goals
- Coordinates with other team members to assess progress and identify service needs
- Monitors the welfare of children in out-of-home placement, assuring needs are met
- Provides information to the court to monitor and assess progress in addressing identified risk factors
- Recommends alternative permanency goals for children as necessary

to the CPS Social worker

- Will identify clinical issues and recommended approaches
- Develops family centered service plan within 5 days of completion of assessment incorporating aspects of the Child Protective Services and treatment plan
- Arranges for appropriate substance abuse and supportive services
- Completes progress reports, gathers information from other service providers
- Facilitates staffings to monitor progress
- Completes case closure form

members

- Participates in program evaluation

Exhibit 8

Guide and Instructions to Assessing Risk Factors for Substance Exposed Newborns

Factor	Low Risk	Intermediate Risk	High Risk
Mother's current drug use	No current drug use	Occasional	Use more than 1x per week; any use of methamphetamine, cocaine, opiates, PCP or inhalents or in combination with alcohol.
Drug treatment history	Entered drug treatment early in pregnancy; remains compliant	Entered drug treatment early in pregnancy, but inconsistent in program; sporadic attendance and/or continues to use drugs; history of drug treatment.	Not in a treatment program; multiple episodes of failed treatment
Mother's functional capacity	No intellectual or physical limitations; in full control of mental faculties; realistic expectations of newborn	Mild physical or emotional handicap; mild intellectual limitations which would not significantly impact ability to care for the newborn	Evidence of poor perception of reality, incapacity due to drug and/ or alcohol intoxication; history of mental health issues; previous involvement with law enforcement, probation or parole; poor impulse control.
Mother's level of cooperation	Willing and able to work with agency to resolve problem and protect the newborn	Overly compliant with investigation and/or demonstrates marginal cooperation with service plan	Does not believe there is a problem; refuses to cooperate; disinterested or evasive
Awareness of impact of continued drug use	Understands drug use impairs functioning; expresses interest in resolving problems	Displays some understanding and interest, but denies symptoms of drug use and special needs of newborn	Displays lack of concern/interest for newborn and denies symptoms of substance use; refuses help
Parenting skills and responsiveness	Exhibits appropriate skills and knowledge including the special needs of the newborn	Shows some understanding of parenting skills; has reasonable expectations of newborn; obtains help from extended family; has other non-drug using adult	May provide some physical care, but has unrealistic expectations of newborn; unresponsive to needs; poor eye contact with newborn; infrequent visitation; ambivalent attitude toward newborn
History of abuse/ neglect	No known history of abuse or neglect	Prior CPS involvement with episode resolved and case closed	Pending abuse or neglect case; prior abuse or neglect case of a serious nature; previous substance exposed newborns; TPR to other children

Factor	Low Risk	Intermediate Risk	High Risk
Conditions of the home environment	Home relatively clean with no safety or health hazards; utilities operable; evidence of preparation for newborn's arrival	Home relatively clean, but no evidence of preparation for newborn's arrival or vice versa	Home unclean with safety or health hazards; no evidence or preparation for newborn's arrival; chemical hazards, drugs, manufactured in the home; family will immediately lose home
Substitute caregiver in the home	Non-drug abusing father or other person in the home is supportive and stabilizing influence and available to assist in caring for newborn	Stable father or other person in the home, but assumes only minimal caregiver responsibilities for newborn	Father or other person in the home resides with family, but is involved in drug activity and/or shows evidence of poor impulse control or violence
Drug use in the home	No members of the household suspected to be involved in drug activity	Anyone in the household suspected of drug activity	Anyone in the household suspected of drug activity
Prenatal care	Sought early prenatal care and was consistent with follow-up	Sought prenatal care, but was inconsistent with follow-up and/ or medical advice	Did not seek prenatal care; sought only in third trimester
Special care needs of newborn	No apparent medical conditions; only routine medical care required	Minor medical or physical problems which do not significantly affect the newborn's vital life functions or physical and intellectual development	Any pre-term newborn and/or physical problems which may impact vital life functions or development; marked withdrawal symptoms
Strengths of family support in the home	Family, neighbors, friends available and committed to help; can include church community	Family supportive, but not in geographic area; some support from friends and neighbors; limited community services available	No relatives or friends available or committed; geographically isolated from services; no phone or transportation available; immediate support persons are dysfunctional due to substance use, CPS history or legal issues.
Siblings Assessment	Educational, medical and environmental needs being met for all siblings	Some, but not all educational, medical and environmental needs being met for siblings	Few educational, medical and environmental needs being met for all siblings

Exhibit 8 (Continued)

INSTRUCTIONS for Completion of the Guide to the SEN

A. PURPOSE

Use the Guide to Assessing Risk Factors for Substance Exposed Newborns to assist in the assessment of family strengths and risk factors. An assessment of these factors, in addition to those required during all CPS investigations, lays the groundwork for building on family strengths and selecting appropriate interventions and services to meet the complex needs of both parents and newborn. Information gathered should assist in determining whether drug and/or alcohol use by the caregiver places the child in immediate danger.

This Guide is intended to be used as a tool to enhance professional judgment. The Guide should be used in totality as no single factor should determine the intervention. Use Information gathered from interviews with parents and other family members, home visits including observations of parent/ child interaction and collateral contacts that may include physicians, nurses, social workers, teachers, neighbors, child care providers, mental health and substance abuse professionals, parole and probation officers to support decision making.

B. FACTOR DESCRIPTIONS

MOTHER'S CURRENT DRUG USE: Consider the drug used, mental set and setting. Examine the primary and secondary effects of the drug use. How much? How often? How long and over what period of time? With what other substances?

DRUG TREATMENT HISTORY: Has there been prior treatment? Where and for how long? What was the motivation for seeking treatment and what were the circumstances under which the parent left treatment? Is there current motivation to participate in treatment?

MOTHER'S FUNCTIONAL CAPACITY: Has the parent ever participated in behavioral health services? Is there a history of violence towards others? History of domestic violence? Does the parent have a criminal history? This can be helpful in gaining information about the parent's lifestyle and how children may have been exposed. It may also provide information about how the family has handled periods of incarceration.

AWARENESS OF IMPACT ON CONTINUED DRUG USE: Assess the parent's understanding of the relationship between his/her substance abuse and their children's care. Is there an acknowledgement of the impact? Has the parent been under the influence of substances when suspected child abuse and neglect occurred? Was it a contributing factor? Is the parent willing to make changes? How has the parent provided for his/her child's needs during periods of use or relapse? For newborns, how does the parent view the newborn's symptoms?

PARENTING SKILLS AND RESPONSIVENESS TO NEWBORN: How does the parent react to the child's behavior? Are expectations age appropriate? How does the parent react to emotional needs of the newborn? How frequent is the contact if the newborn is hospitalized? Does the parent have support?

HISTORY OF ABUSE/NEGLECT: Has there been previous child abuse or neglect investigations,

substantiated reports of abuse or neglect, and/or other children under the court's jurisdiction? Have other children been born substance exposed? Examine long term patterns.

CONDITIONS OF THE HOME ENVIRONMENT: If impoverishment exists, what are the reasons? How long at the current address? Is a recent move related to an attempt to provide a safer environment? Are there health or safety hazards? Has the caregiver attempted to remedy these situations? Is there food? Are there utilities? This is especially critical if the newborn has medical needs that may require refrigeration, apnea monitors, etc. Does the caregiver have supplies for the baby? If not, why? For older children, do they have adequate clothing? Do these children have a safe place to play?

SUBSTITUTE CAREGIVER IN THE HOME: Who else lives in the home? Relationship to the children: do they provide child care? Are there suspicions that others living in the home are involved with the use, manufacture or sale of illicit substances or other criminal activity? Do others in the home display poor impulse control? Is there evidence of child abuse, domestic violence or other forms of violence?

DRUG USE IN THE HOME: Who else lives in the home? Is any individual suspected to be involved in the use, sale or manufacture of illegal substances?

PRENATAL CARE: Did the mother seek prenatal care? If so, at what stage of the pregnancy? This information is important as it can reflect the mother's ability to use health care systems and may be an indicator of the mother's ability to plan and obtain appropriate medical care for her newborn. Are there current health problems related to the mother's alcohol and other drug use?

SPECIAL CARE NEEDS OF NEWBORN: Newborns exposed to alcohol and other drugs prenatally are especially vulnerable, requiring careful assessments of the newborn's health and care requirements. Gather information through examinations and observations of the newborn as well as through interviews with the primary caregivers and involved health professional. Consideration should be given to the following: newborn symptoms of drug exposure; and requirements for special medications and/or equipment that may require training of the caregiver. Does it appear that the parent's substance abuse may interfere with his/her ability to provide the needed level of care and to obtain recommended follow-up medical care for the newborn?

STRENGTHS OF FAMILY SUPPORT IN THE HOME: What is the relationship with extended family, friends and neighbors? Are they a source of support or stress? Are the parents involved in a church, temple, or community or social groups? Are the individuals, identified by the parents as supports, involved in substance use, CPS or other legal issues? How do these individuals support parental attempts to make lifestyle changes? Do they collude in the parent's denial?

SIBLING ASSESSMENT: How many other children are in the home? What are their ages? Who is the primary caregiver? What are their activities as well as their relationships with others in the home? Is supervision adequate? Are there adequate supplies and provisions for the children? Are the children in school? Is there parental involvement? Is the child given inappropriate and/or dangerous responsibilities? Are there adolescent children in the home with their own alcohol and

other drug issues, mental health, legal or educational issues?

C. INTERVENTION

For all reports concerning Substance Exposed Newborns (SEN) reports, determine what further action shall be taken including using the risk guidelines below. The following options shall be considered:

- in-home services including the use of an identified non-substance abusing alternative caregiver in the home;
- placement with relatives outside the home;
- voluntary foster care;
- in-home intervention;
- in-home dependency petition; or
- out-of-home dependency petition.

HIGH RISK: Mother is unable to provide care for the newborn. In the absence of an identified non-substance abusing alternative caregiver who can provide care, the newborn must be taken into custody. These parents do not demonstrate motivation towards recovery, cooperation or reasonable success in improving the safety environment for their newborn.

INTERMEDIATE RISK: The case should be opened for service. An assessment of risk is essential to determine if the newborn can be cared for safely within the family or requires substitute care during the treatment and recovery process.

LOW RISK: Protective services intervention may not be required. In these instances, the primary focus should be on newborn safety and the mother's ability to provide adequate care. A decision not to open a case for services requires consultation with your supervisor and adequate documentation of: the availability of a supportive non-substance abusing adult, the absence of drug users in the home, the results of the substance abuse assessment, participation in a drug treatment program, if recommended, and services to address newborn's special health care needs, if necessary.

Exhibit 9

Arizona Families F.I.R.S.T.

The Arizona Department of Economic Security and the Arizona Department of Health Services are joint administrators of the SB 1280, Arizona Families F.I.R.S.T., which offers a continuum of community-based substance abuse treatment services to:

A parent, guardian or custodian of a child who is named in a report to Child Protective Services as a victim of abuse or neglect and whose substance abuse is a significant barrier to maintaining, preserving or reunifying the family;

Or

A person whose substance abuse is a significant barrier to maintaining or obtaining employment and is a recipient of Temporary Assistance for Needy Families (TANF) pursuant to Title 46, Chapter 2, Article 5.

How to Make Referral:
DES social workers from CPS, DDD foster care and Jobs may make referrals for eligible clients by completing the mandatory request for service forms including:

F For CPS clients - Request for Services (PS-067);

F For DDD Foster care clients - Request for Services (PS-067), CPS report and case plan;

F For Jobs clients - Referral to Provider (JA-006), Special Services Screening Guide, page 2 (JOB-1035A) and a self survey form (JA-001);

F For all clients - provide relevant collateral information to assist in the treatment planning process.

What to expect when I make a referral:
The referral for services is for the entire continuum - outreach, assessment, treatment and aftercare. The assessment will include a recommendation for the appropriate level of care. A service plan will be developed based on level of care, social worker and family input. Random drug and alcohol screening will be conducted throughout the program for participants.

Time Frames
Provider agency will provide outreach to the client within 24 hours to engage into treatment services. Outreach and engagement techniques to encourage and motivate participants to enroll in the program are provided.

The provider agency will screen and conduct a comprehensive assessment within 7 days.
Referral to first therapeutic service should occur in 14 days.

The Array of Services Include:

Substance Abuse Education
Offers substance abuse awareness through group or individual counseling to learn the effects of substance abuse on the body, individual, and family life.

Outpatient Treatment
Services include a minimum of three hours per week of individual, group, and family therapy and other supportive services as necessary

Intensive Outpatient
Services include a minimum of nine hours per week of individual, group and family therapy and other supportive services as necessary

Residential Treatment
Residential services include therapeutic intervention, individual, group and family counseling. Some agencies offer residential treatment services for parents with their children depending upon the child's age.

Aftercare Services
Aftercare services are designed to assist the participant in establishing supports within the community that encourage sobriety. Services include relapse prevention and intervention plans to assist participants in the event relapse should occur.

Supportive Services
Supportive services are based on the needs of the family and designed to assist the participant and family in reaching their goal toward achieving sobriety. Supportive services include but are not limited to childcare, transportation and other supports. These may include connections to faith-based organizations and culturally relevant programs.

In the continuum of treatment services, providers are required to weave the following Best Practice and Essential Elements into the service delivery process:

- Service Coordination
- Family Education & Treatment
- Outreach & Engagement
- Supportive Services
- Motivational Interviewing & Retention
- Culturally Appropriate Services
- Services for Children
- Gender Specific Treatment (Therapeutic family involvement)
- Random Alcohol & Drug Screening
- Relapse Management

Service Providers

***TERROS* - Maricopa County**

Phone: (602) 685-6000
Fax: (602) 685-6060

***CPSA* - Pima County**

Phone: (520) 959-1063
Fax: (520) 318-6983

***AZPAC* - Yavapai County**

Phone: (928) 778-2531
Fax: (928) 771-9531

***AZPAC* - Coconino County**

Phone: (928) 774-9125
Fax: (928) 774-0697

Old Concho - **Navajo/Apache Counties**

Phone: (928) 337-5047
Fax: (928) 337-2376

WestCare - **LaPaz/Mohave Counties**

Phone: (928) 763-1945
Fax: (928) 763-8809

AZPAC - **Yuma County**

Phone: (520) 341-9400
Fax: (520) 341-8428

***Horizon* - Pinal/Gila Counties**

Phone: (520) 836-1688
Fax: (520) 421-1969

***SEABHS* - Graham/Greenlee/Cochise/Santa Cruz Counties**

Phone: (800) 586-7080
Fax: (520) 586-9674

Arizona Families F.I.R.S.T. contracted providers will coordinate with their local Regional Behavioral Health Authorities (RBHA) and RBHA subcontracted providers for the provision of medical necessary Title XIX/XXI services.

Regional Behavioral Health Authorities:

- *The Excel Group - Yuma/LaPaz Counties*
- *Community Partnership of Southern Arizona - Pima/Graham/Greenlee/Santa Cruz/Cochise Counties*
- *Value Options - Maricopa County*
- *Northern Behavioral Health Authority - Mohave/Coconino/Apache/ Navajo/Yavapai/Counties*

Exhibit 10

NATIVE AMERICAN FACT SHEET
FOR THE STATE OF ARIZONA

According to the 2000 U.S. Census there are 4.1 million American Indian/Alaska Natives (AI/AN) residing in the United States (alone or in combination with another race). While 4 out of 10 Indians live in western states, every state in the nation has a measurable AI/AN population. There are currently 563 federally recognized Indian tribes and approximately 245 tribes currently petitioning for federal recognition.

Each of these tribes is a distinct sovereign nation that determines its own membership (citizenship) and exercises the powers of government. The Urban Indian Health Institute estimates that 66% of the AI/AN population lives in metropolitan areas (over 2.7 million)ii The Indian Health Service contracts with 34 Urban Indian Health Clinics.

The U.S. Constitution (Article 1 Section 8) sets the foundation for the federal government's trust responsibility to Indian nations, which has been reinforced over the years through various treaties, laws, and court rulings. Despite this, AI/AN people continue to be underserved due to a lack of adequate federal funding. The Indian Health Service appropriation meets less than 60% of the need, and of that, Behavioral Health typically represents about 1% of their total budget. The Bureau of Indian Affairs continues to eliminate or cut programs due to decreased funding.

Since Indian people are also citizens of the states in which they reside, local government agencies and entities have the responsibility to serve AI/AN populations that reside in their cities, counties, or states. In states that have federally or state recognized tribes, government-to-government relationships should be fostered in ways that promote the principle of tribal self-determination. In other states, efforts should be made to reach out to Urban Indian organizations or other community-based AI/AN organizations. Cities should seek partnerships and offer contracts to Urban Indian organizations. The National Indian Child Welfare Association is available to provide assistance to cities, counties, and states seeking to develop partnerships with AI/AN communities.

Contact Information

Arizona is home to 22 federally recognized tribes. For a complete list of these tribes, please visit the Arizona Commission of Indian Affairs website at http://www.indianaffairs.state.az.us/tribes/tribes.html.

Arizona Commission of Indian Affairs

Debra Krol, Deputy Director
1400 West Washington. Suite 300
Phoenix, Arizona 85007
Phone: (602) 542-3123
Fax: (602) 542-3223
E-mail: Debra.Krol@indianaffairs.state.az.us
Website: http://www.indianaffairs.state.az.us

Inter Tribal Council of Arizona, Inc.
2214 North Central Avenue, Suite 100
Phoenix, AZ 85004
Phone: (602) 258-4822
Fax: (602 258-4825
Website: http://www.itcaonline.com/

Indian Health Services (IHS) Area Offices (*Arizona is home to three IHS Area Offices*):
Phoenix Area Indian Health Service Office (*serving AZ, NV, UT*)
Don J. Davis, M.P.H., Area Director
Two Renaissance Square
40 North Central Avenue
Phoenix, AZ 85004-4424
Phone: (602) 364-5039
Fax: (602) 364- 5042
Website:
http://www.ihs.gov/FacilitiesServices/AreaOffices/Phoenix/Index.cfm

Tucson Area Indian Health Service
(*serving southern Arizona*)
Taylor J. Satala, Area Director
7900 S. J. Stock Road
Tucson, AZ 85746-7012
Phone: (520) 295-2405
Fax: (520) 295-2602
Website:
http://www.ihs.gov/FacilitiesServices/AreaOffices/Tucson/index.asp

Navajo Area Indian Health Service (*serving AZ, NM, UT*)
John Hubbard, Jr., MPH, Area Director
P.O. Box 9020
Window Rock, AZ 86515
Phone: (928) 871-5811
Website: http://www.ihs.gov/FacilitiesServices/AreaOffices/Navajo/

Urban Indian Clinics
Native American Community Health
Center, Inc.
Michael Allison, Executive Director
3008 North 3rd Street, Suite 310
Phoenix, AZ 85012
Phone: (602) 279-5262
Fax: (602) 279-5390

Other Urban Programs
Phoenix Indian Center
Leland Leonard, Executive Director

2601 North 3rd Street, Suite 100
Phoenix, AZ 85004
Phone: (602) 264-6768
Fax: (602) 263-7822

For more information contact the National Indian Child Welfare Association at (503) 222-4044 *or* visit our website at www.nicwa.org.

[i] *The American Indian and Alaska Native Population: 2000 Census Brief. Issued February 2002. US Census Bureau*
[ii] *Urban Indian Health Issue Brief. By Ralph Forquera for the Henry J. Kaiser Foundation. November 2001*
[iii] *Level of Need Funded Study by the LNF Work Group Report II, December 1999 Indian Health Service*
4/15/2005

Exhibit 11

SUBSTANTIATION GUIDELINES

When the CPS Specialist completes an investigation and prepares a finding, the finding must be based on the following:

- Identification of the person(s) about whom the finding will be made (DEFINE WHO)
- Identification of how the person(s) about whom the finding will be made was involved (DEFINE HOW)
- Identification of what activity occurred (DEFINE TYPE OF ACT)
- Identification of the evidence used to make the finding (DEFINE PROBABLE CAUSE)

An investigation always results in a *FINDING.* The *FINDING* either *SUBSTANTIATES* abuse or neglect, or *UNSUBSTANTIATES* abuse or neglect.

SUBSTANTIATED FINDING: The CPS Specialist should propose to substantiate abuse or neglect when there is probably cause to support the finding.

UNSUBSTANTIATED FINDING: The CPS Specialist should unsubstantiate abuse or neglect when there is NOT probably cause to support the finding.

PROBABLE CAUSE: In order for there to be a substantiated finding of abuse or neglect, the CPS specialist must identify facts which provide a reasonable ground to believe that abuse or neglect occurred. The CPS Specialist does not need to prove that maltreatment definitely occurred but should have some credible evidence to support that finding.

1. DEFINE WHO

In order for there to be a substantiated finding of abuse or neglect, the event must be the result of behavior by a parent, legal guardian or custodian. A "custodian" is a person, other than the parent or legal guardian, with whom the child resides AND who assumes responsibility for the child. This could include friends, boyfriends, girlfriends, relatives, foster parents or child welfare agencies.

2. DEFINE HOW

In order for there to be a substantiated finding of abuse or neglect, the parent, legal guardian or custodian has to have:

- acted to harm the child (inflicted the harm themselves), or
- known or had reason to know that the child was at risk, or
- failed to act to protect the child from harm when the parent, legal guardian or custodian:
  - § knew that someone else was inflicting or inflicted harm, or

§ had reason to know that someone else was inflicting or inflicted harm.

3. DEFINE TYPE OF ACT

There are two major finding types which have six categories, as follows:

NEGLECT
(1) Neglect
(2) Death of a Child due to Neglect

ABUSE
3) Physical Abuse
(4) Sexual Abuse
(5) Emotional Abuse
(6) Death of a Child due to Abuse

NEGLECT

Applied Definition
The CPS Specialist should apply the legal definition to the situation under investigation by applying a series of questions using the child's age, culture and development status as a guideline for developing the answers, as follows:

1. What is the minimal level of supervision, food, clothing, shelter or medical care needed for this child based on the child's age, cultural expectations and developmental status?
2. Is this minimal level being met by the parent, legal guardian or custodian?
3. If this minimal level is not being met, how is it not being met?
4. If this minimal level is not being met, what is the substantial risk of harm that has resulted or could result if the need is not met?
5. Is the parent, guardian or custodian using substances known to create a substantial risk of harm to a child? These substances include cocaine (crack), methamphetamines, heroin, PCP, and alcohol.

Substance Exposed Newborn (SEN)
A substance exposed newborn means a child, age one or younger, who is demonstrably adversely affected by the mother's use of a dangerous drug, a narcotic drug or alcohol during pregnancy. (ARS § 8-819) A dangerous drug or narcotic drug has the same meaning as prescribed in ARS § 13-3401.

Propose to substantiate neglect based on the overall substance abuse by the parent (including prenatal exposure to a dangerous drug, narcotic drug or alcohol) when a thorough assessment of safety and risk factors associated with the home environment and parental capacity indicates that the parent is unable or unwilling to meet the newborn's basic need because of abuse and that this failure creates a substantial risk of harm to the newborn's health or welfare. Prenatal substance abuse is only one factor that should be considered in this assessment.

A thorough assessment of the safety and risk factors is key to determining whether the newborn is at substantial risk of harm, and in determining the appropriate level of intervention and services needed to improve the parenting capacity. Current practice tools to assist in completing this assessment include:

- Child Safety Assessment,
- Strengths and Risk Assessment, and
- Guide to Assessing Risk Factors for Substance Exposed Newborns.

You may also propose to substantiate neglect based on prenatal exposure to a dangerous drug, narcotic drug or alcohol when evidence confirms all of the following:

1. The Child is age one or younger.

2. There is documentation that the mother used a dangerous drub, a narcotic drug or alcohol during pregnancy. A dangerous drug or narcotic drug has the same meaning as prescribed in ARS 13-3401. Documentation may include but is not limited to:

   a. positive toxicology screen on the mother or newborn:

   b. admission of the use of the drug or alcohol by the mother including but not limited to the type, frequency and amount of drug used and the last time used:

   c. reliable written corroboration of the mother's use the drug or alcohol during pregnancy by the physician, nurse, worker, law enforcement, emergency personnel and/or other persons that have knowledge of the mother's use of the drug or alcohol:

   d. medical diagnosis of finding that the child was exposed to a dangerous drug, a narcotic drug or alcohol during pregnancy;

   e. medical interpretation that the newborn's symptoms are the result of the mother's use of a dangerous drug, a narcotic drug or alcohol ruing pregnancy; and/or

   f. other documentation including but not limited to law enforcement reports or records

3. There is a medical documentation that the mother's use of a dangerous drug, a narcotic drug or alcohol during pregnancy created a substantial risk of harm to the child's health or welfare, Substantial risk of harm includes the child being demonstrably adversely affected by the mother's use of a dangerous drug, a narcotic drug or alcohol during pregnancy.

To substantiate a finding of NEGLECT, the CPS Specialist must find probable cause that the parent, legal guardian or custodian was unable or unwilling to provide supervision, food, clothing, shelter or medical care **AND** this resulted in substantial risk of harm to the child's health or welfare.

When determining whether a child has been neglected, the CPS Specialist must consider:

- § the drug or alcohol abuse by the child's parent, guardian or custodian;
- § the use by the mother of a dangerous drug, a narcotic drug or alcohol during pregnancy if the child, at birth or within a year after birth, is demonstrably adversely affected by this use. A dangerous drug or narcotic drug has the same meaning as prescribed in ARS *§13-3401.*

It is not an act of neglect if:

- § the child suffers from a disability or chronic illness and services are unavailable to treat the child's disability or chronic illness, or
- § the child, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner for that reason alone, or
- § the parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of such medication for that reason alone.

Substantial risk of harm means actual, tangible and measurable harm or risk of harm to the child which may include physical, emotional, medical, sexual or other types of harm to the child.

PHYSICAL ABUSE
Applied Definition
The CPS Specialist must be able to document the "Who, How and Probable Cause", as well as the type. Physical Abuse includes:

- § skin bruising including bruising to the corners of the mouth which may indicated that the child was gagged.
- § pressure sores
- § bleeding
- § failure to thrive (requires medical diagnosis)
- § malnutrition (requires medical diagnosis)
- § dehydration (requires medical diagnosis)
- § burns, which may include water burns, rope burns, rug burns and other abrasions.
- § subdural hematoma (requires medical diagnosis)
- § soft tissue swelling, which may include bald patches where hair has been pulled out, bite marks and other forms of welt marks from cords or other objects.
- § injury to any internal organ (requires medical diagnosis)
- § any physical condition which imperils a child's health or welfare.

Physical Abuse is impairment of bodily function **OR** disfigurement **OR** the infliction of **OR** allowing (actual, NOT potential) physical injury. Physical injury is the impairment of a physical condition

It is not an act of physical abuse if, for that reason alone,:

- § the child, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner, or
- § the parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of such medication.

EMOTIONAL ABUSE

Applied Definition of Emotional Abuse
Reminder: This finding must be accompanied by a diagnosis and must meet the legal definition. The diagnosis must also be able to determine that the behavior is caused by acts or omissions of the parent, legal guardian or custodian.

In order for the CPS Specialist to substantiate a finding of emotional abuse there must be a diagnosis by a qualified physician, psychiatrist or psychologist of one of the following in the child:

- § Severe anxiety
- § Depression,
- § Withdrawal, OR
- § Untoward aggressive behavior,
- § **AND** there must be probable cause that this condition was caused by the acts or omissions of the parent, legal guardian or custodian.

The CPS Specialist must document the "Who, How and Probable Cause" in addition to defining the type of act.

It is not an act of emotional abuse if, for that reason alone:

- § the child, in good faith, is being furnished Christian Science treatment by a duly accredited practitioner, or
- § the parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of such medication.

Applied Definition of Sexual Abuse

1. The CPS Specialist can substantiate a finding of sexual abuse when one of the

following activities has occurred knowingly and intentionally **AND** the CPS Specialist documents the Who, How and Probable Cause.

a. Any sexual intercourse, oral sexual contact or masturbation involving any person under 18 years of age.

b. Any fondling of any child under 15 years of age, regardless whether or not they have given consent.

c. Any fondling of any child 15 years of age and over if that child has not given consent.

d. Any act involving a person under 18 years of age in pornography or prostitution, whether or not for financial gain.

2. "Sexual intercourse" means penetration into the penis, vulva, or anus by any part of the body or by any object or masturbatory contact with the penis or vulva.

3. "Oral Sexual Contact" means oral sexual contact with the penis, vulva anus.

4. Masturbation means an act of self-stimulation with any part of the body or object.

5. "Fondling" means direct or indirect touching or manipulating, whether above or under clothing, of any part of the genitals, anus or female breast, by any part of a person's body or by any object.

6. "Pornography" means any sexual activity identified in "a" through "d" above in which the child is used, employed, persuaded, enticed, induced, coerced or transported through or across state lines, whether or not there is financial gain. Pornography includes the production of visual or print medium or a live act, which includes film, photograph, video tape, negative, slide, compact disc, laser disk, computer diskette, computer tape, book, magazine, or other form of publication or photographic reproduction including such materials.

7. "Child Prostitution" means the causing, using or permitting a minor to engage in any sexual act identified in "a" through "d" above under a fee arrangement with that person or another person.

Sex Abuse includes the inflicting or allowing - A person commits sexual abuse by intentionally or knowingly engaging in sexual contact with any person fifteen or more years of age without consent of that person or with any person who is under fifteen years of age if the sexual contact involves only the female breast.

1. "Sexual contact" means any direct or indirect touching, fondling or manipulating of any part of the genitals, anus or female breast by any part of the body or by any object or causing a person to engage in such conduct.

2. "Without" consent includes any of the following:

a. The victim is coerced by the immediate use or threatened use of force against a

person or property.

b. The victim is incapable of consent by reason of mental disorder, drugs, alcohol, sleep, or any other similar impairment of cognition and such condition is known or should have reasonably been known to the defendant.

c. The victim is intentionally deceived as to the nature of the act.

d. The victim is intentionally deceived to erroneously believe that the person is the victim's spouse.

3. "Spouse" means any person who is legally married and cohabiting.

Sexual conduct with a minor - A person commits sexual conduct with a minor by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person who is under eighteen years of age.

1. "Sexual intercourse" means penetration into the penis, vulva, or anus by any part of the body or by any object or masturbatory contact with the penis or vulva.

2. "Oral sexual contact" means oral contact with the penis, vulva or anus.

Sexual Assault - A person commits sexual assault by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person without consent of such person.

Molestation of a child - A person commits molestation of a child by intentionally or knowingly engaging in or causing a person to engage in sexual contact except sexual contact with the female breast with a child under fifteen years of age.

Commercial sexual exploitation of a minor - A person commits sexual exploitation of a minor by knowingly:

1. Using, employing, persuading, enticing, inducing or coercing a minor to engage in or assist others to engage in exploitative exhibition or other sexual conduct for the purpose of producing any visual or print medium or live act depicting such conduct.

2. Using, employing, persuading, enticing, inducing or coercing a minor to expose the genitals or anus or the areola or nipple of the female breast for financial or commercial gain.

3. Permitting a minor under such person's custody or control to engage in or assist others to engage in exploitative exhibition or other sexual conduct for the purpose of producing any visual or print medium or live act depicting such conduct.

4. Transporting or financing the transportation of any minor through or across the state with the intent that such minor engage in prostitution, exploitative exhibition or other sexual conduct for the purpose of producing a visual or print medium or live act depicting such conduct.

5. "Exploitative exhibition" means the actual or simulated exhibition of the genitals or pubic or rectal areas of any person for the purpose of sexual stimulation of the viewer.

6. "Producing" means financing, directing, manufacturing, issuing, publishing, or advertising

for pecuniary gain.

7. "Sexual conduct" means actual or simulated"

a. Sexual intercourse including genital-genital, oral-genital, anal-genital or oral-anal, whether between persons of the same sex or opposite sex;

b. Penetration of the vagina or rectum by any object except as one does as part of a recognized medical procedure;

c. Sexual bestiality/

d. Masturbation for the purpose of the sexual stimulation of the viewer;

e. Sadomasochistic abuse for the purpose of sexual stimulation of the viewer;

f. Defecation or urination for the purpose of sexual stimulation of the viewer.

8. "Simulated" means any depicting of the genitals or rectal areas which give the appearance of sexual contact or incipient sexual conduct.

9. "Visual or print medium" means:

a. Any film, photograph, video tape, negative, slide, compact or laser disk, computer diskette or computer tape; or

b. Any book, magazine or other form of publication or photographic reproduction containing or incorporating in any manner any film, photograph, video tape, negative, slide or computer generated image of a minor.

Sexual exploitation of a minor

1. A person commits sexual exploitation of a minor by knowingly recording, filming, photographing, developing or duplicating any visual or print medium in which minors are engaged in exploitative exhibition or other sexual conduct.

2. Distributing, transporting, exhibiting, receiving, selling, purchasing, possessing or engaging in any visual or print medium in which minors are engaged in exploitative exhibition or other sexual conduct.

Incest - Persons who are fifteen or more years of age and who are within the degree of consanguinity, within which marriages are declared by law to be incestuous and void, knowingly intermarry with each other or who knowingly commit fornication or adultery with each other are guilty of incest.

Child Prostitution - A person commits child prostitution by knowingly:

1. Causing any minor to engage in prostitution;

2. Using any minor for purposes of prostitution;

3. Permitting a minor under such person' custody or control to engage in prostitution;

4. Receiving any benefit for or on account of procuring or placing a minor in place or in charge or custody of any person for the purpose of prostitution;

5. Receiving any benefit pursuant to an agreement to participate in the proceeds of prostitution of a minor;

6. Financing, managing, supervising, controlling or owning either alone or in association with others prostitution activity involving a minor;

7. Transporting or financing the transportation of any minor through or across the state with the intent that such minor engage in prostitution;

8. "Prostitution" means engaging in or agreeing or offering to engage in sexual conduct with any person under a fee arrangement with that person or any other person;

9. "Sexual conduct" means sexual contact, sexual intercourse, or oral sexual contact, or sadomasochistic abuse;

10. "Sadomasochistic abuse" means flagellation or torture by or upon a person who is nude or clad in undergarments or in revealing or bizarre costume or the condition of being fettered, bound or otherwise physically restrained on the part of one so clothed.

Exhibit 12

Relative Search Best Practice Guide

Chapter 1 Introduction

The purpose of this guide is to assist social service agencies in performing relative searches when a child is removed from the home.

A. Benefits of Relative Placement

Relative placements provide for a child's need for safety, well-being and permanency, and can play a pivotal role in achieving reunification. The federal Children and Family Service Reviews found that placements with relatives result in more frequent contact between the children in foster care and their parents. Factors associated with timely reunification include child visitation with parents and siblings. Relative placement promotes timely reunification, and placement stability, as children placed with relatives experience fewer placement disruptions than children placed with non-related foster parents. Preserving the child's existing connections and relationships to familiar adults is achieved with relative placements. In many instances, relative placement preserves the continuity of care, relationships, culture and environment that are essential to a child's overall well-being. Relative placement maintains the family system as the primary provider of care for the child, as day-to-day decisions continue to be made by adults that the child already knows and understands to be their family. The child continues to participate in family celebrations, traditions, vacations and activities. *(U.S. Department of Health and Human Services Administration for Children and Families, 2001-2004 Children and Family Service Review Findings)*

Relative placements facilitate the development of positive self-image, self-esteem, identity, and consequently, may help children to avoid the double jeopardy of feeling abandoned by both parents and family. Children placed in relative care continue to feel a sense of belonging, worth, history and value to others.

(Excerpts from Relatives Raising Children: An Overview of Kinship Care, Joseph Crumbley & Robert L. Little, (1997), Child Welfare League of America)

B. Definition of Relative

Family members are the first placement consideration for children who are not able to live with their parents or guardians. Relative means a person related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact. For an Indian child, relative includes member's of the extended family as defined by the law or custom of the Indian child's tribe or, in the absence of such law or custom, shall be a person who has reached the age of eighteen and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent. *(Indian Child Welfare Act of 1978, United States Code, Title 25, Chapter 21, Section 1903)*

D. Family-Centered Practice

The values and principles of family-centered practice provide a framework for conducting relative searches. The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities. Social workers partner with families to use their expert knowledge throughout the decision-making process and provide individualized, culturally-responsive and relevant services for each family. Family-centered interventions such as Family Group Decision-Making assist in mobilizing resources to maximize communication, shared planning and collaboration among the several agency and community systems that are directly involved with the family. Families are engaged in ways relevant to the situation and sensitive to the values of their culture. The assessment protocols of this approach look at families' capabilities, strengths and resources throughout the life of the case and are continuously assessed and discussed. *(National Child Welfare Resource Center for Family-Centered Practice, Summer 2000)*

Chapter 2 Conducting a Relative Search

The process of conducting a relative search includes the elements of gathering and documenting information, assessing the information, consulting and making a placement recommendation based on the best interests of the child. The agency must document the reasons the specific family was selected.

Best practice includes:

- Identification of maternal and paternal relatives as soon as the child enters foster care
- Consideration of relatives as potential caregivers any time the child enters foster care
- Consideration of relatives as caregivers when it is necessary for the child to move from the current foster home to a new foster home
- Consideration of relatives when the agency is no longer considering reunification as the permanency plan for the child, such as in the case of :
- Transfer of permanent legal and physical custody
- Adoption

And, as long as the child remains in foster care, the agency will review the appropriateness of renewing relative search efforts during the annual permanency review hearings. Children ordered into long-term foster care with non-related foster parents may achieve permanency with relatives because of the renewed relative search efforts.

A. Identifying and Contacting Relatives

The most valuable resources in identifying, locating and engaging family members are the parents or guardians, the child, the child's tribe, relatives and kin themselves, previous foster parents, guardians ad litem and other professionals that have past or current experience with the family.

The agency must begin the search for relatives without delay. This means that as soon as the agency has knowledge of a need for out-of-home placement they must begin efforts to identify

maternal and paternal family members who can safely care for the child, and must continue the search for six months following the child's first placement, even if the child's current placement is with a relative. After six months, the agency may continue the search if the agency determines that it is in the best interests of the child or if the court orders it. If the child returns home and later returns to foster care the local agency must renew the search for relatives who may be available as foster care providers.

The agency must make special efforts to recruit a foster family from among the child's relatives. The special efforts that the agency must make include:

- Asking the child, the child's parents or guardians, and the child's guardian ad litem, who the child's relatives are, and preferences regarding which relative should be considered for placement
- Requesting that the child's tribe provide the names of the child's extended family in accordance with the Indian Child Welfare Act, United States Code, Title 25, Chapter 21, Section 1915. The local agency must defer to tribal judgment as to suitability of a relative's home when the tribe has intervened pursuant to the Indian Child Welfare Act
- Contacting relatives and sharing only information necessary for them to consider possible placement and requesting names of other relatives
- With the written consent of the parent or guardian for release of information about the child, or by order of the court, consulting with: (1) persons, other than those the local agency, providing services to the child or the child's family; and (2 other persons who know the child's family.

Reasonable and Comprehensive Efforts

To be comprehensive, the agency must identify and contact both:

- Immediate and extended family members, and
- Maternal and paternal relatives.

The relatives that should be identified and contacted include:

- Grandparents
- Aunts and uncles
- Great grandparents
- Great aunts and uncles
- Adult siblings
- Other relatives or individuals the family considers important
- Individuals who have a significant relationship with the child
- Previous foster parents for the child

Fathers and Locating Paternal Relatives

Identifying and notifying fathers early in the process is important for children who are in foster care. Working with fathers will lead to locating paternal relatives who may become a placement resource or provide support for the family. When a child is in out-of-home placement, the responsible social services agency shall make diligent efforts to identify, locate and where appropriate, offer services to both parents of the child. If a non-custodial parent or non-adjudicated parent is willing and capable of providing for the day-to-day care of the child, the

agency may seek authority from the custodial parent, or the court, to have that parent assume care of the child. If the parent is not an adjudicated parent, the agency shall require the non-adjudicated parent to cooperate with paternity establishment as part of a case plan.

For American Indian children, the local social services agency, private child-placing agency, the court, petitioner, or any other party, has reason to believe that a child who is a subject of an adoptive placement proceeding, is or may be, an Indian child but the father of the child is unknown, the agency or person should provide to the tribe believed to be the Indian child's tribe, information sufficient to enable the tribe to determine the child's eligibility for membership and to assist in possible identity, tribal affiliation, or location of the birth father.

Diligent efforts to identify, locate and engage fathers include:
• Talking with mothers, relatives, kin and others
• Talking with the child, when appropriate
• Consulting and working with the child's tribe
• Following up on leads
• Documenting efforts and consult with the county attorney's office
• Documenting when agency efforts are not possible (i.e., parent is deceased)
• Using resources, tools, including
• Phone book/online directory
• Court records
• Social service records
• Birth certificate
• Department of Corrections.
• U.S. military armed forces (air force, army, marines, navy)

The National Family Preservation Network provides some practice recommendations for working with fathers. For example:

- Family-centered practice includes both the mother and the father.
- Outreach programs are critical to engaging fathers.
- For fathers to comply with case plans, they need services designed specifically to meet their needs.
- Child welfare programs need to establish links with employment programs, as employment is a predictor of an absent father's involvement with his children
- How a worker communicates with parents impacts the outcome of services provided. Workers need to use empowering and validating communication skills.
- Attitudes, beliefs and stereotypes about fathers need to be addressed.
- Fathers' strengths should be identified and utilized in case planning.

When Parents Object to Relative Search
The responsible social services agency must consider the request of a parent to not contact relatives or to not contact specific relatives.

If a child's parent objects to the search for relatives, the local agency must, without contacting

relatives, evaluate and address the parent's concerns by considering:

- The child's and the parent's or guardian's preferences about relatives and the reasons for those preferences
- The child's current relationships with relatives and impact of placement with people the child does not know
- Whether there are other relatives who may be contacted if there are specific relatives the parent does not want contacted
- Whether any relatives have offered to care for the child
- Whether placement with relatives would interfere with the parent's ability to follow a case plan
- The tribe's position on contacting the relatives, in the case of an Indian child.

When a child's parent objects to the search for relatives, the agency may not contact the child's relatives unless ordered to do so by the court. Ask the parent about their concern and consider the individual circumstances.

Cultural Considerations in Identifying and Finding Relatives

The tradition of relative/kin caring for children is part of all cultural, racial an socioeconomic communities. How kinship care is understood and experienced may vary from community to community, from family member to family member, and parent to parent.

During the conversation with parent(s) about identifying and locating relatives, the worker should be mindful that culture is one of the lenses that we use to help us interpret, interact and respond to others and situations. Culture is defined as a system of share beliefs, values, customs and behaviors that members of society use to cope and interact with their world and with one another and that are transmitted from generation to generation from learning.

Culture impacts our communication, the assumptions we make and our relationships. From the very beginning, the social worker needs to be knowledgeable of the family's culture and what that means for being able to effectively communicate and develop a relationship with them.

After locating relatives, workers should be mindful of the role culture may plan in relatives' perception of what the relative is being asked to do. Concepts of ethnographic interviewing may help guide the worker in this conversation. Ethnographic interviewing is a method to meet with a person of another culture in order to begin understanding his or her worldview, beliefs and life situation. Ethnographic interviewing helps a person understand another culture while avoiding stereotypes. Workers should also be mindful of fully and openly discussing options, roles and responsibilities to help alleviate any misunderstandings between the relative and the worker. A relative may be interested in providing temporary care, however, decline initially out of respect for the parents. They may feel that by giving the parent more time the parent will be able to resolve the issues that brought their children into foster care on their own. Kinship care supports the transmission of a child's culture, ethnic and family identity and legacies, components vital to the child's psychological development and emotional integrity. *(Shondra Jackson, Black Administrators in Child Welfare, Inc.)*

The following are some questions to consider when beginning a relative search:

- What are the roles, hierarchy and authority of relatives in the raising of children, in both the presence and absence of parents?
- What is the family's hierarchy of responsible relatives (e.g., godparents, grandparents, siblings) in the temporary or permanent absence of parents?
- Does the family practice or reject formal or informal placement of relative's children (e.g., adoption, guardianship)?
- How do gender and cultural traditions affect the family's decision-making structure, child-rearing practices and selection of a family spokesperson?
- What has been/is the family's experience and attitude towards social service professionals and institutions?
- How have environmental conditions or changes affected the family's
- socioeconomic stability, child-rearing practices and family members (e.g., unemployment, migration, housing, rural or urban settings, language)? *(Relatives*
- *Raising Children: An Overview of Kinship Care, Crumbley and Little, 1997)*

Chapter 3 Supervisor's Role in Supporting Relative Search Efforts

Supervisors have an important role in ensuring that reasonable and comprehensive relative searches are conducted in all cases. Supervisors can do this by communicating the policies and values of the agency, and supporting current research and best practice in relative searches.

Some overall practice areas to consider:

- What factors may be impacting staff's ability to conduct a comprehensive relative search?
- What assessment process is staff using to make placement decisions?
- What are the reasons for not placing with relatives?
- Is staff documenting relative search efforts?
- How is quality assurance achieved in this practice area?

An individual social worker's attitudes, beliefs and their own family experience can influence the relative search process. For example, if a social worker places a high value on children being raised within their family system, they will be determined to find a relative that can care for the child safely and meet the child's needs. The social worker will consider both the immediate needs of the child and the life long needs of a child. The worker understands that children who are placed outside of their family system will be raised differently than had they grown up with relative caregivers. They realize that placement decisions early in the case may have life long implications for the child. Supervisors need to have a clear concept of what knowledge, skills, and abilities workers should possess in order to conduct relative searches. Supervisors can assist workers in exploring how their own bias may enter into their practice.

Example #1: A social worker complains that the family has not been involved in the child' life before or has failed to demonstrate an interest in the child since the agency became involved and approaches the relative with suspicion or judgment.

Supervisor Response: The supervisor encourages the worker to talk with the relative about how the agency makes placement decisions for children and the worker's need t know more about their relationship with the child. Unknown to the worker, the relative I interested in developing a relationship with the child but had a falling out with the parent.
The supervisor takes the opportunity to explain that the absence of a close relationship between the child and relative may be considered as one of the factors in determining placement decision but should not be the sole reason.

Example#2 : A social worker has developed a close working relationship with the foster parents. In the process of jointly caring for the child and through direct observations o the foster parents, the social worker knows that the foster parent has the capacity to meet the needs of the child. So when a relative is identified, it is difficult for the social worker to believe that an unknown relative can meet the same standard of care they have observed in the foster home. The social worker is also concerned about moving the child to another home since the child has attached to the foster parents, the family situation is stable and the child's needs are being met. The foster family has expressed an interest in adopting the child. The social worker is reluctant to place the child with the relative.

Supervisor Response: The supervisor meets with the social worker to discuss the out-of home placement plan for the child and the results of the relative search efforts. The supervisor listens to the reasons the social worker presents for continuing the child's placement with the current foster parents and reasons for not placing with the child's relative. Together they answer questions such as: Does the relative meet foster care licensing requirements? Can the relative safely care for the child? Is the relative willing to maintain the relationship the child has developed with the foster family? How could the foster family help the child accept the relative as a primary caregiver? What would be an appropriate transition plan to the relative's home? Can the relative meet the needs of the child? If the relative was offered the same level of support and services that the current foster family is receiving, could they meet the needs of the child?
In these situations, supervisor's can provide objectivity and balance to the placement decision-making process. Permanent placement decisions in these cases can be difficult. Considering the life long needs of a child is just as and may be more important than meeting the child's immediate needs. Overall, supervisors can encourage workers to improve practice in conducting relative searches by providing timely feedback.

Here are some questions to consider when assessing the worker's knowledge, skills and abilities to work with relatives:

- Does the worker have knowledge of the requirements for conducting a relative search?
- Does the worker have knowledge of the best practices for conducting a relative search?
- Does the worker have the tools they need to identify relatives?
- Does the worker have the skills to locate maternal and paternal relatives?
- Does the worker have the knowledge of the family's cultural concept of family?
- Does the worker have the skill to engage relatives?

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Exhibit 13

State of Arizona
Administration for Children, Youth & Families

Family Foster Home Care Rates and Fees Schedule

Rates effective July 1, 2005

Licensed Foster Home Rates (Non-Relative and Kinship Foster Care) Service Group: Foster Care

Service Type Category	Service Type Description	Age Range	Daily Rate	Daily Clothing Allowance	Daily Personal Allowance	Daily Total
FAM FHM DAY/ Basic	Foster Care	0-12 mos.	$21.87	$0.53	$**2.10***	$24.50
FAM FHM DAY/ Basic	Foster Care	1-2 years	$21.87	$0.53	$**0.95****	$23.35
FAM FHM DAY/ Basic	Foster Care	3-5 years	$21.87	$0.53	$0.10	$22.50
FAM FHM DAY/ Basic	Foster Care	6-11 years	$21.87	$0.79	$0.33	$22.99
FAM FHM DAY/ Basic	Foster Care	12-18+ years	$24.13	$1.02	$0.72	$25.87
Rates for children approved at higher levels of care.						
SP2 Level	Foster Care Special 2	0-12 mos.	$26.13	$0.53	$**2.10***	$28.76
SP2 Level	Foster Care Special 2	1-2 years	$26.13	$0.53	$**0.95****	$27.61
SP2 Level	Foster Care Special 2	3-5 years	$26.13	$0.53	$0.10	$26.76
SP2 Level	Foster Care Special 2	6-11 years	$26.13	$0.79	$0.33	$27.25
SP2 Level	Foster Care Special 2	12-18+ years	$26.13	$1.02	$0.72	$27.87
SP3 Level	Foster Care Special 3	0-12 mos.	$33.26	$0.53	$**2.10***	$35.89
SP3 Level	Foster Care Special 3	1-2 years	$33.26	$0.53	$**0.95****	$34.74
SP3 Level	Foster Care Special 3	3-5 years	$33.26	$0.53	$0.10	$33.89
SP3 Level	Foster Care Special 3	6-11 years	$33.26	$0.79	$0.33	$34.38
SP3 Level	Foster Care Special 3	12-18+ years	$33.26	$1.02	$0.72	$35.00
PAR THR	FC + Parent Therapist	0-12 mos.	$39.72	$0.53	$**2.10***	$42.35
PAR THR	FC + Parent Therapist	1-2 years	$39.72	$0.53	$**0.95****	$41.20
PAR THR	FC + Parent Therapist	3-5 years	$39.72	$0.53	$0.10	$40.35
PAR THR	FC + Parent Therapist	6-11 years	$39.72	$0.79	$0.33	$40.84
PAR THR	FC + Parent Therapist	12-18+ years	$39.72	$1.02	$0.72	$41.46

***For diapers and formula **For diapers**

Daily rates are determined by the age of the child on the first day of the month.

Unlicensed Kinship Foster Care (Relative Providers)

Service Group: Foster Care

Service Type	Service Type Description	Age Range	Daily Clothing Allowance	Daily Personal Allowance	Daily Total
Kinship Foster Care (Unlicensed Relative)	URE	0-12 mos.	$0.53	$2.10*	$2.63
		1-2 years	$0.53	$0.95**	$1.48
		3-5 years	$0.53	$0.10	$0.63
		6-11 years	$0.79	$0.33	$1.12
		12-18+ years	$1.02	$0.72	$1.74

*For diapers and formula **For diapers

Unlicensed Non-Relative Providers

Service Group: Foster Care

Service Type	Service Type Description	Age Range	Daily Clothing Allowance	Daily Personal Allowance	Daily Total
Unlicensed Non-Relatives	URN	0-12 mos.	$0.53	$2.10*	$2.63
		1-2 years	$0.53	$0.95**	$1.48
		3-5 years	$0.53	$0.10	$0.63
		6-11 years	$0.79	$0.33	$1.12
		12-18+ years	$1.02	$0.72	$1.74

*For diapers and formula **For diapers

Auxiliary Payments and Special Allowances/Supplemental Financial Supports

Service Group: Allowances

Service Type	**Service Type Description**	**Uses, Maximum Amounts and Qualifiers Approval levels are designated in CHILDS.**
EMRG CLTH ALLOW	Emergency Clothing	$300 maximum per state fiscal year. Independent Living Subsidy program youth are *not* eligible for this allowance
EMRG CLTH EXTRA	Emergency Clothing - Extra	$200 maximum per state fiscal year. (examples: Fire, Flood, Theft) Independent Living Subsidy program youth are *not* eligible for this allowance.
BOOKS/EDUCATION	Books Education Expenses	$165 maximum per school year for *all dependent children.* For books, supplies, course fees, student services and physical education fees/ equipment. May be approved for special pre-school and college level, technical and vocational classes.
SUPP SCH TUIT	Supplemental Extra School Tuition and Fees	$165 maximum per session. For use during summer sessions or interim sessions at year round schools.
GRADUATION	Graduation Expenses	$220 maximum. Available for High School only for cap, gown, ring, yearbook, and other graduation related fees.
SPECIAL NEEDS	Special Needs Allowance	$45 maximum per state fiscal year. Available to assist foster parents with expenses such as holidays, birthdays, and special occasions. Independent Living Subsidy program youth are *not* eligible for this allowance.

DAY CAMP	Day Camp	$350 maximum fiscal per year for day camp For use during summer sessions or interim sessions at year round schools. This allowance is available only to children in licensed and unlicensed (kinship and non-relative) foster homes.
OVERNIGHT CAMP	Overnight Camp	$550 maximum fiscal per year for combination of Day and Overnight Camp **or** for family vacations for children in licensed and non-licensed (kinship and non-relative) foster homes. For use during summer sessions or interim sessions at year round schools**.** This allowance is available only to children in licensed and unlicensed foster homes. Requires Assistant Program Manager approval.
DIAPERS-SPECIAL	Diapers - Special	$125 maximum per month. This allowance must be authorized monthly. Available with medical documentation for children who require additional funds for diapers.
FORMULA-SPECIAL	Special Formula	Medically prescribed for children with certain medical conditions that are not covered by CMDP or are not eligible for WIC program.

Auxiliary Payments and Special Allowances/Supplemental Financial Supports are available to licensed family foster care providers and unlicensed kinship and non-relative providers.

Exhibit 14

Family Advocacy Office Policy

Legal Basis: A.R.S. §8-828 establishes the Family Advocacy Office within the DES Director's Office. Pursuant to Section B(1), the Office is mandated, upon request, to immediately review the removal of a child before a petition for dependency is filed.

Policy: The Family Advocacy Office (FAO) shall, upon request of a parent, guardian or custodian, review the removal of a child from that parent, guardian or custodian before the Department files a dependency petition. This review shall evaluate all the facts and circumstances that indicate imminent harm or risk of imminent harm and need for removal. Alternatives to the child's removal shall also be considered.

The FAO shall accept for review all requests by the parent, guardian or custodian received within 72 hours of the date and time that the Temporary Custody Notice (TCN) was served.

Decision Making Guide

When determining if the child was suffering or would imminently suffer abuse or neglect and emergency intervention was required to ensure the safety of the child, the Family Advocacy Specialist (FAS), through review and as a participant in the Removal Review Team Conference, shall determine whether the facts and circumstances of the child's removal meet any one of the following:

- no caretaker is present and the child cannot care for him or herself or other children in the household;
- a child has severe or serious non-accidental injuries or another condition that requires immediate medical treatment;
- a child requires immediate medical treatment for a life-threatening medical condition or a condition is likely to result in impairment of bodily functions or disfigurement, and the child's caretaker is not willing or able to obtain treatment;
- a child is suffering from nutritional deprivation that has resulted in malnourishment or dehydration to the extent the child is at risk of death or permanent physical impairment;
- the home environment has conditions that endanger the child's health or safety, such as human or animal feces, undisposed garbage, exposed wiring, access to dangerous objects, or harmful substances that present a substantial risk of harm to the child;
- a doctor or psychologist has determined that the child's caretaker is unable or unwilling to provide minimally adequate care;
- the physical or mental condition of the parent, guardian or custodian endangers the child's health or safety;
- a doctor or psychologist has determined that the child's caretaker has emotionally damaged the child; the child is exhibiting severe anxiety, depression, withdrawal, or aggressive behavior due to emotional damage; and the caretaker is unwilling or unable to

seek treatment for the child;
- there is reason to believe that a caretaker has engaged in sexual conduct with the child, or allowed the child to participate in sexual activity with others; and/or
- a family assessment identifies other critical circumstances that place a child at imminent risk of harm requiring removal.

In determining whether alternatives to the child's removal from the home were considered, the FAS shall look for documentation or information that one or more of the following occurred:

- additional safeguards or resources were considered and/or provided so the child could remain in the home;
- assistance was provided to the parent, guardian, or custodian in identifying a relative or friend who can care for the child temporarily during the investigation;
- assistance was provided to the parent, guardian, or custodian in identifying a community placement for the child, if available;
- assistance was provided to the parent, guardian, or custodian and child to leave the home and go to a safe environment; and/or
- voluntary foster care placement for the child was offered.

To determine if continued out-of-home placement is needed, each of the following should be considered:

- returning the child to the home with no services or intervention;
- returning the child to the home with additional safeguards or services in place, with or without a dependency petition;
- assisting the parent, guardian or custodian in placing the child temporarily with a relative or friend with or without services;
- placing the child with a relative and filing a dependency petition; and/or
- placing the child in voluntary foster care placement.

Implementation and Procedures Guide

To initiate the review process, the FAS shall:

- receive request for a review of the child's removal, routed through the Family Advocacy Office Call Screener;
- determine if the request was made by the parent, guardian or custodian within 72 hours of the date and time that the TCN was served (if this criteria is met, proceed to the next step);
- collect additional information from the person requesting the review, and participate as a member of the Removal Review Team Conference.

To prepare for the review process, the FAS shall:

- immediately review the Custody Notices window to determine the date and time the

Temporary Custody Notice (TCN) was served to the parent, guardian or custodian. If this information is not available in CHILDS, the FAS shall contact the CPS Specialist or Supervisor to obtain the information;

- contact the CPS Specialist or Supervisor to ascertain if a Removal Review Team Conference is necessary, and, if necessary, whether the Conference has been held. If the Conference was held, discuss the reasons for the removal and alternatives to removal that were considered;

- request to be included in the Removal Review Team Conference if it has not been held, for purposes of obtaining necessary information to complete the review. The Removal Review Team Conference must include a licensed professional with an advanced degree in social work, or in another comparable human services profession with clinical orientation and with two years of related experience;
- view the Removal Review and Review Findings Detail windows to assist with the review;
- consider all information provided by the requester, CPS Specialist and Supervisor, and information documented in the CHILDS case record that pertain to the child's removal and prior CPS report and history, and any other information provided within the review period; and
- within two hours from receipt of the request for a review or within one hour of the Removal Review Team Conference, complete the review of the child's removal.

To complete a review of the removal of the child, the FAS shall:

- determine if the CPS Specialist:
    - documented or described a circumstance that indicated imminent harm,
    - considered alternatives to the child's removal, and
    - had reason to believe the removal was clearly necessary to prevent abuse or neglect;
- contact the requester (parent, guardian or custodian), as necessary, to clarify information gathered;
- complete the FAO Child's Removal Summary;
- discuss the conclusions and any recommendations of the review and FAO Child's Removal Summary with the Manager, and if necessary, the Attorney General's Office;
- participate in the Removal Review Team Conference;
- verbally inform the requester (parent, guardian or custodian) of the outcome within two hours of completing the review;
- send written confirmation of the outcome of the review of the child's removal to the requester within five working days of completing the review; and
- submit the completed FAO Child's Removal Summary, final Management Contact Case Note, copy Review Outcome Notification letter and collected case documentation, to the Manager within two working days of receipt from the FAS.

Documentation Guide

Using the CHILDS Case Notes window designated as Management Contact type, document within two hours of occurrence:

- the request for review of the child's removal;
- the outcome and any recommendations of the review;
- all other activities described in the Implementation and Procedures Guide; and
- the outcome of the Removal Review Team Conference.

File the following documents in the Family Advocacy Office hard copy record:

- FAO Child's Removal Summary; and
- Copy of the Review Outcome Notification letter to the requester.

Exhibit 15

Family-Centered Strengths and Risks Assessment
Introduction and Instructions

Assessment of families in which child maltreatment (abuse and neglect) is alleged or known to have occurred requires expert interviewing and communication skills. Skilled CPS Specialists gather comprehensive information to assess child safety and risk of future harm using techniques that engage the family and nurture trust, self-assessment, motivation, and positive change. Family-centered assessment engages children and caregivers in the assessment process through open-ended, non-confrontational questions and active listening techniques. This assessment approach is recognized as a best practice guide by child welfare professionals because of the following benefits to children, families, CPS Specialists, and other team members:

- By developing trust and reducing defensiveness, family-centered assessments produce more comprehensive and accurate information about the family's history and functioning.
- As a result of the more thorough and accurate information gathered, CPS Specialists are able to more accurately assess child safety and risk of future harm.
- More accurate assessments improve the team's decision making around the level and type of intervention needed.
- Family-centered assessments encourage children and caregivers to identify their own strengths and needs, leading to intervention plans that are individualized and relevant to the child and family.
- By gathering information on strengths as well as needs, family members gain hopefulness and motivation, increasing the likelihood that goals will be achieved, and achieved more quickly.

Engaging families in family-centered assessment and case planning improves child safety, promotes early achievement of permanency, and increases child and family well-being.

The Family-Centered Strengths and Risks Assessment package includes three inter-related documents to lead CPS Specialists through a conscientious and planful assessment process that will result in sound decision making at key points of a case, including the development of an effective case plan or aftercare plan. These documents include:

- The ***Interview and Documentation Guide*** is designed for use in the field and provides recommended family-centered interview questions and space to take notes;
- The ***Strengths and Risks Assessment Rating Reference*** lists specific indicators of strengths/protective factors and each risk level to be considered when determining the current level of risk; and

- The ***Strengths and Risks Assessment Tool*** guides the CPS Specialist to consider each of the research-based factors associated with the risk of maltreatment (abuse and neglect), assists the CPS Specialist to determine the overall level of risk, and provides a location to document the results of the risk assessment.

Completion of the ***Strengths and Risk Assessment*** is required. Use of the ***Interview and Documentation Guide*** provides the best means to complete this assessment.

USING THE INTERVIEW AND DOCUMENTATION GUIDE

The family-centered ***Interview and Documentation Guide*** is intended for use in the field, during interviews with caregivers and children. The Guide recommends questions to engage the family in the interview and the assessment process. Using the Guide, CPS Specialists gather and record information related to each risk factor identified in the ***Strengths and Risks Assessment Tool.*** CPS Specialists use the information obtained during the interviews to determine the level of risk to each child in the family, and to develop an individualized case plan or aftercare plan with family input.

It is not an expectation, nor is it recommended, that every family be asked every question. CPS Specialists should select questions that feel natural to them, ensuring that enough information is gathered on each area (domain) to allow accurate completion of the ***Strengths and Risks Assessment Tool.*** If it is likely the family will require in-home or out-of-home CPS services, the CPS Specialist should ask more questions to fully explore areas of risk and develop an effective case plan.

Defer to your District Operating Procedures and/or Interagency/Law Enforcement Protocols when joint CPS/law enforcement interviews for specific types of reports are required; for example, reports involving sexual abuse or a criminal investigation is in progress or anticipated. It may not be appropriate to use the ***Interview and Documentation Guide*** to complete the family interviews. However, you still need to gather sufficient information to assess each area (domain) of the family's life.

To engage caregivers and children who may be defensive, angry, and resistive, keep the following in mind:

- Be aware of your personal values and do not let them get in the way of conducting a meaningful assessment.
- During the assessment process, let the family tell the story the way that they see it.
- A supportive relationship must be developed before a person's coping methods can be challenged.
- It is best not to try to create or force a sense of responsibility during the assessment phase.

- A person's dignity may be the only thing that is holding them up; so, be non-judgmental and comment on strengths during the assessment.
- Families come from very different perspectives and cultures. During the assessment, listen and learn how the family perceives life, parenting, and safety of their children. Don't attempt to change this perspective during the assessment phase.

Lifelines, EcoMaps, and Genograms are valuable tools for learning about a family. If CPS Specialists are familiar with these tools, they should use them.

USING THE STRENGTHS AND RISKS ASSESSMENT TOOL AND RATING REFERENCE

The ***Strengths and Risks Assessment Tool*** assists CPS Specialists to apply the information gathered during the family-centered interviews to:

- make a determination of overall risk to children in the family;
- make appropriate decisions about the level and type of intervention required by a family; and
- document that these decisions are based on a research-based process, using factual and observable indicators of risk and strengths/protective factors.

The Tool includes five sections and 17 risk factors that are associated with child maltreatment (abuse and neglect). The five sections are:

- **Baseline Level of Risk --** considers the **prior history** of child abuse and neglect and the current incident of abuse and/or neglect Information regarding prior reported or unreported abuse or neglect history, including history from Arizona and other states, law enforcement reports, medical records, etc. should be reviewed. Include victimization of any child and describe injuries or accidents related to the child abuse and neglect, dangerous acts, neglectful conditions, extent of sexual abuse and developmental and/or emotional harm to the child. Chronic, recurrent episodes of abuse and neglect identifies a family pattern of child maltreatment (abuse and neglect) rather than an isolated incident. Include the severity and effects on the child when considering the **current** child abuse and/or neglect. **Remember that emotional abuse can only be diagnosed by a medical doctor or psychologist. Emotional abuse is defined as the infliction of or allowing another person to cause serious emotional harm to a child as evidenced by the child's severe anxiety, depression, withdrawal or untoward aggressive behavior.**

- **Child Vulnerability --** considers the childs special needs and ability to self protect. The level of susceptibility to child abuse and neglect is related to the child's vulnerability, ability to protect him/herself, special needs (i.e., developmental delays), behavioral problems and past victimization. Practice and research indicate younger children are more likely to be severely harmed as a result of child maltreatment (abuse and neglect). Assess each child separately. Use the most vulnerable to develop the level and type of intervention.

- **Caregiver Characteristics --** considers the past and present parenting functioning of the child's caregiver. These risk factors include substance abuse; parental impairment; parenting skills/child expectation; parent-child relationship; history of violence by caregiver-protective capacity of the non-abusive caregiver; recognition of the problem and motivation to change; history of child maltreatment of the caregiver as a child; and level of cooperation. These risk factors are predictive of future risk of harm. Gather "reliable" information about each risk factor and, whenever possible, corroborate the information collected.

- **Familial, Social and Economic Factors --** considers factors such as family stress, social support, economic resources and domestic violence. The presence or absence of these factors has been shown to impact the level of risk of child abuse or neglect in families.

- **Overall Level of Risk --** considers the Baseline Level of Risk and the ratings of the remaining 15 factors to reach a determination of the Overall Level of Risk to the most vulnerable child in the family. Briefly describe the risk factors and strengths/protective factors that led to the Overall Level of Risk.

The Tool requires the CPS Specialist to consider risks and strengths/protective factors in relation to the 17 factors. The list of strengths/protective factors is not an inclusive list. You may consider other strengths/protective factors not listed. The Baseline Level of Risk and ratings for the remaining 15 factors are then considered together to reach a determination of the Overall Level of Risk. **A risk factor may be mitigated by a protective factor** by:

- reducing the child's physical or emotional vulnerability;
- increasing internal or social prohibitions against child abuse and neglect;
- providing support and assistance from extended family and the community;
- increasing the parent's understanding of the child's needs; and
- reducing stress to provide for the family's basic needs.

Completing the Strengths and Risks Assessment Tool

To determine a level (rating) of risk for each factor and the overall level of risk, complete the following steps in consultation with the supervisor:

• Review the ***Interview and Documentation Guide*** and Case Notes for pertinent information gathered during the family-centered interviews.

• Review all other available information, including police and medical reports, information gathered during interviews with collateral sources, etc.

• Using the ***Strengths and Risks Assessment Rating Reference***, find the level (rating) of risk that best describes the family's prior abuse and neglect history (Factor 1).

• Using the ***Strengths and Risks Assessment Rating Reference***, identify the family's strengths/protective factors that are related to the family's prior abuse and neglect history.

• Evaluate the effect of the strengths/protective factors on the identified level of risk associated with the family's prior abuse and neglect history. If the protective factors mitigate (decrease) the level of risk, lower the level of risk for that factor. If the protective factors are not sufficient to mitigate the level of risk, do not lower the level of risk for that factor. Rate each risk factor as N (No Risk), L (Low Risk), ML (Moderately Low Risk), M (Moderate Risk), MH (Moderately High Risk) or H (High Risk).

• Document the assessed level of risk on the ***Strengths and Risks Assessment Tool.***

• Repeat these steps for each of the 17 risk factors.

• Consider the rating for the Baseline Level of Risk and each of the remaining 15 risk factors to determine the Overall Level of Risk. The more risk factors rated as Moderately High or High Risk, the more likely the Overall Level of Risk is increased for the child.

USING THE STRENGTHS AND RISKS ASSESSMENT FOR DECISION MAKING AND CASE PLANNING

When risk factors are balanced by strengths or protective factors, CPS may not need to remain involved in this area (domain) of the family's life. It is important to not build CPS involvement on areas (domains) that the family is already managing. CPS involvement may not be the best solution for a family that is struggling. CPS Specialists must consider other options that will support the family sufficiently to ensure child safety and minimize risk of future maltreatment. This balance must be achieved by a conversation between the supervisor, the CPS Specialist and the family. What is the community responsibility for the safety of the child? Can the community better serve the family?

Timeframe Requirements

The initial ***Strengths and Risks Assessment Tool*** is completed **within 45 days of case opening, or prior to closing the case at investigation, whichever occurs first.** This assessment may be completed by the investigative or ongoing CPS Specialist, as appropriate to the case circumstances. For example:

- In cases where the initial response and safety assessment indicated the child is safe and no voluntary foster care or dependency is necessary, the investigative CPS Specialist uses the ***Interview and Documentation Guide*** to complete an assessment of strengths and risks within 45 days of case opening (prior to investigation closure). In this scenario, the assessment assists the CPS Specialist to determine if the case should remain open or be closed, and to develop an individualized and relevant case plan or aftercare plan.

- In cases where the initial response or safety assessment indicates the child is unsafe and requires out-of-home placement, the ongoing CPS Specialist uses the ***Interview and Documentation Guide*** to complete an assessment of strengths and risks within 45 days of case opening, prior to developing the permanent case plan. In this scenario, the assessment assists the CPS Specialist to develop an individualized and relevant case plan.

The ***Strengths and Risks Assessment Tool*** is completed to document **reassessments** at the following key decision points:

- **Whenever evidence or case circumstances suggest an increase in levels of risk.**

- **Prior to supervisory approval when considering whether to close an ongoing case** to determine if risks have been sufficiently mitigated that the likelihood of future maltreatment in the absence of CPS services and monitoring is low, and to determine an appropriate aftercare plan.

The Strengths and Risks Assessment Tool is not required when:

- **Action Request Communications:** Communications that do not require an investigation, but may require an action by CPS. These specific communications are contained in Exhibit 2, CPS Response System, Tracking Characteristics.

- **Border Cases:** A case involving a child whose family does not reside within the US and the agency's involvement is limited to returning the child to his/her family in coordination with the Border Patrol and /or INS and the case is being closed. In this type of case, the family is not available to complete the SRA.

- **False (Malicious) Reports:** After investigation, evidence indicates the reporting source knowingly made a false (malicious) report, and the investigation results in no identified safety concerns or indication of risk. To determine if the reporting source knowingly made a false (malicious) report and should be referred to the County Attorney, refer to Chapter 2, Section 9; Determining Whether Maltreatment Occurred.

- **Transitional Independent Living Program:** Closing a case involving a youth age 18 or older who has signed a voluntary foster care agreement.

- **Alternative Investigation:** The SRA should not be completed if the child was not seen.

The ***Interview and Documentation Guide*** may be helpful when reassessing risk at other key decision points such as prior to or during the case plan staffing. CPS Specialists can use the ***Interview and Documentation Guide*** as an aide for gathering thorough and relevant information using a family-centered approach. It is not necessary to conduct a formal interview using the ***Interview and Documentation Guide*** at reassessment points, since the CPS Specialist will have all or most necessary information through ongoing contact with the family and reports from service providers and other team members. CPS Specialists may want to review and consider the Guide when completing the reassessment of risks.

Documentation Requirements

CPS Specialists can take notes during interviews directly on the ***Interview and Documentation Guide*** and file the Guide in the hard copy record. A Case Note must be entered in CHILDS to document the date, time, location and other aspects of the contact, but the detailed notes on the ***Interview and Documentation Guide*** need not be repeated in the Case Note if the hard copy form has been used, filed, and referenced in the Case Note.

Exhibit 16

Family Centered Strengths and Risks Assessment Interview and Documentation Guide

I. Baseline Level of Risk: Abuse and Neglect

1. Abuse and Neglect History (Severity/Chronicity)

Review information regarding prior reported or unreported abuse or neglect history, including history from Arizona and other states, police reports, medical records, etc.

Questions to ask the Caregiver:

Do you have any idea why I am here today to talk with you and your family?
What have your experiences with CPS been like in the past (in Arizona or any other state)?
Have you or has anyone else ever been concerned that ___ was being hurt or neglected?

Family Strengths/ Protective Factors:

The circumstances that contributed to the historical abuse or neglect no longer exist (for example, the abusive caregiver is deceased or no longer has access to the child victim, significant stressors resolved, child s difficult behavior improved, etc.)
There is a realization that the child needs more than what the family is currently providing.
The non-abusive caregiver sought to protect the child.

2. Current CA/N

Physical Abuse (Injury)

Observe child for bruises or other sign of injury. Obtain a medical examination if indicated.

Questions to ask the Caregiver:

Would you describe for me how ___ s injury happened?
What was your day like that day? How were you feeling?
Did you intend to hurt ___ as a means to teach him/her a lesson, or did you simply lose control?

Family Strengths/ Protective Factors:

Non-abusive caregiver sought to protect the child.
Child was taken promptly for medical care.
Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.
Abusive caregiver admits he/she injured the child and voices a concern and commitment to improve parenting skills.

Exploitation (Non Sexual)

Questions to ask the Caregiver:

What chores/responsibilities does ___ have at home?
How do the members of your family contribute to the family s income (including the children)?
When ___earns money, how is it spent/used?

Family Strengths/ Protective Factors:

Alternative financial and/or child care resources are available to meet the family s need, and the caregiver is willing to use the alternative resources.

Neglect

Observe the home s physical condition; sleeping, cooking and toilet facilities, utility functioning; adequacy of food and clothing; cleanliness, weight, and health of child.

Questions to ask the Caregiver:

Have you ever (or when was the last time you) needed/requested/applied for assistance for food/rent/utilities etc.?
Would you please show me where ___ sleeps/your family eats?
How many times have you moved in the past year? Why did you move?
What concerns do you have about your house or neighborhood being safe for you or ___?
Do you have trouble keeping an eye on ___ or has ___ever gotten away from you?
Who helps you watch ___?
Would you describe for me a time when you were proud of how you took care of ___?
Does ___ have any health conditions we should know about?
Does ___ have a medical doctor? If so, what is the doctor s name?
When was the last time ___ saw a doctor/had his shots updated?

Questions to ask the Child:

What kind of foods do you eat at home? Who cooks/makes meals in your family?
Have you ever gone to sleep hungry, or had to skip meals?
Have you ever been left alone? If so, how did that make you feel?
Do you know what to do to stay safe?
Do you remember the last time you visited a doctor/got a shot?
Do you ever get scared playing in your neighborhood?

Family Strengths/ Protective Factors:

Caregiver has family or friends that do or could assist in meeting the child s needs for food, clothing, shelter, etc.
Community resources to ensure that child has food, clothing, housing and/or heat are available to the family and the caregiver is willing to use these resources.
Caregiver has made an attempt to correct the home s physical deficiencies within financial limitations

Sexual Abuse

Observe environment for pornographic material in plain view.

Questions to ask the Caregiver:

Do you have any concerns that ____has been sexually abused?
Has anyone in your family been a victim of sexual abuse?
Have you ever talked to ___about what to do if someone touches her private parts?
Has anyone in your family been accused of sexually abusing another person? What contact does ___ have with this person?
Are you aware of anyone who may have attempted to touch ___ inappropriately or who may have made ___ uncomfortable by the way he or she touched him/her?

Questions to ask the Child:

If there are no allegations or indications of sexual abuse, ask one or more of the following questions near the end of the interview:
Is there anything else you want/need to tell me?
Is there anything else you think I might need to know?
Has anyone ever touched you in a way that hurt or made you feel uncomfortable?
If the report includes allegations of sexual abuse or the child begins to disclose sexual abuse during the investigation, follow district protocols for joint CPS-law enforcement interviews. End the interview and contact law enforcement if required by district protocol.

The following questions are recommended when proceeding with an investigation of alleged sexual abuse:
For children under age 7, have the child identify body parts including what the child calls the penis, vagina and butt. Use the child s name for these body parts when asking questions.
For school age children age 7 to 12, ask: Do you know what your private parts are?
For children 12 and under ask: Has anyone ever touched you on your (child s term)/private parts?
If yes, tell me about that.
If no, what would you do if something like that happened?

For teenagers, ask:

Has anyone ever touched you in a way that made you feel uncomfortable?
Has anyone ever asked you to touch them in a way that made you feel uncomfortable?
Do you know what to do if someone makes you feel uncomfortable?
Is there anyone you can talk to if this happened?

Family Strengths/ Protective Factors:

Non-abusive caregiver took appropriate action to protect the child.
Non-abusive caregiver (believes) supports the child.
Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.

Emotional Abuse

Questions to ask the Caregiver:

Would you describe ___ for me? (Listen for any indication of scapegoating or unrealistic expectations)
Are any of your children more difficult for you to parent/handle than others?
When was a time that you felt positive about how you understood and supported ___ emotions?
When do you feel most emotionally connected to ___?
How does ___ know when you are angry? How would ___ describe you when you are angry?
What do you say to ___ when you are angry or frustrated? How do you think ___ feels when you get angry or frustrated?
What does ___ say or do when you are angry or frustrated at him/her?
Has ___ ever hurt him/herself or others?
How does ___ get your attention?

Questions to ask the Child:

Observe child s emotional state and indications of social functioning level.
What are you good at/love to do/like about school/favorite subject?
What would you like to see change about your family?
Are there times you feel scared? What happens then? Who is around?
What is the best time at home? What is the worst time at home?
Have you ever been embarrassed or called names at home?
What do you and your friends do together? Do you have a close/best friend?
Are all the kids in your home treated the same by your mom/dad/parents?

Family Strengths/Protective Factors:

Non-abusive caregiver took appropriate action to protect the child.
Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.
Abusive caregiver has an understanding of how his/her behavior hurt child.
Caregiver demonstrates an understanding of how developmental stages impact child s behavior.
Caregiver seems to take the child s attention seeking behavior in stride without becoming overly frustrated.
Caregiver has a strong emotional bond and connection to the child.

Dangerous Acts

Observe and assess the intent of the harmful act (if there was one) committed against the child.

Questions to ask the Caregiver:

What was your intention when you (describe harmful act)? Were you disciplining ___?
What was your day like that day? How were you feeling?
What do you do to calm down when you are angry/frustrated with ___?

Family Strengths/Protective Factors:

Non-abusive caregiver took appropriate action to protect the child.
Abusive caregiver is no longer residing with the child and has no unsupervised access to the child.
Caregiver is responsive to education regarding the impact of his/her dangerous behavior, and is willing and able to use alternative parenting techniques.
Caregiver has an alternative plan (Plan B) when he/she is concerned about hurting child. For example, takes time out to protect child such as takes a walk, washes his/her face, calls a neighbor, etc.

II. Child Vulnerability

3. Self Protection

Questions to ask the Caregiver:

Who can ___ go to when he/she needs help? Who can he/she go to if there is no adult at home?
Does ___ attend child care or school/participate in any activities outside of school?
How does ___ get to and after school?
Who is home before and after school with ___?
How do you know when ___ is hurt or upset?
How do you comfort ___? Is ___ easily comforted?
In addition to you, who else does ___ see on a regular basis?

Questions to ask the Child:

Observe whether there are any physical or developmental characteristics that would inhibit the child s ability to seek help or protect himself.
Are there times that you feel scared? What are you afraid will happen?
Are there times that you are left alone? What do you do?
Where can you go/who can you call if you need help?
What do you do when your momma or daddy gets mad?
What happens when you get into trouble?
What is the best time at your home?
What is the worst time at your home?

Family Strengths/Protective Factors:

Child knows where to go for help can dial phone number or go to neighbor, etc.
Non-abusive caregiver or other person in the home assists or encourages child to protect himself/herself.
Child expresses trust of caregivers does not appear fearful.
Child has developed relationships with people outside the family system who can support him/her.
Caregiver is supportive of these relationships.

4. Special Needs/Difficult Behaviors

Observe child s physical, mental, social and developmental health.

Questions to ask the Caregiver:

Would you describe for me any special needs that has (such as in school, physical health, eating, sleeping, getting along with others, behaviors)?
Does ___ have any health conditions we should know about?
What behaviors does ___have that upset you the most? What is your most effective means of handling them?
Have you or has anyone else ever described ___ as out-of-control or difficult? Tell me about this.
Has ___ ever hurt or threatened to hurt anyone or damaged property?
Who helps you manage any of ___ s difficult behaviors?
Does ___get services from other agencies? Which agencies/services?
Do you ever feel like ___needs additional help? What type of help?
What do you like about ___?
What does ___ do well?
Besides you, who knows ___ the best? How would they describe ___ ?
Tell me about your child s friends.

Questions to ask the Child

Do you like school? What parts of school do you like the best? Why?
Which part of school do you dislike? Why?
Who is your best friend?
Do you ever feel like you can t get along with the kids at school?
Do you ever get in trouble at school or at home? What for?

Family Strengths/Protective Factors:

Caregiver is sympathetic to child s needs.
Caregiver is knowledgeable about the child s special needs (i.e. diet, medication, medical condition, etc.) and has skills to meet the child s special needs.
Caregiver has sought services or supports for the child.
Another person is providing for the child s special needs or assists the caregiver with the child s special needs or difficult behavior.
Child is confident in school.
Child has friends.

III. Caregiver Characteristics

5. Substance Abuse

Review prior CPS history and police reports for indication of substance abuse

Questions to ask the Caregiver:

Has drinking or drugs been an issue in your family?
Have you ever felt like you should cut back on your drinking or drug use of felt bad or guilty about it?
Have you ever used alcohol or drugs to get though a bad time?
Has your drinking or drug use caused job, school, family or legal problems?
Has your current or past drug or alcohol use ever impacted your ability to parent ___ in the way that you would like to parent?
Have you ever felt annoyed by criticism of your drinking or drug use?
Do others in your home use alcohol or other drugs?
When was the last time you used alcohol or drugs? What did you use?
How often did (do) you use?
Have you ever participated in substance abuse treatment? If so, when?
What type, i.e. outpatient, residential?
Did you complete the treatment?
If applicable, are you in recovery? If not in recovery, how long have you maintained your sobriety in the past? What has contributed to you not maintaining sobriety?
Have you ever been arrested? Did the arrest relate to drugs or alcohol?
Are there any other adults in your home whose drug or alcohol use would affect your child s safety? If so, explain.

Family Strengths/Protective Factors:

Caregiver has a strong sense of his/her own struggle in the area of drugs and alcohol.
Caregiver has sought treatment in the past.
Caregiver has a sponsor through AA or NA.

6. Mental, Emotional, Intellectual or Physical Impairments

Observe caregiver s mental, emotional, intellectual and physical condition.

Questions to ask the Caregiver:

Do you have any physical health or mental health conditions that ever prevent you from being able to take care of ___?
Do you or any member of the family have any health conditions we should know about?
Have you or any member of the family been sick lately?
Do you have a medical doctor? When was the last time that you saw your doctor?
Has your health ever held you back from getting a job or taking care of ___?
Are you or any member of the family taking any medications for any reason? Are you taking your medications according to doctor s orders?
Do you feel like you just can t take it anymore? What do you do when you feel this way?
Have you ever seen a counselor?
Do you get services from other agencies? Which agencies/services?
Do you ever feel like you need additional help? What type of help?

Family Strengths/Protective Factors:

Caregiver has supportive family or friends in local area who assist with the care of the children, to compensate for the caregiver s impairments.
Community resources and supports can be provided to compensate for the caregiver s impairments.
Caregiver is in touch with his/her feelings about the child.
Caregiver has sought treatment for mental health issues.
Caregiver uses medications as prescribed.
Caregiver is aware of disabilities and involved in support groups and activities to compensate for these disabilities.
Caregiver uses assistive device (technologies) to enable timely interaction with the child and community (TDD, hearing aids, guide dog).
Caregiver is willing, but does not have resources or knowledge to obtain services.

7. Parenting Skills/Expectations of Child

Observe home for indication of a child friendly physical environment.

Questions to ask the Caregiver:

Tell me something about each of your children.
What can ___ do at this age?
Do you feel that ___ can do what you expect at this age? If not, describe.
Do you and your spouse/partner/significant other agree about what ___is able to do at this age?
What happens when ___ is not able to do what you expect?
How do you help ___ do what you expect?
If ___ is being really difficult, how do you deal with him/her?
What bugs you about ___? What pushes your button? Who does he/she remind you of?
Describe a time when ___ was successful? How did you help him/her succeed?
On a scale of 1-10, with 1 the lowest and 10 the highest, how would you rate yourself as a parent?
Describe a time when you thought you did a good job as parent.
What was happening at that time?
Parenting isn t something you wake up and know how to do. Would you tell me about a time when you felt unsure as a parent?
Who taught you to be a parent? Who is your biggest influence as a parent?
What are the ways that you show love to ___ ?

Family Strengths/Protective Factors:

Caregiver clearly interacts with the child in loving and/or fun ways.
Caregiver uses visual aids such as pictures on the refrigerator to complement the child s progress.
Caregiver is able to change his/her parenting style based on the needs of the child.
Caregivers are able to work out parenting approaches.
Caregiver redirects child in positive ways.
Caregiver is able to identify child strengths.
Caregiver is proud of child and expresses this to child.
Caregiver is responsive to parenting education, and is willing and able to use new parenting techniques.

8.	Empathy, Nurturance, Bonding

Observe whether books, toys, school work are present in home. Observe interaction between child and caregiver:

- **Physical contact between the child and caregiver;**
- **Eye to eye contact;**
- **Caregiver s tone of voice used when communicating with the child; and**
- **Caregiver s attention to the child s needs during interview.**

Questions to ask the Caregiver:

How do you spend time with ___each day?
How do you know when ___ needs something? Or Does ___ come to you when he/she needs something?
Whom does ___ seek for comfort?
How do you attend to ___ needs? Or How do you help ___ get his/her needs met?
On a scale of 1-10 with one being not at all and 10 being completely, how much do you think that ___ trusts you?
Using the same scale, how much do you trust ___?
How do you get along with ___?
Describe a great memory with ___?
How does your family have fun?
Is there something that keeps you from spending time and attention with ___?

Family Strengths/Protective Factors:

Another caregiver or adult in the home is empathetic and nurturing toward the child.
Caregiver engages child in play.
Caregiver has toys that are age appropriate.
Caregiver reads to child.
Caregiver spends time with child and asks questions about child s day.
Caregiver attends school meetings and/or activities.
Caregiver hugs child in comfort.

9. History of Violence By Caregiver Toward Peers and/or Children

Questions to ask the Caregiver:

What do you do when things go wrong (home, work, life)?
Have you ever used physical force with anyone? Why? In what way? If so, were the police involved?
How do you handle disagreement or conflict in your work relationships?
Describe your work environment. Do you feel successful and respected? Trusted?
When was a time that you handled conflict well with your co-workers?
Do these fights ever result in someone getting hurt?
Do you own any weapons?
Is anyone afraid of you?
Have you ever been told that violence is a problem with you? By whom?
Have you gone, or felt a need to go, to counseling for your temper?

Family Strengths/Protective Factors:

Caregiver is able to admit that he/she has a temper.
Caregiver has sought help for his/her temper.
Caregiver has good relationships with co-workers.
Caregiver is assertive, but not aggressive about getting needs met.
Caregiver is able to redirect anger toward accomplishing something positive.
Caregiver is able to identify times when conflict has been an opportunity for change.

10. Protection of Child by Non-Abusive Caregiver

Questions to ask the Caregiver:

What is your relationship to (name of abusive caregiver)?
Before this incident, did you feel that (name of abusive caregiver) would hurt ___?
How do you think the experience (abuse or neglect) has affected ___?
Have you left ___ with someone who has harmed him/her or another child in the past? Does this worry you?
Now, when you think that ___ is in danger, what do you do?
Describe a time that you have protected ___ from someone wanting to harm him/her.
What is your plan to protect ___ in the future?

Family Strengths/Protective Factors:

Non-abusive caregiver does not cover for abusive caregiver.
Caregiver believes and supports the child.
Caregiver recognizes dangerous situations and steps in to protect.
Non-abusive caregiver is able to put the child s needs above his/her own.
Non-abusive caregiver uses family or other resources to protect the child.

11. Recognition of Problem/Motivation to Change

Questions to ask the Caregiver:

What goals do you have for yourself, ___ and your family? What are you willing to do to reach these goals? What do you see as barriers?
From your point-of-view, why do you think CPS is involved with your family? Are our concerns real to you?
What were the reasons stated by CPS for involvement?
In what ways do you feel you need to improve or change as a parent?
What is needed for you to ensure ___s safety?
How are you parenting ___differently than your parents parented you?

Family Strengths/Protective Factors:

Caregiver asks for help.
Caregiver expresses a motivation to change.

12. History of CA/N as a Child

Questions to ask the Caregiver:

Would you describe your family for me-mother, father, sisters and brothers?
Can you tell me what it was like growing up in your family? Where did you grow up? What memories do you have of your childhood?
When you were a child, what happened when you got in trouble?
What kind of punishment did you receive when you misbehaved? Who disciplined you?
What do you think that child abuse or neglect is?
Were you neglected or abused any way when you were growing up?
Describe any involvement, if any that CPS had in your life as a child?
Did you have other important adults in your life as a child? If so, who were they and how did they make your life easier?

Family Strengths/Protective Factors:

Caregiver has worked through issues relating to his/her upbringing.
Caregiver talks to siblings about how to avoid the mistakes of his/her parents; thus, avoiding the cycle of abuse.
Caregiver has been able to learn form the past and its influences on his/ her child rearing.
Caregiver sought help to learn how to parent more effectively.

13. Level of Cooperation with Intervention

Questions to ask the Caregiver:

Do you think you are going to be able to make the changes we have talked about? What supports will help you the most?
What scares you most about CPS involvement with your family?
Describe who of your family and friends will be the most helpful and supportive to you. (Develop a genogram or an ecomap with the family)
What kind of help do you need from others to meet ___ s needs? Who do you think could provide the help you need?
What past or current services have you received to help with ___? What was the outcome?
On a scale of 1-10 with 1 being the lowest and 10 the highest, how willing are you to work with CPS and/or other service providers to address any concern for your child? (Don t look for a magical number as this is just a point in time piece of information that helps us to know how to work with the family.)
What are you willing to do to reach your goals for you, ___ and your family?

What do you feel are the biggest barriers to working with CPS and/or other service providers in order to address your child s needs?
How will you address disagreements or concerns you have with CPS and/ or other service providers?
How will you ask for what you need from CPS and/or other service providers?

Family Strengths/Protective Factors:

Caregiver wants to make things right for his/her family and is willing to work with CPS to get there although that may scare him/her.
Caregiver requests intervention and services.
Caregiver follows through with what he/she says that he/she will do.

IV. Familial, Social and Economic Factors

14. Stress on Family

Questions to ask the Caregiver:

Sometimes when you don t know how you are going to feed your family it is hard to focus on anything else. Do you ever struggle like this? Who helps you during these times?
What is a day in your life like?
Does your relationship with your partner cause you stress?
What times of the day are most stressful?
What do you do to get through a stressful day?
What major changes has your family experienced in the last year?
How have these changes affected you and your family?
How is your child dealing with the changes?

Family Strengths/Protective Factors:

Caregiver manages stress in healthy ways such as exercise, yoga, music.
Caregiver has support to manage stress a place to vent.

15. Social Support for Family

Questions to ask the Caregiver:

What family members and/or friends live nearby who are willing to help you when you need something?
Who do you consider family? Do you visit, call or write your family/ relatives?
What is your relationship with your family like?
Where do you consider home?
How Are you connected to any tribe or family?
Are you involved with any church or community group?
Who can you rely on?
Who do you trust?
Who helps you when you are stressed out?
Do you feel comfortable asking for help?
What kind of support do you need from your family, friends or community?

Family Strengths/Protective Factors:

Caregiver is involved with activities outside the home.
Family is open to feedback and support from their personal network.

16. Economic Resources of Family

Questions to ask the Caregiver:

What financial resources do you have to support your family?
Who handles your family s money? Are you able to access it?
What creative ways have you used to make ends meet?
Have you ever (or when was the last time that you) asked for assistance in paying for food, rent, mortgage and/or utilities?
How many times have you moved in the past year? Why did you move?
Are you able to pay rent most months?
What needs are difficult for you to meet for your family on a consistent basis?
What kind of work do you do? What kind of work do you enjoy?
What is the longest time that you had a job?
Have you had any training that you wish you could use in your work?
Are people in your life supportive of you working?

Do you have a car or access to public transportation?

Family Strengths/Protective Factors:

Caregiver maintains gainful employment.
Caregiver knows and uses community resources to extend or increase financial resources.
Caregiver has knowledge of budgetary, meal preparation, and other skills to stretch limited resources.
Caregiver has found free ways to have fun with his/her children in the community.
Caregiver has gone to family and friends to ask for help to ensure that basic needs are met.

17. Domestic Violence

Questions to ask the Caregiver:

Tell me about your relationship with your spouse/partner/significant other.
How do you handle disagreement/conflict in your relationship/family?
What kinds of things do you expect from your partner/family?
How are decisions made in your relationship?
What do you do when things go wrong in your family?
Do you feel that your partner ever embarrasses you or calls you names or criticizes?
Have you ever felt worried about your safety because of your spouse/ partner/significant other? In what way?
Have you ever been concerned about ___ s safety?
Do you have a pet? If so, have you ever been worried about your pet s safety?
Are you afraid of your spouse/partner/significant other?
How safe do you feel with your partner right now? If not safe, what makes you feel unsafe?
If needed, do you have a safety plan in place for you and ___? If so, tell me about it.
Have you ever needed to use a shelter to keep your family safe?

Questions to ask the Child:

Do your Mom and Dad (partner, etc.) ever fight?
What kinds of things do they fight about? Is there yelling? Is there hitting?
Have you ever gotten hurt when they are fighting?
Have you ever tried to stop the fighting? What happened?
What is it like for you when there is fighting?
When Mom and Dad are fighting, what do you worry about most?
What do you want to do when your parents fight?
If your Mom and Dad were fighting and you felt so afraid that you could not stay in the house, who would you call? What would you say?

Family Strengths/Protective Factors:

Abusive caregiver no longer resides with the family and there are legal or other protections in place to prevent his/her access to the family.
Caregiver has a safety plan.
Caregiver protects child.
Caregiver seeks assistance to ensure that the family is safe.

Exhibit 17

FAMILY-CENTERED STRENGTHS AND RISKS ASSESSMENT RATING REFERENCE

I. Baseline Level of Risk: Abuse and Neglect

1. Abuse and Neglect History Severity/Chronicity

No Risk (N)	There have been no incidents of abuse or neglect in the past.
Low/Moderately Low Risk (L/ML)	Isolated incidents of abuse and neglect. One incident of abuse or neglect. Intermittent incidents of abuse or neglect.
Moderate Risk (M)	More than one incident of abuse or neglect separated by long intervals of non-abusive or non-neglectful behavior.
Moderately High/High Risk (MH/H)	Repeated or ongoing pattern of abuse or neglect. Abuse occurs periodically as conditions and situations vary. Abuse occurs regularly on a daily or weekly basis. Neglect is ongoing and constant with infrequent interludes of appropriate care. For an infant or preschool child, a dangerous pattern may occur within a period of hours, days or weeks. For an older child, a dangerous pattern may emerge over a period of weeks to months.
Family Strengths/ Protective Factors	The circumstances that contributed to the historical abuse or neglect no longer exist. (For example, the abusive caregiver is deceased or no longer has access to the child victim, significant stressors resolved, child's difficult behavior improved, etc.). There is a realization that the child needs more than what the family is currently providing. The non-abusive caregiver sought to protect the child.

2. CURRENT CA/N

PHYSICAL ABUSE (INJURY)

No Risk (N)	No injury and no medical treatment required.
Low/Moderately Low Risk (L/ML)	Inflicted bruises confined to extremities and buttock that do not require medical treatment. Superficial welts, scratches or abrasions confined to knees, shins, arms and buttocks.

Moderate Risk (M)	Any bruises on pre-ambulatory child or child under age one. Bite marks with breaks in the skin. Cuts, bruises or abrasions on protected body areas such as inner thighs, neck, and genitalia. Cuts, bruises or abrasions on facial area such as eye, cheek, lip, forehead or nose. Multiple superficial injuries or multiple plane injuries. Patches of hair pulled from child's scalp. First and/or second degree burns confined to a small area of child's hand, leg, or arm.
Moderately High/High Risk (MH/H)	Cuts that require stitches. Head injuries, i.e.. concussion, retinal or cerebral hemorrhage, skull fractures. Fractured bones. Extensive and multiple bruises (battering). First and/or second degree burns on face, abdomen or genitals. Third degree burns to any area of the body. Displaced joints. Injuries resulting in significant sight, hearing, or mental impairment. Internal injuries. Evidence of neck injury that interferes with breathing. Near drowning inflicted.
Family Strengths/ Protective Factors	Non-abusive caregiver sought to protect the child. Child was taken promptly for medical care. Abusive caregiver admits he/she injured the child and voices concern and commitment to improve parenting skills

EXPLOITATION (NON-SEXUAL)

No Risk (N)	Caregiver has non-exploitative relationship with the child.
Low/Moderately Low Risk (L/ML)	Caregiver uses child to obtain food or shelter
Moderate Risk (M)	Caregiver demands that child work outside the home and relinquish most of earnings to adult for his/her own use. Caregiver expects child to do all the household tasks including meal preparation and laundry. Child is frequently forced to miss school to care for younger siblings or adult. Caregiver used child for illegal non-violent activities such as betting or selling stolen items.
Moderately High/ High Risk (MH/H)	Caregiver engages child in property crimes such as robbery, auto theft, burglary, etc. Caregiver uses child to sell or transport drugs. Caregiver forces child to work full-time and relinquish all earnings for adult's use. Caregiver indentures child to third party for monetary benefit.
Family Strengths/ Protective Factors	Alternative financial and/or child care resources are available to meet the family's needs, and the caregiver is willing to use the alternative resources.

NEGLECT

No Risk (N)	Caregiver appropriately provides for the basic needs of the child.
Low/Moderately Low Risk (L/ML)	Child's clothing is consistently dirty or in need of repair. Child has insufficient clothing for current weather. Shelter is only sporadically heating in the winter, causing child some discomfort. Regular meals provided, but may be nutritionally poor. Child occasionally left alone or with inappropriate or inadequate caregivers.
Moderate Risk (M)	Shelter does not provide adequate protection from the elements. Inadequate provisions for sleeping such as rough surface, dirty, smelly, noisy or damp. Food provided is inadequate to sustain a healthy, growing child. Infant is not fed regularly. Infant or young child not bathed regularly, causing itching, rash or matted hair. Infant's or young child's diapers changed irregularly, causing rashes or significant discomfort. Child responsible for caring for younger sibling. Mild to moderate developmental delays due to neglect.
Moderately High/High Risk (MH/H)	Health or safety hazards in living environment including exposure to elements, human/animal feces, exposed wiring, access to dangerous objects or harmful substances. Sleeping provisions are cold, wet or unsafe. Food is not provided or only provided sporadically for child. Infant is not fed within 12 hours. Clothes are inadequate to protect child from elements. Infant or young child smells strongly, has a painful skin condition, hair or teeth loss. Infant or young child left in soiled diapers for extended periods of time, resulting in a bleeding, painful skin condition. Child is alone and cannot care for self or other children or child is left to his or her own resources. Child has delayed or untreated medical condition which is life-threatening or permanently disabling such as comatose state or debilitation from starvation or non-organic failure to thrive. History of extensive gestational substance abuse or child tests positive for non-prescribed or illegal drug or alcohol at time of birth or child displays withdrawal symptoms. Significant developmental delays due to neglect.
Family Strengths/ Protective Factors	Caregiver has family or friends that do or could assist in meeting the child's needs for food, clothing, shelter, etc. Community resources to ensure that child has food, clothing, housing and/or heat are available to the family and the caregiver is willing to use these resources. Caregiver has made an attempt to correct the home's physical deficiencies within financial limitations.

SEXUAL ABUSE

No Risk (N)	Caregiver has a non-sexualized relationship with child and protects from sexual abuse or exploitation.
Low/Moderately Low Risk (L/ML)	Caregiver makes sexually suggestive remarks or flirtations with child without clear overtures or physical contact. Caregiver makes sexual innuendoes, provocative statements, or lewd comments to child. Sexual activities are discussed inappropriately in front of child. Pornographic media material is viewed in child's presence or available for child to see it.
Moderate Risk (M)	Caregiver engages in sexually stimulating grooming behavior with child. Child is propositioned or pressured to have sexual contact by the caregiver. Caregiver exposes self to child or masturbates in child's presence. Child is encouraged or forced to view pornographic material by the caregiver. Caregiver engages in sexual activities in front of child. Child is photographed in provocative poses or clothing by the caregiver. Caregiver does not intervene in inappropriate sex play between siblings.
Moderately High/ High Risk (MH/H)	Child is engaged by an adult or older child in sexual penetration. Child is forced by an adult to engage in sexual activity with another child. Child is engaged in masturbation by an adult or older child. Child is engaged in sadomasochistic practices. Caregiver forces child to watch or perform sex with an animal. Pornographic photographs are taken of child. Caregiver forces child to act out sexually in front of him/her or others. Caregiver pressures or forces child to engage in sexual activity with another adult. Child has a sexually transmitted disease. Child is **unsupervised** in the presence of a known sex offender.
Family Strengths/ Protective Factors	Non-abusive caregiver took appropriate action to protect the child. Non-abusive caregiver (believes) supports the child. Abusive Caregiver is no longer residing with the child and has no unsupervised access to the child.

EMOTIONAL ABUSE

No Risk (N)	Child exhibits normal behavior and social functioning. Child appears happy and well adjusted (not overly worried or anxious).
Low/Moderately Low Risk (L/ML)	Child has some negative attention-seeking behavior. Lack of impulse control. Limited attention span. Child displays minor behavioral problems.

Moderate Risk (M)	Emotional or social impairment resulting in social isolation. Sadness caused by CA/N resulting in decreased capacity to perform age appropriate tasks. Depression evidenced by listlessness, withdrawal or daydreaming, impairing academic performance and/or peer relationships. Signs of anxiety or fear that interfere with learning new skills or making new friends. Antisocial behaviors such as chronic lying, destruction or property, or stealing.
Moderately High/High Risk (MH/H)	Fire setting. Lack of emotional attachments. Assaultive behavior. Sexual victimization of younger child. Mutilation of animals. Severe psychological reaction such as suicide attempt, self-mutilation, loss of ability to speak or extreme social fear. Severe depression which immobilizes child or leads to suicidal behavior. Chronic ridiculing, belittling, humiliation or debasement of child. Terrorizing a child.
Family Strengths/ Protective Factors	Non-abusive caregiver took appropriate action to protect the child. Abusive caregiver is no longer residing with the child and has no unsupervised access to the child. Abusive caregiver has an understanding of how his/her behavior hurt child. Caregiver demonstrates an understanding of how developmental stages impact child's behavior. Caregiver seems to take the child's attention seeking behavior in stride without becoming overly frustrated. Caregiver has a strong emotional bond and connection to the child.

DANGEROUS ACTS

No Risk (N)	Caregiver exercises care and control to ensure child's safety and not cause injury to child.
Low/Moderately Low Risk (L/ML)	Forcing child to eat small amounts of an inappropriate food item such as Tabasco sauce, hot peppers or soap. Allowing toddler on elevated surface without close supervision. Pulling child off floor by arm or leg.

Moderate Risk (M)	Dragging child by hair. Biting child. Twisting or pulling body parts, such as arms, wrists or ears. Locking child in area without a means of escape. Denying food for more that two consecutive meals. Forcing a child to eat a non-food item. Throwing hard objects at child. Forcing young child to be outside in the heat, cold or rain. Hitting child with an object or instrument. Making child stand in corner for excessive time periods. Pulling out patches of hair.
Moderately High/High Risk (MH/H)	Shaking an infant. Spanking an infant. Any physical discipline to an infant. Interfering with a child's breathing. Hitting a child with fist or object or instrument on head, face, neck, stomach, abdomen, genitals or kidneys. Throwing a child against a wall or other surface. Holding head of young child in toilet bowl. Head banging. Threatening child with a deadly weapon. Tying child down or using restraining devices such as handcuffs, ropes or chains. Burning a child including immersion burns. Using electric shock as punishment. Leaving child unattended in a hot car. Denial of food or water for 24 hours. Introducing into a child's body any substance which could temporarily or permanently impair bodily functions. Assaultive behavior which poses a physical threat to the safety of child. Smearing feces or urine in a child's face. Munchausen's by Proxy.
Family Strengths/ Protective Factors	Non-Abusive caregiver took appropriate action to protect the child. Abusive caregiver is no longer residing with the child and has no unsupervised access to the child. Caregiver is responsive to education regarding the impact of his/her dangerous behavior, and is willing and able to use alternative parenting techniques. Caregiver has an alternative plan (Plan B) when he/she is concerned about hurting child. For example, takes time out to protect the child such as takes a walk, washes his/her face, calls a neighbor, etc.

II. Child Vulnerability

The level of susceptibility to child abuse and neglect is related to a child's ability to protect himself/ herself, developmental delays, behavioral problems and past victimization. Research, practice and child mortality studies indicate that younger children are more likely to be severely harmed as a result of abuse and neglect.

3. SELF PROTECTION

No Risk (N)	Child is able to consistently protect self.
Low/Moderately Low Risk (L/ML)	May escape or hide to avoid abuse. Recognizes the behavior as abusive, but cannot consistently avoid it. May be able to physically resist abuse. May not consistently seek help from non-abusive caregiver.
Moderate Risk (M)	Child displays occasional ability to protect self. Child is unable to distinguish between abuse and discipline. School-age child has reduced ability for self-care. Child is unable to leave abusive situations. Child occasionally seeks assistance to protect self. Child has a relationship with person outside home, not consistently available for protection. Child is reluctant to be with caregiver. Child is fearful of retaliation from caregiver. Child is fearful of home environment due to domestic violence, drug/alcohol use, dangerous people and/or health and safety issues.
Moderately High/High Risk (MH/H)	Child is unable to protect self. Child views abuse as normal and acceptable. Child lives or is left in unsafe environments. Child is not supported in efforts to seek help or protection. Child is unable to communicate. Child is unable to seek assistance. Child is 0 to 5 years old or a child with special needs. Child has no visibility in the community. Child blames self for abuse. Child recants or denies substantiated abuse. Child hides or minimizes injuries.
Family Strengths/ Protective Factors	Child knows where to go for help--can dial phone number or go to neighbor, etc. Non-abusive caregiver or other person in the home assists or encourages child to protect himself/herself. Child expresses trust of caregivers--does not appear fearful. Child has developed relationships with people outside the family system who can support him/her. Caregiver is supportive of these relationships.

4. SPECIAL NEEDS/DIFFICULT BEHAVIORS

No Risk (N)	Child displays age appropriate behavior with no physical, mental, social or developmental delays.

Low/Moderately Low Risk (L/ML)	Child displays minor behavioral problems with no physical, mental, social or developmental delays. Child often has age appropriate behaviors. Child has minor illness/medical condition requiring periodic parental attention. Child has mild developmental delay. Child has minor hyperactivity or depression. Child has minor school problems or occasional truancy.
Moderate Risk (M)	Child is behaviorally disturbed/significant physical, mental, social or developmental delays. Irritable and/or distressed infant is difficult to console. Child has medical condition, physical disability or psychological condition requiring regular parental and/or medical attention. Child has been diagnosed with attention deficit disorder, fetal alcohol syndrome or some other condition. Child has behavior problems which interfere with academic performance and social relationships with peers. Child has significant pattern of aggression or withdrawal at school, home or with friends. Child is periodically absent from school or runs away for short periods of time. Child may exhibit inappropriate behavior for his/her age. Child has difficulty concentrating at school. Child is overeating, losing weight or other changes in diet. Child is occasionally violent and dangerous to others. Child displays some self-destructive behavior. Child destroys objects. Child has sleep disorders. Child experiments with drugs and alcohol.
Moderately High/High Risk (MH/H)	Profound physical, mental, social or developmental delay. Low birth weight and/or medically fragile infant. Child has extreme and challenging behaviors requiring almost constant management and supervision. Child is reliant on parent for total care due to physical/developmental disability. Child regularly uses drugs and/or alcohol. Child's behavior causes regular removal from academic and social environments. Child exposes himself to risky situations without knowledge of danger. Child is violent and dangerous to others and self. Child has criminal history. Child is involved in coercive, aggressive sexual behavior. Mutilation/killing of animals.
Family Strengths/ Protective Factors	Caregiver is sympathetic to the child's needs. Caregiver is knowledgeable about the child's special needs (i.e.. diet, medication, medical condition, etc.) and has skills to met the child's special needs. Caregiver has sought services or supports for the child. Another person is providing for the child's special needs or assisting the caregiver with the child's special needs or difficult behavior. Child is confident in school. Child has friends.

III. Caregiver Characteristics

The risk factors identified under caregiver characteristics provide information about the history and present parenting function of the child's caregiver. Since the following caregiver risk factors are predictive of future abuse and neglect, it is important to gather reliable information about each factor.

5. SUBSTANCE ABUSE

Substance abuse may interfere with a person's ability to perform essential life functions such as parenting, work, interpersonal relationships and self-care.

No Risk (N)	Caregiver does not abuse alcohol or drugs and is not involved in manufacturing or selling illegal drugs.
Low/Moderately Low Risk (L/ML)	History of substance abuse, but no current problem. Has completed treatment and remained free from substance abuse for more than one year. Is voluntarily involved in treatment, has regularly attended support groups or meetings for at least six months. Infrequent use of drugs and/or alcohol which occasionally impairs parenting skills or abilities.
Moderate Risk (M)	Reduced effectiveness due to substance abuse or addiction. Caregiver's use of drugs and/or alcohol results in erratic and unreliable parenting of child. Social and/or support network includes known abusers of drugs and alcohol. Has failed treatment programs or has not completed treatment in past. Successful completion of treatment and current regular use of alcohol or drugs. History of DUI and/or drug or alcohol related criminal activities. Has begun treatment although has not established consistent participation. Heavy use is occasional, weekends or situational, rather than an established pattern indicating addiction.
Moderately High/High Risk (MH/H)	Substantial incapacity due to substance abuse or addiction. Caregiver's use of substances results in inability to meet any of child's basic needs. Use of substances results in emotionally abusive and/or violent behavior. Drug-using or drug-making paraphernalia accessible to child. Recent history of DUI/DWI and/or drug or alcohol related criminal activities. Inability to maintain employment due to substance abuse. Denial of impact substance abuse has on caregiver's ability to provide for child's needs. History of extensive gestational substance abuse.
Family Strengths/ Protective Factors	Caregiver has a strong sense of his/her own struggle in the area of drugs and alcohol. Caregiver has sought treatment in the past. Caregiver has a sponsor through AA or NA.

6. MENTAL, EMOTIONAL, INTELLECTUAL, OR PHYSICAL IMPAIRMENTS

In any case in which mental health, emotional, intellectual or physical impairments incapacitates a parent for extended periods of time, CPS staff should ask themselves the questions, "who will be caring for this child when the parent is unable to do so?" The presence of these conditions **does not necessarily mean** that the person cannot parent adequately or that a child is unsafe.

No Risk (N)	Caregiver is mentally, emotionally, intellectually and physically capable of parenting child.
Low/Moderately Low Risk (L/ML)	A mental, emotional, intellectual or physical impairment mildly interferes with the capacity to parent. Caregiver has some mild physical or emotional impairment causing minimal interference with some daily activities. Caregiver has emotional problems for which he/she is receiving effective treatment. Caregiver has low tolerance for stressors and may react in emotionally inappropriate ways. Caregiver has developmental delay and relies on consistent support to manage daily activities. Caregiver has low-self esteem, anxiety attacks and mood swings that minimally impact parenting functions.
Moderate Risk (M)	A mental, emotional, intellectual or physical impairment interferes significantly with the capacity to parent. Caregiver has a physical, mental or emotional impairment that interferes with daily parenting activities. Caregiver is being supervised by a physician for a physical, mental or emotional condition, but does not consistently comply with treatment plan. Caregiver is depressed and unable to provide nurturance and stimulation to child. Caregiver requires consistent support to manage daily activities, but does not have the help required.
Moderately High/High Risk (MH/H)	Due to a mental, emotional, intellectual or physical impairment, capacity to parent severely inadequate. Acute or chronic illness or disability that significantly impairs the caregiver's ability to care for child. Caregiver has serious mental illness, but refuses to participate in treatment plan. Caregiver's physical, mental or emotional impairment causes them to be vulnerable to dangerous situations. Caregiver impairment causes failure of caregiver to recognize dangers and protect child from harm. Caregiver has history of injuries, assaults, exploitation due to physical, mental or emotional impairment. Caregiver behavior may include delusions and hallucinations. Caregiver has history of suicide attempts.

Family Strengths/ Protective Factors	Caregiver has supportive family or friends in local area who assist with the children's care, to compensate for the caregiver's impairments. Community resources and supports can be provided to compensate for the caregiver's impairments. Caregiver is in touch with his/her feelings about the child. Caregiver has sought treatment for mental health issues. Caregiver uses medications as prescribed. Caregiver is aware of disabilities and involved in support groups and activities to compensate for these disabilities. Caregiver uses assisted device (technologies) to enable timely interaction with the child and community (TDD, hearing aids, guide dog). Caregiver is willing, but does not have resources or knowledge to obtain services.

7. PARENTING SKILLS/EXPECTIONS OF CHILD

Parenting skills and expectations of the child should demonstrate an ability to provide for a child's basic needs and to guide, educate, and discipline in a way that facilitates a child's positive social and emotional development.

No Risk (N)	Caregiver provides environment that is child friendly and has age-appropriate expectations.
Low/Moderately Low Risk (L/ML)	Caregiver has some unrealistic expectations of child and/or gaps in parenting skills. Caregiver is inconsistent in disciplining child based on age and behavior. Caregiver does not consistently offer assistance or encouragement to promote child's healthy development. Caregiver has some understanding of normal child development.
Moderate Risk (M)	Caregiver has significant gaps in knowledge or skills that interfere with effective parenting. Caregiver has limited understanding of child's developmental stage, skills and abilities. Caregiver consistently demonstrates unrealistic expectations of child. Caregiver assigns child responsibilities that exceed child's developmental skills and abilities. Caregiver reacts with a consistently negative response to child. Caregiver engages in harsh physical punishment.
Moderately High/High Risk (MH/H)	Caregiver has gross deficits in parenting knowledge and skills or inappropriate demands and expectations of child. Caregiver has little or no understanding of child's developmental skills and assigns child tasks beyond their capacities. Caregiver scapegoats child, assigning blame and engaging in physical punishment. Caregiver punishes child for age appropriate behaviors. Caregiver does not intervene when young child is in dangerous situations. Caregiver demonstrates helplessness and hopelessness to control child's dangerous or out-of-control behaviors. Caregiver rewards child for anti-social and/or negative behaviors. Caregiver does not express affection or interest in child. Caregiver does not recognize or respond to child's needs.

Family Strengths/ Protective Factors	Caregiver clearly interacts with the child in loving and/or fun ways. Caregiver uses visual aids such as pictures on the refrigerator to compliment the child's progress. Caregiver is able to change his/her parenting style based on the needs of the child. Caregivers are able to work out parenting approaches. Caregiver redirects child in positive ways. Caregiver is able to identify child strengths. Caregiver is proud of child and expresses this to child. Caregiver is responsive to parenting education, and is willing and able to use new parenting techniques.

8. EMPATHY, NURTURANCE, BONDING

Empathy, nurturance and bonding with a child requires a parent to be appropriately responsive to a child's feelings, situations and motives. It also requires that parents provide a strong emotional connection, consistent loving care, and acceptance with a commitment to the overall well-being of the child.

No Risk (N)	Caregiver is openly accepting of child, interacts with child and provides appropriate and adequate stimulation.
Low/Moderately Low Risk (L/ML)	Caregiver provides inconsistent expression of acceptance and inconsistent stimulation and interaction. Caregiver rarely praises child although can identify strengths and positive qualities in child if asked. Caregiver is critical when child makes normal developmental mistakes or errors. Caregiver is overly protective of child limiting interaction with peers, family members and community.
Moderate Risk (M)	Caregiver withholds affection and acceptance, but is not openly rejecting or hostile to child. Caregiver rarely enjoys company of or spends time with child. Caregiver isolates child from rest of family or social situations. Caregiver is punitive when child makes normal developmental mistakes. Caregiver demonstrates frequent lack of interest in child's activities, interests or accomplishments. Caregiver uses belittling language when talking to or about child. Caregiver rarely demonstrates verbal or physical affection toward child. Caregiver does not recognize nor intervene when child needs help.
Moderately High/High Risk (MH/H)	Caregiver severely rejects child, providing no affection, attention or stimulation. No demonstration of attachment or bonding between child and caregiver. Caregiver is physically rejecting of child, providing no attention or affection. Caregiver expects child to meet own needs. Caregiver makes statements to child that devalue, demoralize and reject. Child is immediately friendly with strangers, clinging to or seeking physical affection.

Family Strengths/ Protective Factors	Another Caregiver or adult in home is empathetic and nurturing toward the child. Caregiver engages child in play. Child has toys that are age appropriate. Caregiver reads to child. Caregiver spends time with child and asks questions about child's day. Caregiver attends school meetings and/or activities. Caregiver hugs child in comfort.

9. HISTORY OF VIOLENCE BY CAREGIVER TOWARDS PEERS AND/OR CHILDREN

Parent has caused physical or sexual injury to another person not limited to family members or children. Information is supplied by a credible source that has direct knowledge of the caregiver's violent or sexually assaultive behavior.

No Risk (N)	Caregiver resolves conflicts in non-aggressive manner.
Low/Moderately Low Risk (L/ML)	Caregiver has engaged in isolated incident of assaultive behavior not resulting in injury. Caregiver has engaged in yelling, shoving or other physically aggressive behaviors with children and/or adults that have not resulted in injuries. Caregiver has a history of violence and has successfully participated in credible treatment program designed to address violent behaviors. Caregiver has history of reports of physical abuse toward children.
Moderate Risk (M)	Caregiver has sporadic incidents of assaultive behavior which result in or could result in minor injury. Caregiver has engaged in physical altercations with children and/or adults resulting in minor injuries. Caregiver has occasionally engaged in abusive/assaultive or intimidating behaviors toward children and/or adults. Caregiver's family, social contacts or others express fear of the caregiver's assaultive behavior. Caregiver has difficulty in work, social or other situations as a result of intimidating and aggressive language and behaviors.
Moderately High/ High Risk (MH/H)	Single incident or repeated incidents of assaultive behavior which results in or could result in major injury. Caregiver has had a prior substantiated report for child abuse. Caregiver engages in behaviors with children and/or adults resulting in serious injuries. Caregiver frequently engages in abuse/assaultive/intimidating behaviors toward children and/or adults. Caregiver has an arrest history of assault or crimes against others. Caregiver's family, social contacts or others are afraid of the caregiver and avoid contact with him/her. Caregiver has a history of restraining orders against him/her for violence or assault. Caregiver has refused, failed, or not completed treatment and persists in violent behavior.

Family Strengths/ Protective Factors	Caregiver is able to admit that he/she has a temper. Caregiver has sought help for his/her temper. Caregiver has good relationships with co-workers. Caregiver is assertive, but not aggressive about getting needs met. Caregiver is able to redirect anger toward accomplishing something positive. Caregiver is able to identify times when conflict has been an opportunity for change.

10. PROTECTION OF CHILD BY NON-ABUSIVE CAREGIVER

When there are instances of abuse or neglect, we need to observe that the non-abusive caregiver acknowledges the threat that the abusive caregiver poses to the child and possesses the capabilities and resources necessary to protect the child and keep the child safe from harm.

No Risk (N)	Caregiver is able and willing to protect child from dangerous person and situations.
Low/Moderately Low Risk (L/ML)	Caregiver is willing, but occasionally unable to protect the child. Caregiver is willing to protect child although lacks confidence in ability to do so. Caregiver provides protection by having child stay with appropriate friends or relatives.
Moderate Risk (M)	Caregiver's protection of child is inconsistent or unreliable. Caregiver obtains protection order, but allows violation of the order. Caregiver questions or doubts need to provide protection for child. Caregiver maintains relationship with abusive caregiver. Caregiver allows supervised contact between abusive caregiver and child. Caregiver questions child's account of abuse.
Moderately High/ High Risk (MH/H)	Caregiver is unwilling to protect child. Caregiver does not follow through with obtaining protection order. Caregiver allows contact between child and abusive caregiver. Caregiver does not recognize danger posed by abusive caregiver. Caregiver remains committed to relationship. Caregiver leaves child alone with abusive caregiver. Caregiver blames child for abuse. Caregiver pressures child to deny or recant reports of abuse.
Family Strengths/ Protective Factors	Non-abusive caregiver does not cover for abusive caregiver. Caregiver believes and supports the child. Caregiver recognizes dangerous situations and steps in to protect. Non-abusive caregiver is able to put the child's needs above his/her own. Non-abusive caregiver uses family or other resources to protect the child.

11. RECOGNITION OF PROBLEM AND MOTIVATION TO CHANGE

The recognition of the problem and the motivation to change are two separate issues. Both issues help determine a parent's commitment and ability to make positive change. Both indicators must be positive in order for a positive outcome to be completely supported. If both indicators are negative, a negative outcome would be most likely.

There may be circumstances where one indicator is positive and the other indicator is negative. A parent who does not fully recognize the problem, but is motivated to change may have difficulty changing the behavior since there is limited insight into the problem. If highly motivated, however, the parent may over time gain the insight required to resolve the issues. A parent that recognizes the problem, but has limited motivation to change will also be hindered in making progress unless circumstances change to increase the parent's motivation to alter the behavior.

The rating assigned under these circumstances will best be determined by case specifics. A parent that recognizes the problem, but is debilitated by depression may be unable to take the necessary steps to change. The rating would indicate lower risk if the parent was aware of the effects of the depression and expressed willingness to seek professional help.

Parents who are able to process new information about the behavior toward their children are more likely to experience positive outcomes. In contrast, if parents are unwilling or unable to process new information regarding the problem, progress will be limited and the risk greater.

Recognition of the problem and the motivation to change involves a parent's acknowledgement and awareness of CA/N issues combined with a readiness and commitment to change regardless of how difficult, painful, or costly those changes might be.

No Risk (N)	Caregiver openly acknowledges the problem and is willing to accept responsibility.
Low/Moderately Low Risk (L/ML)	Caregiver recognizes a problem exists and is willing to take some responsibility. Caregiver recognizes, but may not understand problem. Caregiver understands that child has been affected by CA/N, but does not understand the consequences to child. Caregiver is initially angry at allegations, but later agrees to comply.
Moderate Risk (M)	Caregiver has a superficial understanding of the problem and fails to accept responsibility for own behavior. Caregiver projects blame onto child or others. Caregiver minimizes impact of the problem on child and/or family. Caregiver overestimates child's resilience and ability to cope with abuse. Caregiver makes statements and promises indicating willingness to make changes, but fails to follow through.
Moderately High/ High Risk (MH/H)	Caregiver has no understanding of the problem and refuses to accept any responsibility. Caregiver maintains denial although presented with evidence. Caregiver believes that behavior is socially accepted norm. Caregiver denies emotional and behavioral impacts of problem/abuse on child. Caregiver refuses to change behaviors to alleviate CA/N. Caregiver has support of family and social network that supports continued CA/N.
Family Strengths/ Protective Factors	Caregiver asks for help. Caregiver expresses a motivation to change.

12. HISTORY OF CA/N AS A CHILD

A parent's history of CA/N as a child includes a parent's experience of physical abuse, sexual abuse, neglect and emotional abuse by caregivers in a manner that had the potential to result in significant physical, developmental or emotional harm.

No Risk (N)	Caregiver was raised in healthy, non-abusive environment.
Low/Moderately Low Risk (L/ML)	Caregiver had occasional incidents of abuse or neglect as a child. Caregiver remembers incidents of harsh punishment although did not perceive it as abuse. Caregiver recalls some abusive discipline. Caregiver's siblings were abused, but caregiver was not. Caregiver was victim of abuse and received support and protection from other family members.
Moderate Risk (M)	Caregiver has repeated incidents of abuse or neglect as a child. Caregiver reports basic needs not frequently met. Caregiver received harsh physical punishment on a regular basis resulting in frequent injuries. Caregiver has no sense of belonging or attachment to a family. Caregiver experienced a lack of consistent parenting by a loving caregiver. Caregiver has a history of hostile and verbally assaultive relationship with own parents.
Moderately High/ High Risk (MH/H)	Caregiver has history of chronic/severe abuse as a child. Caregiver reports being a victim of severe neglect that resulted in physical problems. Caregiver was victim of assaults resulting in fractured bones, physical disability, or emotional trauma. Caregiver was victim of sexual abuse and received no support, protection or affirmation from family. Caregiver recalls repeated beatings and/or physical attacks. Caregiver recalls no appropriate discipline. Caregiver reports severe emotional rejection, scapegoating and humiliation by own parents. Caregiver was deprived of food, clothing, rest or medical care as a form of punishment.
Family Strengths/ Protective Factors	Caregiver has worked through issues relating to his/her upbringing. Caregiver talks to siblings about how to avoid the mistakes of his/her parents; thus, avoiding the cycle of abuse. Caregiver has been able to learn from the past and its influences on his/her child rearing. Caregiver sought help to learn how to parent more effectively.

13. LEVEL OF COOPERATION WITH INTERVENTION

A parent's level of cooperation is determined by a family's willingness to work in partnership with DCYF/ CPS and service providers toward child safety, reunification, permanency and case closure.

No Risk (N)	Parent is receptive to intervention.
Low/Moderately Low Risk (L/ML)	Caregiver accepts intervention and is intermittently cooperative. Caregiver expresses willingness to participate in service plan, but occasionally fails to follow through. Caregiver appears angry and uncooperative, but complies with service plan.
Moderate Risk (M)	Caregiver accepts intervention, but is non-cooperative. Caregiver does not consistently comply with service plan. Caregiver undermines attempts to provide services. Caregiver undermines communication between service providers and CPS. Caregiver is verbally abusive toward service providers and CPS. Participation is unproductive, conflict-ridden, argumentative and/or caregiver is passive giving no attention to the service. Caregiver demonstrates no change in behavior despite service participation. Caregiver expresses justification for problem and/or abusive behaviors.
Moderately High/ High Risk (MH/H)	Caregiver is extremely hostile to CPS contact or involvement with the family. Caregiver refuses to work with CPS and/or service providers. Caregiver continues to blame others for abuse after intervention. Caregiver threatens violence toward CPS or service providers. Caregiver refuses to support child in services. Caregiver prevents CPS or services providers from seeing child. Caregiver avoids contact with social and service providers. Caregiver has extensive CPS history of non-compliance. Caregiver has past history of termination of parental rights. Caregiver flees with child to avoid CPS intervention and the CPS Specialist is unable to contact after numerous attempts.
Family Strengths/ Protective Factors	Caregiver wants to make things right for his/her family and is willing to work with CPS to get there-although that may scare him/her. Caregiver requests intervention and services. Caregiver follows through with what he/she says that he/she will do.

IV. Familial, Social and Economic Factors

Familial, social and economic factors are defined as employment status, family stress and social support. The presence or absence of these factors has been shown to impact the level of risk of CA/N in families.

14. STRESS ON FAMILY

Stress on the family includes life events that significantly diminish the ability to provide basic needs for the child.

No Risk (N)	Family has normal amount of stress and is able to manage it effectively.

Low/Moderately Low Risk (L/ML)	Family is experiencing mild stress. Caregiver experiences difficulty managing disruptions in household. Minor irritants lead to emotional distress for caregiver. Caregiver has difficulty maintaining perspective and mood stability under normal stress. Caregiver has limited income and regularly struggles to meet basic needs.
Moderate Risk (M)	Family is experiencing significant stress. Crisis and/or losses have led to intense anxiety, depression or frequent family conflict. Caregiver has ongoing conflict with intimate partner and/or intense conflict with siblings and extended family members. Caregiver has lost significant portion of financial income. Caregiver has chronic physical/medical problems resulting in pain and emotional discomfort.
Moderately High/High Risk (MH/H)	Family is experiencing multiple and/or severe stress or life changes. Caregiver has been evicted from housing and is homeless. Caregiver has lost major source of financial income. Caregiver has recently experienced the death of a child or other family member. Caregiver has recently experienced divorce or the loss of an intimate partner.
Family Strengths/ Protective Factor	Caregiver manages stress in healthy ways such as exercise, yoga, music. Caregiver has support to manage stress-a place to vent.

15. SOCIAL SUPPORT FOR FAMILY

Social support includes ongoing positive social contacts from extended family, friends and community that contribute to the overall well-being of family members.

No Risk (N)	Frequent supportive contact with friends and relatives with appropriate use of community support.
Low/Moderately Low Risk (L/ML)	Family is supportive, but not close by. Community services are available, but difficult to access or too infrequent. Family is new to the area and has yet to access social supports. Caregiver does not see the services being provided as helpful. Caregiver has social acquaintances, but no close friends, family or intimate partner.
Moderate Risk (M)	Family lives in an isolated area and is unable to access community or family supports. Limited community resources available. Services may be offered to the family, but remain inaccessible due to language barriers or the service provider's lack of familiarity with the culture of the family. Caregiver asks for help only when he/she is in crisis. The support the family receives from family and friends is inconsistent and unreliable. Social contacts are not emotionally supportive and some may be emotionally destructive. Caregiver cannot maintain friendships or casual social acquaintances.

Moderately High/High Risk (MH/H)	Caregiver has no one to turn to for emotional support or practical assistance in crisis or emergency. Family is geographically isolated and has no means to access help or support in times of emergency or crisis, i.e.. transportation or telephone. Caregiver is hostile and threatening toward offers of help with basic needs even though family is suffering. Primary caregiver is largely restricted to the home with little opportunity for periodic relief from continuous interaction with child. Family is alienated from or has an ongoing conflict with extended family, friends or neighbors.
Family Strengths/ Protective Factors	Caregiver is involved with activities outside the home. Family is open to feedback and support from their personal network.

16. ECONOMIC RESOURCES OF FAMILY

Economic resources for a family might include income from employment, public assistance, charitable contributions, or extended family or friends. Income from these resources is available to meet the family's basic physical needs.

No Risk (N)	Family has resources to meet basic needs.
Low/Moderately Low Risk (L/ML)	Caregiver works long hours or multiple jobs to make ends meet. Family lacks resources to meet educational, recreational or social needs. Family is unable to seek regular medical care due to financial limitations. Family seeks help from extended family, community and charities to supplement the meeting of basic needs.
Moderate Risk (M)	Family can minimally meet basic needs, but crisis leaves family without means to provide for basic needs. Family lives in unsafe environment due to lack of resources. Family member has ongoing medical condition, but is unable to treat due to lack of financial resources. Family is dependent upon extended family, community and charities to meet basic needs.
Moderately High/High Risk (MH/H)	Family resorts to illegal means to provide financial support. Family member has life-threatening medical condition that goes untreated due to lack of financial resources. Family has no access to supports that can provide help with basic needs. Family lacks a source of income to meet basic needs. Family's resources are so limited that caregiver must juggle meeting needs based on level of crisis.

Family Strengths/ Protective Factors	Caregiver maintains gainful employment. Caregiver knows and uses community resources to extend or increase financial resources. Caregiver has knowledge of budgetary, meal preparation, and other skills to stretch limited resources. Caregiver has found "free" ways to have fun with children in community. Caregiver has gone to family and friends to ask for help to ensure that basic needs are met.

17. DOMESTIC VIOLENCE

Domestic violence is defined as a pattern of verbal, physical, sexual and economic assaultive and coercive behaviors that occurs between intimate partners with one partner dominating the other.

No Risk (N)	Caregivers do not engage in any domestic violence behavior.
Low/Moderately Low Risk (L/ML)	Abusive caregiver engages in isolated incidents of domestic violence. Abusive caregiver engages in socially isolating behaviors with partner, limiting partner's contact with friends and family. Abusive caregiver engages in pushing and shoving partner. Abusive caregiver uses emotionally abusive language toward partner. Child may be present or witness domestic violence.`
Moderate Risk (M)	Abusive caregiver frequently engages in incidents of domestic violence. Abusive caregiver is frequently emotionally abusive toward partner. Abusive caregiver threatens or harms family members causing minor injuries. Abusive caregiver threatens to harm family pets. Abusive caregiver uses finances to control behaviors/life of family members. Abusive caregiver destroys property. Abusive caregiver cuts partner off from family and other social supports. Child may try to intervene or seek help from others.
Moderately High/ High Risk (MH/H)	Abusive caregiver engages in repeated incidents of domestic violence with severe emotional/physical consequences. Abusive caregiver coerces partner into sexual relations in front of child. Abusive caregiver engages in patterns of physical assaults, threats or intimidation of partner. Abusive caregiver isolates partner and partner is punished if outside contact occurs. Abusive caregiver uses/threatens to use weapons to harm family members. Abusive caregiver does not allow partner access to finances and controls all expenditures. Abusive caregiver does not allow partner access to transportation. Non-abusive caregiver denies violence despite evidence. Non-abusive caregiver appears detached, withdrawn or emotionless in light of extreme violence.

	Abusive caregiver severely injures or kills pet as a means if intimidation. Repeated police interventions for DV. Abusive caregiver threatens to kill partner if attempts are made to leave. Child is physically harmed during DV altercation. Non-abusive caregiver is frequently hospitalized for serious physical injuries due to DV. Abusive caregiver has refused, failed or not completed treatment and persists in violent and coercive behavior.
Family Strengths/ Protective Factors	Abusive Caregiver no longer resides with the family and there are legal or other protections in place to prevent his/her access to the family. Caregiver has a safety plan. Caregiver protects child. Caregiver seeks assistance to ensure that the family is safe.

Exhibit 18

Guide To
Conducting a Family Centered Team Meeting

Worker's Guide to Engaging Family

Based on family centered practice principles and philosophy, this practice will remain simple and basic. Remember:

- A group can often be more effective in making good decisions than an individual
- Families are the experts on themselves—we need to engage them as experts.
- When families are included in decision making, they are capable of identifying their own needs and strengths and are much more committed to the successful completion of the plan.
- Members of the family's own community add value to the process by serving as natural allies to the family and as experts on the community's resources
- Nothing about me without me!

The intent of the engaging the family is to:

- Prevent removal if possible by identifying the natural supports that the family has available, or services that can be utilized and wrapped around the family to create safety.
- Establish a relationship between the worker, the family and kin.
- Learn about any family progress since the safety assessment:
  - *Reinforce and celebrate any steps that the family has taken to mitigate the reasons we are involved in the system*
- Engage the family and secure an investment in working together.
- Ensure a common definition of success.
- Explore family needs and appropriate services to address those needs—relating to the reason the family is involved in the system.
- Learn about family existing strengths, resources, and protective capacities.
- Identify roles and responsibilities for each member of the team
- Provide sample documents so that the families understand what is required by the court.
- Identifying a member of the team that will stay connected to the family—and help the team assess progress toward to an agreed upon definition of success.

If a child is in care the intent of the meeting is also to:

- Establish a relationship between the resource family and the birth family.
- Address the predictable tension that can exist between a resource family and a birth family and talk about how to resolve the tension—be very transparent.
- Have the birth family share their knowledge about the child's needs, likes, dislikes, sleeping schedules, napping, favorite food, medical history, etc.
- Discuss ongoing interaction between the child and their family—the role of each in making sure the child stays connected to his kin (this can include teachers, best friend, neighbor and relative)
- Be very specific about the process—and the timeframes—create a visual aide to show the flow of the case through the system. FULL DISCLOSURE!

Setting the Stage:

- Inviting the right people—not "forgetting" to invite someone because they may be difficult or you don't want to hear what they have to say.
- Knowing the state laws and policies—clarify expectations for permanence, safety and child well being.
- In the verbal invitation describe the intent and the outcomes expected.
- Identifying a site that is most conducive to family engagement: churches, community sites,

resource family home, birth family home, school

Facilitation of the Meeting:

Facilitators need to set the ground rules to ensure a productive meeting:

- Engage the family in setting their own rules
- No disrespectful language, behavior or negative tones—team members have the right to call one another if they observe these behaviors.
- No talking over another person.
- No cell phones or pagers during the meetings
- Unless it is an emergency—no one leaves the meeting until the meeting is done

A Good Facilitator:

- Facilitator will protect ideas and individuals from attack or being ignored through the provision of a safe, supportive environment to permit communication
- Models supportive, non-threatening, respectful behavior.
- Conflict resolution in family team meetings: Getting to consensus
- Understand the difference between effective sharing of self—and telling people what to do.
- Finds ways to use humor to diffuse conflict—although we don't want to be afraid of conflict
- Fine line between being a part of the team—and facilitating the process.
- Periodically summarize, clarify, reframe and identify areas of agreement to assist the group.
- Make certain that the family's voice is heard and validate their feelings. Seek to find the balance between task and process.
- Inviting diverse perspectives without taking sides.
- Facilitators are sensitive and responsive to nonverbal cues. They must manage conflict and emotions.
- Facilitators move the group through the problem-solving/decision-making process, maintaining reasonable time frames.
- Facilitators accurately record information and decisions. They provide a copy of the safety/ action steps at the completion of the staffing to all participants.

TEN TIPS FOR CPS SPECIALISTS

[1]

FOR EFFECTIVE FAMILY TEAM MEETINGS

1. Be on time. It you are going to be delayed for any reason let the facilitator know so attendees can be informed.

2. Assist parent(s) with transportation if needed.

3. Explain the purpose of the meeting in advance to non-agency attendees.

4. Ensure that every person in the room feels that their perspective is validated.

5. Be sensitive and respectful of the serious nature of the staffing. Parents and others are watching, not just during the meeting but also before the meeting begins and after it ends.

6. Schedule adequate time for yourself. While it is important to adhere to timeframes for the meeting, remember we are dealing with critical and emotional decisions in the lives of families and whatever time is needed to make a quality decision should be expended.

7. Be clear on the goal of developing a decision, with the assistance of the child's family and others, which keeps the child safe in the least restrictive placement/least intrusive manner.

8. Come organized to present a summary of the situation and prepared with ideas and a recommendation, while receptive to the opinions and ideas of the other participants.

9. Be honest and fair in what you say. Discussion should be strengths-based, direct and straightforward.

10. Assist in keeping the group focused and productive. Invite others to share their perspectives, information and opinion.

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[1] *This is borrowed in part from Casey Family Programs Family to Family Team Decision Making Model*

Exhibit 19

About the Multi-Ethnic Placement Act and Interethnic Placement Act

Multiethnic Placement Act (MEPA), (P.L. 103-382) and the Interethnic Placement Provisions (IEP), (P.L. 104-188). Enacted in 1994, MEPA outlawed discriminatory practices, and, in 1996, the IEP clarified the original legislation and created sanctions for states and agencies which fail to comply with the act. MEPA forbids the delay or denial of a foster or adoptive placement solely on the basis of the race, color or national origin of the prospective foster parent, adoptive parent or the child involved. It also compels states to make diligent efforts to recruit and retain foster and adoptive families that reflect the racial and ethnic diversity of the children for whom homes are needed.

With the Interethnic Placement Provisions, Congress subsequently clarified MEPA and repealed that section of the law containing "permissible consideration" language which could have been used to obfuscate the law's intent. The amendment also dictates a penalty structure and corrective action planning for any state or private agency, which receives federal funds, that violates the amended section of the act. These two statutes are noteworthy for child welfare because they not only required changes in laws and policy; they also required changes in child welfare practice to facilitate more timely placement of children into foster and adoptive homes.

Exhibit 20

Title XIX Covered Services

Title XIX Covered Services:
The following is a summary of TXIX covered services. DBHS has redefined its covered services to create a comprehensive array of behavioral health services that are designed to assist, support and encourage each eligible person to achieve and maintain the highest possible level of health and self-sufficiency. Service changes and additions became effective on October 3, 2001.
Covered services are organized into a continuum of services domains. The domains include:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Services
- Prevention Services

Treatment Services
Designed to reduce symptoms and improve or maintain functioning. They are provided by or under the supervision of a behavioral health professional in homes, treatment facilities or in the office. Services include

§ Behavioral health assessment and consultation to determine level of need and to begin planning a course of action with person and family,
§ Counseling (individual, family and group) and
§ Other professional services (traditional healing, auricular acupuncture).

Rehabilitation Services
Designed for the remediation of residual or the prevention of anticipated functional deficits. They may be provided by a variety of levels of practitioners and in a number of settings. Providers may have professional degrees or they may be non-degreed persons experienced in working with a specific behavioral health population or issue. Providers may also work out of non-traditional agencies (community service agency) that previously have been unable to contract with ADHS/Regional Behavioral Health Authorities - as well as agencies that are licensed by behavioral health. Services include

§ Living skills training - coaching and support in activities of daily living,

- § Health promotion - education/training about wellness and coping with illness
- § Supported employment and
- § Cognitive rehabilitation.

Medical Services
Designed to reduce symptoms and improve or maintain functioning. They are provided or ordered by a licensed physician, nurse practitioner, physician's assistant or nurse and include medication, laboratory services, medical management and electro-convulsive therapy.

Support Services
Designed to facilitate the delivery of or enhance the benefits-received from other behavioral health services. They may be provided by a variety of levels of practitioners and in a number of settings. Providers may have professional degrees or they may be non-degreed persons experienced in working with a specific behavioral health population or issue. Providers of many of these services may also work out of non-traditional agencies that previously have been unable to contract with ADHS/Regional Behavioral Health Authorities - as well as agencies that are licensed by behavioral health.

Services include

- § Case management,
- § Personal assistance - hands-on help with activities of daily living,
- § Family support - training, coaching, modeling and hands-on help in dealing with a family member's illness,
- § Respite - temporary relief from care giving,
- § Peer support - coaching and support from someone who has had personal experience in the behavioral health system,
- § Flex funds - dollars available to fill some gaps not covered by behavioral health services,
- § Therapeutic foster care,
- § Housing support, interpreter service and transportation.

Crisis Intervention Services
Designed to stabilize or prevent a sudden, potentially deleterious behavioral health situation. These services are provided in a variety of settings (face to face, on the phone or in an urgent care center) and are generally intensive and time limited. Therapeutic activities may include screening, assessment, counseling, observation, medication, referral and support.

Inpatient Services
Designed to provide a 24-hour intensive, structured treatment. Includes hospital, sub-acute and Level I residential treatment centers.

Residential Treatment Service
Designed to provide a 24-hour structured setting in which to provide counseling and other

therapeutic activities. Includes Level II and Level III behavioral health facilities.

Behavioral Health Day Programs
Designed to improve the ability of the person to function in the community by providing regularly scheduled, structured services. Day programs may be provided in a variety of settings with programming that includes rehabilitation, support, counseling and/or medical services. The programs are graduated and vary in the availability and intensity of treatment provided as part of the program. They are classified as supervised day, therapeutic day and medical day programs.

Prevention
Designed to promote the health of the individual, families and communities through education, engagement and outreach. Generally provided for persons in groups who are not enrolled in the behavioral health system. Prevention-type services (such as relapse prevention, mentoring and stress management) may be provided to enrolled members through other services in the continuum; e.g. health promotion, peer support and living skills.

AZ has been utilizing Medicaid Title XIX funding through AHCCCS for behavioral health care since 1990 and SCHIP Title XXI (Kids Care) since 1998. This money is routed via AHCCCS and ADHS to the Regional and Tribal Behavioral Health Authorities (RBHA). The RBHAs are contracted to plan, develop, implement and monitor the provision of mental health and substance abuse services to eligible members throughout their geographic service areas. RBHAs have generally contracted with licensed, behavioral health agencies to provide the needed services. Through this revision of the covered services, RBHAs will now be able to contract with providers who are not licensed by behavioral health. Through a simplified certification process, agencies that otherwise were excluded from the behavioral health system may now work in collaboration with the RBHAs and be paid for appropriate services provided. These new partners in behavioral health service provision are called Community Service Agencies (CSA). They may include organizations such as the YMCA, Boys and Girls Clubs, respite providers, Parents Anonymous, home health care providers etc.

A significant step in the revision and redefinition of available behavioral health services was the process to make more of the services reimbursable by AHCCCS Title XIX and Title XXI. Maximizing the use of federal dollars for services allows state dollars to reach more people. It is essential, therefore, that all persons who may be eligible for these services are enrolled in AHCCCS.

The revised services are intended to be flexible, to reduce barriers to care and to support a person/family to be the "primary care giving unit" and is inclusive of those biological, legal, or self-created units of people who share a significant relationship with the enrolled person.

The ADHS behavioral health licensing rules have also been revised and rewritten as part of this effort to make quality behavioral health services more available and accessible to the people of Arizona.

ADHS has recently adopted 12 Principles of care delivery for children and their families. These Principles affirm the use of best practices to achieve positive functional outcomes, stability and independence for the enrolled person. Services are to be tailored to the individual, respectful of culture and designed in collaboration with the person's family and other agencies involved in care. Services are required to be accessible, timely and offered in the most appropriate setting. For all children, individuals and families, connection to community and natural supports is to be pursued. It is anticipated that the new covered services will facilitate adherence to these 12 Principles and enable each individual to achieve and maintain the highest possible level of health and self sufficiency **(See Exhibit 21, Twelve Principles to Develop the Behavioral Health Plan).**

Exhibit 21

Twelve Principles to Develop the Individualized Behavioral Health Plan

PRINCIPLE	QUESTIONS
Collaboration with child and family	Was the child and parents asked for their preferences in the planning? Does the plan show some of the following: § lists or descriptions of child or family strengths that later show up in treatment options; § parent statements that are included as part of the assessment. § evidence that parent were respected for their knowledge of the child. Does the examination by professional of parents/child have the some of the following; ■ Non-deficit or non-blaming statements. ■ Goes beyond engagement strategies; and most importantly, look to see if parent/child voice is present in the action steps of the plans.
Functional outcomes	Is there reference to clear behavioral objectives to help the child function better in the community, including success in school, living with family and avoiding delinquency? Do the assessments target behaviors to be changed and if those behaviors were described in terms of what would be better for the child/family if new appropriate behaviors were learned.
Collaboration with others	Is there evidence that the plan implementation has ongoing collaborative participation by every agency with whom the child has significant involvement? Includes meeting dates and signatures from those people.
Accessible	Is there assignment of case management or advocacy to help access to the system? ■ Look for timeliness for assessment, intake, and onset of first services. ■ Look for evidence of client satisfaction on accessibility. Were any measures taken of client satisfaction?
Best Practices	Best Practices refers to attempts to serve the youth in any way that would work -- through intensive individualization, through use of informal supports? ■ Is there evidence of use of best practices, such as supervision or clinical oversight. ■ Look for integration of non-traditional services into categorical services plans.
Most appropriate settings	Is there presence of alternatives tried beyond inpatient, residential and traditional outpatient services?

§ Look to see if a Comprehensive array of Services has been made available prior to use of restrictive care. For example, only outpatient therapy was tried prior to residential treatment.

Timeliness

Check dates to see if assessments and recommendations were followed by treatment actions within DBHS time frames?

Were there long stays in shelters or in transition living settings?

Services tailored

Is the assessment of strengths and needs followed by tailored traditional services or non-traditional treatment options?

§ Look for evidence of individualization through presence of unique interventions such as use of informal supports identified by the family and that indicate different solutions were tailored to overcome barriers.

Stability

Is there provider commitment to keeping the child in an appropriate setting over time without frequent moves?

§ If commitment is not present, provider would refer youth to other settings due to their behaviors.

§ Look for frequent statements such as "The needs of the child are not being met in this setting" or Youth is too dysfunctional for this setting" just prior to a move.

Culture

How does the plan clearly reflect unique family and/or ethnic/racial culture?

What are the family preferences, traditions, family rules, family habits?

- Look for evidence that special family preferences such as religious holidays were woven into the plan.
- Look for different interventions that cite family culture or preferences.

Independence

How does the plan address parent and youth capacity for self management; for example is it addressed through transition plans, graduation plans, etc?

- Does it include statements or plan for the eventual need for transition or independent living?
- Were adult services providers asked to participate or did participate in planning meetings?

Connection to natural supports

What informal supports are noted in the plan and used?

Are surrogate supports provided and included in the plan if family has lost their own support networks?

Exhibit 22

Checklists for CPS Specialists:

Providing Family Planning Services

Family planning information:

Information on abstinence from Department of Health Services, school, or other community resource provided to child.

CMDP's family planning information (CMD-078) provided to an reviewed with child over age 12 and provider, within ten days of placement and annually.

CHILDS documentation complete.

For a child age 12 or older requesting family planning services:

- Who the child wants to know about the request and participate in decision making discussed with child.
- Family planning services provided through CMDP or child referred to AHCCCS health plan for referral.
- Information on abstinence from ADHS, school, or other community resource provided to child.
- CHILDS documentation complete.

PROVIDING PREGNANCY CARE SERVICES

1. For a child who believes she is pregnant:

- **Prior to arranging the medical examination,** discussion held with child about involvement of out-of-home provider, other support persons, who to inform, medical arrangements, and accompaniment to appointment.
- Medical examination to confirm pregnancy arranged, using a CMDP or AHCCCS provider, to occur no more than **5 work days** from notification of the possible pregnancy.
- If the relationship with the alleged father is against the law or the pregnancy may be due to rape or incest, notification of law enforcement confirmed **within 24 hours** of being notified of the possible pregnancy.

- CHILDS documentation complete.

If the child is not pregnant:

- Provision of information on abstinence arranged through DHS, school, or other community resource confirmed.
- Family planning consultation arranged with CMDP or AHCCCS plan health care provider.
- Discussion held with child regarding involvement of the out-of-home care provider, accompaniment to medical appointment, and transportation arrangements.
- CHILDS documentation complete.

2. If the pregnancy is confirmed:

- CMDP nurse notified or out-of-home care provider instructed to contact child's primary care physician **within 1 work day** of the pregnancy.
- Case consultation held with supervisor **within 5 work days** to discuss who should participate in planning services for the child.
- Discussion held with child about who must, and who she wants to, be made aware of her pregnancy and participate in the case conference.
- Assigned AG notified of confirmed pregnancy **at least 2 days** prior to the case conference.
- Case conference held **within 10 days** of pregnancy confirmation to determine roles and responsibilities of service team members, and other services to be provided to the child.
- Non-directive, neutral counseling to provide information on options related to the pregnancy arranged **no more than 5 work days** after the case conference, and child assisted to schedule an appointment and arrange transportation.
- Child informed medical assistance and other benefits may be available for her or her child through the DES Family Assistance.
- Child informed of the father's financial liability for the infant.
- All known identifying information on any alleged father obtained and pregnant child assisted to confirm the identity of the father.
- Paternity test or affidavit of paternity obtained, when needed.
- Out-of-home care provider fully informed of services being offered to the pregnant child.
- Child's parents and the alleged father of the infant involved in counseling sessions when appropriate and in the pregnant child's best interest.
- CHILDS documentation complete.

1. When the child will carry the pregnancy to term:

- CMDP or primary care physician notified **within 5 work days** of learning the child's decision.
- Assigned AG notified of child's decision to carry the pregnancy to term **at least 2 days prior** to the case conference.
- Case conference held **within 10 work days** of learning the child's decision to assist child in understanding the options available; to identify needs; and to identify current and future living arrangements.
- Preliminary plan developed at case conference to address identified needs.
- Communication held with child's physician and/or out-of-home care provider on medical appointment scheduling and results.
- Potential health risks to the unborn child or the pregnant child fully shared with the physician.
- Out-of-home care provider fully informed of child's pre-natal and emotional needs and confirmed to be willing and able to meet those needs.
- Transportation to medical and other appointments arranged.
- Participation in parenting instruction encouraged and arranged, when child plans to parent the infant.
- Child and out-of-home care provider encouraged to plan for child's continuing educational needs.
- Child assisted to obtain information on, and apply for, medical and other benefits available to her or her child through DES, Family Assistance Administration.
- Counseling arranged related to the pregnancy, if needed.
- Identity of the father, his role in planning for the unborn child, and his financial liability discussed with pregnant child.
- Affidavit of paternity or paternity test completed, if possible.
- Pregnant child's parents' role in planning for the unborn child discussed with pregnant child.
- Child fully informed of services available from DES and the community to support her ability to parent the child, including temporary care options.
- Options available for the placement of the minor parent and her infant together reviewed with current out-of-home care provider and district designated staff.
- CHILDS documentation complete.

2. When the child decides on a plan of adoption:

- Child assisted to arrange adoption planning services through DES or a private agency.

- Child assisted to obtain any additional information needed to make an informed choice between available resources.
- Child's parents and the alleged father of the infant involved in the planning when agreed upon by the child and determined to be in the pregnant child's best interest.
- Involvement of child's GAL and attorney facilitated throughout process.
- CHILDS documentation complete.

3. When the child decides on a plan of legal guardianship:

- Child assisted to consider the ability of the proposed guardian(s) to provide custodial care.
- Proposed guardian(s) informed of process for obtaining legal guardianship for non-dependent children.
- Supervisor consulted to determine steps to be taken to protect the infant, if after the child's birth the mother pursues guardianship with a proposed guardian who may not be able to meet the health and safety needs of the infant.
- Child's parents and the alleged father of the infant involved in the planning when appropriate and in the pregnant child's best interest.
- Involvement of child's GAL and attorney facilitated throughout process.
- CHILDS documentation complete.

6. When a foster child is the alleged or confirmed father of an unborn infant:

Child advised and assisted to:

- determine his role in planning for the unborn infant;
- establish his parental rights;
- file a notice of claim of paternity, when applicable; and
- determine his role and responsibility in meeting the needs of the infant.
- CHILDS documentation complete.

7. Providing abortion services:

a. When an abortion is necessary to save the mother's life:

- Medical procedure and CMDP prior authorization arranged.
- Determine whether the child agrees to the notification and involvement of her parents.
- With supervisor and other involved persons, whenever possible, determine whether involvement of her parents is detrimental to her safety and welfare of best interests.
- Unless informing the parent is detrimental to the safety and welfare of the child or the child has requested her parents not be informed, **immediately** notify the child's

parents of medical condition and signature of medical facility's consent form facilitated.

þ Unless an emergency exists: if no available parent is willing and able to consent to the medical procedure, motion for medical/surgical treatment completed **no more than 1 work day** from learning of the need for the medical procedure, and court order obtained.

þ Post-termination counseling arranged for child, family members, and other significant persons.

b. When an abortion is not necessary to save the mother's life:

þ DCYF eligibility unit called **within 2 work days** to personally verify the child's Title XIX eligibility status and confirm the eligibility specialist has the most recent and accurate information

þ Determine whether the child agrees to the notification and involvement of her parents.

þ With supervisor and other involved persons, whenever possible, determine whether involvement of her parents is detrimental to her safety and welfare or best interests.

c. If the pregnancy is due to rape or incest and the child is Title XIX eligible:

þ Assigned AG notified child has chosen option of abortion, **no less than 2 days prior to the case conference.**

þ Case conference held **no later than 5 days** from the date of notification of the child's decision.

þ At the case conference, recommendations obtained from the involved team members regarding supportive services for the child, and roles and responsibilities of the participating team members determined.

þ Child's parent informed before the case conference, at the case conference or **no more than 2 work days** after the case conference, of the child's decision and arrangements for the medical procedure, unless informing the parent is detrimental to the safety and welfare of the child or the child has requested her parents not be informed.

þ If a parent is willing and able to consent to the procedure, facilitate the parent's signing of the medical facility's consent forms.

þ Unless an emergency exists: if no available parent is willing and able to consent to the medical procedure, motion for medical/surgical treatment completed **no more than 1 work day** from learning of the need for the medical procedure, and court order obtained.

þ Documentation provided to CMDP that the rape or incest was reported to a law enforcement agency.

þ Documentation provided to CMDP that the rape or incest was reported to a

law enforcement agency.

þ Post-termination counseling arranged for a child, family members and other significant persons.

d. When no state or federal funds are available for abortion services because (1) the abortion is not necessary to save the life of the pregnant child, not due to rape or incest; or (2) the pregnancy is due to rape or incest, but the child is not XIX eligible:

þ Child, out-of-home care provider, involved parents, and other participating service team members informed there are no federal or state funds available to pay for the abortion.

þ Recommendations obtained from an independent child welfare professional regarding the child's choice to terminate the pregnancy, the child's best interest relative to the pregnancy, and supportive services.

þ Assigned AG notified child has chosen option of abortion, **no less than 2 days prior to the case conference.**

þ Case conference held **no later than 10 work days** from the date of notification of the child's decision.

þ At the case conference, recommendations obtained from the involved team members regarding the child's choice of abortion and supportive services for the child.

þ At the case conference, or **no more than 2 work days following,** involved team members informed of the department's position relative to the medical procedure.

þ Roles and responsibilities of the participating team members determined in regard to timely arrangement of the medical procedure, obtaining parental consent or a court order for medical/surgical treatment, and supporting the child.

þ Service team members' and independent child welfare processional;s recommendation provided to court with motion for medical treatment, if court order required because no available parent is willing and able to consent.

þ Policy reviewed and assigned AG contacted if motion regarding abortion filed by GAL or another non-DES party.

þ Post termination counseling arranged for the child, family members and other significant persons.

þ CHILDS documentation complete.

Exhibit 23

Quality Supervision and Contacts with Children in Out-of-Home Care

Face-to-face contacts with out-of-home care providers and children in out-of-home care are a CPS Specialist's opportunity to gather first hand information about the child and placement. The CPS Specialist should plan contacts with children and providers in a way that allows him or her to assess these areas:

- The safety of the child.
- The provider's and the child's adjustment to each other.
- The ability of the placement to meet the child's needs.
- The developmental progress of the child.
- The appropriateness of the child's out-of-home care plan.
- The appropriateness of the provider's service and support of the case plan.

DES policy requires at least one face-to-face contact per month with each child and out-of-home care provider. However, there are circumstances where a provider or child will need more frequent contact. To determine if visits should occur more than once per month, consider the following questions:

- Is the provider a new provider?
- Is the child new to the provider's home?
- Does the child have a history of placement disruptions?
- Are there indications of problems with the placement?
- Are there stressors in the provider's home?
- Have there been changes in services, contact and visitation, or family circumstances which could be disruptive to the child or provider?
- Has the child or provider asked for more frequent visits?

DES policy requires that a minimum of one visit every three months occur with the child and the caregiver together in the caregiver's home. CPS Specialists should plan other contacts so they can observe the child in a variety of settings, or in settings where problems have occurred. If problems have occurred in the caregiver's home, it may be helpful to visit the child and caregiver in the home more frequently. If the problems have occurred in the relationship between the caregiver and child, more frequent visits with the child and the caregiver may be helpful.

Visits with a foster child who is verbal should always include time for the child or caregiver to speak with the CPS Specialist privately. To determine the best place to hold a visit, consider these questions:

- Is there a need to observe the caregiver's home?
- Is there a setting where the child has been having difficulty and could be observed?
- Have I observed the child in a variety of settings?
- Where will the child be most comfortable?
- What setting will allow adequate time and privacy?
- Is there a way I can hold a quality contact and complete another task at the same time? (i. e. transport the child to a visit or appointment or speak with a provider after a staffing)

Face-to-face contacts between CPS Specialists and children are an opportunity for CPS Specialists to give children current, accurate information and for children to share their thoughts and feelings. To guide the content of a visit with a verbal child, consider these questions:

- Does the child have current, accurate information about any plans, changes, etc. that affect his or her life?
- Does the child understand the current case plan and team members roles and responsibilities?
- Has the child had a recent opportunity to share his/her thoughts and feelings about
    - the reasons for initial or continued placement?
    - the current placement?
    - the current case plan?
    - parent and sibling visitation?
    - contacts with relatives and family members, friends, and former out-of-home care providers?
    - the case plan and how well it is working?
    - any other needs, fears, impressions, wishes, etc.?

- Have I recently reminded the child that he or she can contact the CPS Specialist between scheduled meetings?

Face-to-face contacts with out-of-home care providers are an opportunity for CPS Specialists to give them current, accurate information about issues affecting the child. To determine if the provider has current, accurate information, consider these questions:

- When was the Child's Placement Packet last updated by the CPS Specialist?
- Have any changes in visitation, services, or family circumstances occurred which are likely

to affect the child?

- Has the provider been given a copy of the current case plan?
- Has the provider requested and received a copy of the court reports?
- Have there been any changes in the case plan or expected length of placement?
- Has any historical information been learned since the last contact which would impact the care of the child?
- Has the provider been notified of all upcoming staffings, court hearings, Foster Care Review Boards or other appointments?

Face-to-face contacts give the CPS Specialist an opportunity to support the caregiver by allowing the provider to share his or her thoughts and feelings about the child, the effect the child is having in the home, and any aspects of the case plan. The CPS Specialist can further improve the quality of the child's care by answering any questions the caregiver has and reviewing the suitability of the services being provided to the child and/or the caregiver. To guide the content of discussions with a caregiver, consider these questions:

- Has the caregiver had a recent opportunity to:
  - discuss any problems or issues related to the care of the child?
  - share his or her thoughts and feelings about the case plan?
  - discuss the suitability of services to the child or the provider?
- Were questions or concerns raised during the previous contacts that require a follow-up discussion?
- Have I recently reviewed with the caregiver::
  - § the permanency plans and concurrent for the child?
  - § the expected length of placement?
  - § disciplinary issues and positive discipline techniques?
  - ▪ the caregiver's tasks and responsibilities?

BEST PRACTICE TIP:
Research and exit interviews with resource parents tell us that we lose good resource families because we do not provide information to them on a timely basis. Respectful engagement of resource families means that we provide them information as we have it, that we include them as an active, vital important part of the team. Further, we cannot expect a resource parent to actively participate if they do not have a copy of the case plan, if they do not understand their roles and responsibilities, and if they are not a part of the case plan review process.

- Does the caregiver need assistance identifying resources to enable him or her to provide for the special needs of the child, such as specialized training, culturally relevant activities,

community resources, educational opportunities, leisure activities and etc.?

- Has the caregiver indicated a behavioral concern about the child?
- Until a behavioral or mental health assessment can be completed, advise the caregiver to supervise the child at all times or arrange supervision of the child by another responsible person.

Exhibit 24

Parental Visiting and Family Reunification: How Inclusive Practice Make a Difference

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596 CHILD WELFARE • Vol. LXXXI, #4 • July/August

Sonya J. Leathers

This study examines whether inclusive practice, or parental involvement in foster children's lives while in placement, is correlated with more frequent visiting and a greater likelihood of reunification. This hypothesis was tested among a random sample of 230 twelve and thirteen-year-olds placed in traditional family foster care. Results suggest that mothers who visit their child and are involved in case reviews and child care activities visit more frequently than mothers who visit in settings such as agency offices and have no other types of involvement. In addition, visiting frequency is highly predictive of reunification. These associations were not explained by maternal substance abuse, mental illness, or the child's placement history.

In 1997, the passage of the Adoption and Safe Families Act

(ASFA; P.L. 105-89) signaled a significant shift in the orientation of the child welfare system. The 1997 legislation defined child safety as the primary concern of child welfare services, and reunification of families became secondary to child safety. Consistent with this new focus, provisions of the bill mandate termination of parental rights (TPR) for foster children within a limited time frame to ensure that children do not grow up in impermanent living situations. After a child has remained in care for 15 out of the most recent 22 months, a petition for TPR must be filed in most cases. Parents are provided with some protection from the potential consequences of this legislation. Exceptions may be made to the termination provision when TPR is not in the best interests of the child and when state agencies are shown to have failed to provide appropriate services that are necessary to return the child to a safe home.

ASFA will reduce the number of children who experience extended stays in foster care and provide important safeguards for children who might otherwise be returned to unsafe homes. This legislation also increases the pressure on birthparents and the child welfare system to move quickly toward reunification. These changes intensify the need for child welfare providers to provide appropriate, effective reunification services to families. An essential question is raised by this change in policy: What types of services increase a parent's chances of achieving reunification? Parental visiting is clearly an essential aspect of

permanency planning. Although few studies have tested the effectiveness of family reunification services after a child has been placed in care (Carlo, 1993; Landy & Munro, 1998), research indicates that frequency of parental visiting is a strong predictor of a child's beingreunified with his or her parents (Fanshel, 1982; Fanshel & Shinn,1978; Mech, 1985; Milner, 1987). Other than scheduling visits frequently (Hess, 1988), however, little is known about how visiting can be increased. This study examines whether certain practice patterns are correlated with more frequent visiting and an increased likelihood of reunification. If significant relationships are detected between practice patterns and visitation frequency, structured interventions that replicate these practices may increase rates of reunification.

Factors Complicating Parental Visitation

The parent's role in maintaining contact with his or her child is often emphasized by practitioners. Once a child enters care, a parent's failure to visit is documented to build a case for TPR should this be necessary (Proch & Howard, 1984). Yet the system's influence on parental visitation should not be discounted. Caseworkers themselves have suggested that the frequency of visits is influenced by a variety of agency- and system-determined factors, such as time constraints, agency policies and norms, transportation resources, foster parent requests, and caseworker perceptions about the best interests of the child (Hess, 1988). Policies regarding contacts with parents may be structured to encourage parents to participate in the child's life while in placement, or policies may inadvertently or explicitly discourage contact. Parents' experiences with caseworkers and agency constraints on visiting influence parents' feelings about their role in their children's lives and their ability to sustain contact (Jenkins &Norman, 1972; Millham, Bullock, Hosie, & Haak, 1986; Palmer, 1995). Research has suggested that as many as half of all foster children may be formally restricted from contact with their families for reasons other than concern for the safety of the child (Millham et al., 1986).

Some theorists have suggested that in addition to formal restrictions on visiting, parents must overcome psychological barriers related to the placement of their child. Parents are likely to feel intense shame and ambivalence after the removal of their child (Levin, 1992), and they may avoid contact with the child to protect themselves from feelings of inadequacy (Jenkins &Norman, 1972). Policies that restrict a parent's access to the child may reinforce these feelings. Practice that attempts to integrate the birthparent into the foster child's life while in placement has-been proposed as an antidote to such a process (Palmer, 1995). This type of care, called *inclusive practice*, encourages or requires birth parents to participate in the direct care of the child whenever possible by allowing them to have access to the child through informal visiting and other contacts. Proponents of inclusive practice suggest that parents should participate in the initial placement of the child and, after placement, in activities such as school conferences, clothes shopping, and doctor's appointments. In the inclusive practice model of care, the foster parent functions as a temporary caregiver for the child and a supportive role model to the parent (see Landy & Munro, 1998). Advocates of inclusive practice argue that it results in increased parental visiting, is less disruptive for the child, and results in fewer attachment conflicts and placement disruptions (Palmer, 1995, 1996). Very few studies, however, have been conducted that test these hypotheses.

Thus, the role of inclusive practice in influencing frequency of visiting and children's adaptation is unknown. Parents who have certain types of problems, such as substance abuse and serious mental illness, have been shown to be less likely than other parents to visit and regain custody of their children

(Fanshel,1975; Lawder, Poulin, & Andrews, 1986). It may be that inclusive practice occurs only in cases in which birthparents have relatively few problems. If this is the case, any associations between inclusive practice, reunification, and child adaptation to care might be explained by the parent's characteristics, rather than the type of practice that the family experienced.

The present study addresses this question by examining the relationships between inclusive visiting practices and frequency of visiting, chances of reunification, and current child adaptation, while controlling for parental substance abuse and mental illness. The author included indicators of earlier child adaptation(placement movement and time spent in group care) and other child characteristics (sex, race, and time in care) as control variables, as they might also explain associations between visiting, reunification, and current adaptation (Fanshel & Shinn, 1978;McMurtry & Lie,1992).

Understanding the relationships between inclusive practice, parental visiting, and children's adaptation to foster care is important. If inclusive practice is associated with greater visiting frequency even after controlling for parental problems, it might help increase rates of reunification. In addition, if inclusive practice is associated with better adaptation to care, encouraging such practice may provide benefits to children even when they remain in long-term care. Although this study does not involve testing the effects of a structured intervention, results may suggest that certain patterns of practice should be incorporated in interventions that attempt to increase parental visiting.

Results

Sample Description: Demographics, Visiting, Inclusive Practice, and Reunification

Most children (81%) included in the study were African American, as are most foster children in the area in which the study was conducted. About half were boys, and half were girls. Slightly less than half (48%) of the children had visited with their mothers at least once in the past six months. Only 16% of the children had visited with their fathers in the past six months. Among the 114 children who were visited at least once by their mothers, the average number of visits was 13.1 (*SD* = 16.7) in six months. Among the entire sample, the average number of visits with mothers was 5.6 (*SD* = 10). Demographic characteristics and frequency of visiting are shown in Table 1. Among the children who were visited by their mothers in the past six months, inclusive practice was infrequent. As shown in Table 2, only 6% had visits with their mothers informally in their foster homes; an additional 10% had visits that were always formally scheduled in their foster homes. Most children (51%) who were visited had visits in an agency office or a fast-food restaurant. Parental involvement in the child's care through participation in activities such as school conferences was also infrequent.

Among the entire sample of 230 children, just 4% of all parents participated in these types of activities. An additional 24% attended administrative case reviews every six months. Caseworkers did not expect many of the children sampled to return home. Just 11% were rated as very likely to return home, and 7% were rated as somewhat likely to return home. Most (71%) were believed to be very unlikely to return home. Most children(58%) had permanency goals of long-term foster care; 18.5% had a return home permanency goal. Consistent with caseworkers' expectations, very few children actually did return home in the year following their selection into the study. As of June 30, 1998, 20 children (9%) had returned home.

Does Visiting Frequency Predict Reunification Expectations?

The mother's frequency of visiting was strongly associated with the caseworker's prediction of reunification even after controlling for parental and child characteristics. As found in other studies (Fanshel, 1982; Fanshel & Shinn, 1978; Mech, 1985; Milner,1987), visiting frequency was a stronger predictor of reunification than maternal problems with substance abuse and mental illness and demographic characteristics. Visiting accounted for40% of the variation in caseworker prediction of reunification, as shown in Table 3. In comparison, maternal substance abuse and mental illness accounted for just 7% of the variation in likelihood of reunification. Before controlling for frequency of visiting, maternal severity of substance abuse predicted a low expectation of reunification (® = –.25, $p < .01$, not shown). After controlling for frequency of visiting and the indicators of inclusive practice, however, the effect of severity of substance abuse was weakened, such that it was non significant).

This indicates that the propensity for substance-abusing mothers to visit less often and to have less involvement in their children's care accounts for the association between substance abuse and lower expectations for reunification. Similarly, a highly significant association between length of time in care and lower caseworker expectations for reunification that was found before entering frequency of visiting (® = –.19, $p <.01$, not shown) was non significant after frequency of visiting was included (® = –.06, $p = .25$). This indicates that less frequent visiting of children who remain in care for a longer period of time explains the significant association between length of time in care and lower expectations for reunification. In contrast, maternal mental illness remained highly significant after entering the visiting and inclusive practice variables, suggesting that mentally ill mothers are not expected to achieve reunification regardless of whether they visit and are involved in their children's care.

As expected, visiting in the mother's home was a highly significant predictor of the caseworker's expectation that the child would be reunified. Maternal participation in administrative case reviews and other types of care, such as school conferences and doctor's appointments, was also predictive of reunification, even after controlling for frequency of visiting. Visiting in the mother's home was expected to be predictive of reunification because this type of visiting is often used to transition a child to the parent's home before the child returns home. The author did not expect the direct correlation between reunification and participation incase reviews and other types of care. This finding suggests that mothers who attend meetings in which permanency decisions are made may have a better chance at having their children returned than mothers who do not, regardless of whether they have a problem with substance abuse or mental illness, their frequency of visiting, or child characteristics, including length of time in care. This may be because mothers who have a strong motivation to get their children back may be more likely to attend administrative case reviews and remain involved in other types of care.

Attendance at administrative case reviews may also increase a mother's chances for reunification because attendance may be reported to judges and others who ultimately decide whether a child is returned. However, as compared to the indicators of inclusive practice, visiting frequency accounted for a much larger proportion of the variation in the likelihood of returning home,
indicating that visiting is a much stronger predictor of reunification than any of these other factors.

Is Inclusive Practice Predictive of Visiting Frequency?

Both indicators of inclusive practice were significantly correlated with higher frequency of maternal visiting, even after controlling for maternal substance abuse, mental illness, and child characteristics, including length of time in care (see Table 4). Location of visiting and maternal participation in other types of care accounted for 36% of the variation in maternal visiting frequency. As compared to children who visited at agencies, fast-food restaurants, or other settings, the unstandardized beta coefficients suggest that children who visited in their mother's homes experienced an average of 18.9 more visits over a period of six months after controlling for maternal problems and child characteristics.
Children who were visited in their foster homes experienced an average of 6.6 more visits. In addition, parents who participated in administrative case reviews visited an average of 4.5 more times over a period of six months than parents who did not; parents who participated in case reviews and other activities such as doctor's appointments and school conferences visited an average of 9.6 more times. These results support the hypothesis that parents who visit their children in foster homes or their own homes are likely to visit more frequently than parents who visit in agency offices, fast-food restaurants, and other settings. As discussed above, visiting in a parent's home might be expected to occur more often than visiting in other locations, as visiting in the home may include weekend visits and other frequent visiting arrangements just prior to reunification. This finding does not necessarily support the benefits of inclusive practice, as visiting in the parent's home does not necessarily mean that the parent integrated into the child's life while the child was in care. The association between visiting frequency and visiting in the foster home does provide support for the potential benefits of inclusive practice. This finding also raises many questions. Parents who visit in foster homes may be more comfortable with the visiting environment, or possibly with the child's foster parents, leading to fewer missed visits as well as the opportunity to feel included in the child's life while the child is in placement. Parents may also be served by agencies that not only encourage visiting in the foster home, but also support visiting by providing other services. Notably, however, only 16 parents visited their child in his or her foster home; replication of this finding will be necessary before this association can be assumed to generalize to other foster children. Whether increasing the proportion of parents who visit in the foster home through a structured intervention would increase visiting also cannot be determined from these results. Given the demonstrated importance of visiting for reunification, these questions should be pursued in additional research in which a larger number of families are randomly assigned to an inclusive practice program and compared with families who do not receive the program.

The associations between visiting frequency and participation in administrative case reviews and other types of care also provide support for the notion that parents who are involved in their children's lives in multiple areas are likely to visit frequently. Again, the small number of parents who participated in these activities means that it is essential that these results are replicated before they are accepted. In addition, a causal relationship between inclusive practice and visiting frequency cannot be assumed, because parents were not randomized to inclusive practice services and compared with parents who received traditional services. Parents who advocated for frequent visiting might also be those who advocated for more intensive involvement in their children's lives. An explanation for these findings might also be that parents with more extensive contact with a foster family are those who have the fewest problems and who are more likely to visit regardless of the type of practice. Because these associations were found even after controlling for parental problems, however, parental problems do not appear to account for the

associations that were detected. Although replication of these findings with a wider range of foster children whose parents are assigned to different types of service is needed, these findings provide support for the potential role of inclusive visiting practices in increasing parental visitation.

Is Inclusive Practice Predictive of Better Adaptation to Care?

Inclusive practice was not found to be associated with either better or worse child adaptation. None of the indicators of inclusive practice were associated with behavior problems, emotional disturbance, or loyalty conflict. The failure to detect an association between inclusive practice and child adaptation does not appear to be due to the use of a fairly small sample size, as none of the coefficients for the inclusive practice variables even approached significance. However, it is possible that too few children experienced practices such as informal visiting and maternal involvement in other types of care to detect their positive effects on child adaptation. Further research, in which families are randomly assigned to inclusive visiting practice programs, will be needed to assess the effects of these types of visiting practices. In addition, inclusive practice might have provided other, unmeasured benefits, perhaps as the result of increasing children's knowledge of their birthparents. In terms of emotional and behavioral disturbance and loyalty conflict, however, these findings provide no support for the hypothesis that children who experienced inclusive practice were better adjusted than children who did not.

Limitations

The author conducted this study with a random sample of young adolescents who had been in care a year or longer. Thus, the study only addressed how inclusive practice is related to visiting, reunification, and child adaptation among young adolescents who are in care for an extended period of time. Because the sample did not include children who had just entered care, results may not be generalizable to children who enter and exit care within a year or to children who are older or younger than the children sampled. Any significant results will need to be replicated in wider samples of children.

Future research should also include additional measures of inclusive practice, such as parental involvement in the placement of the child and, eventually, should test interventions that randomize children to an enhanced services intervention. In addition, it should be recognized that agencies serving parents who experienced inclusive practice may or may not have specifically attempted to promote inclusive practice. Some foster parents may have decided to have contact with birthparents although this was not the agency's general policy. If this is the case, these foster parents may have had other exceptional qualities that could be responsible for any effects of inclusive practice that are detected. Although this study may detect associations between certain practice patterns and positive outcomes, only research that involves randomized assignment to enhanced services could demonstrate that providing such services will produce these outcomes.

In addition, the author conducted this research at about the same time that ASFA was enacted. This may limit the generalizability of the findings, as practice may have changed following the passage of the legislation. This research, however, tests previously unexamined associations among specific practice patterns, visiting frequency, and children's adaptation to care, which provides a starting point for future research as well as baseline information to which future findings may be compared.

Conclusion

Consistent with the results of other studies, the results of this study support the theory that maternal visiting is a stronger predictor of reunification than maternal problems, such as substance abuse, or children's characteristics, including length of time in care. The results of this study also suggest that where visits take place is related to how frequently they occur. Visiting in the birth parent's home or the foster home were both associated with more frequent maternal visiting than visiting at an agency, a fast food restaurant, or another setting. In addition, maternal involvement in case reviews and other activities in the child's life was found to be associated with more frequent visiting. These results suggest that among young adolescents who have been placed in foster care longer than a year, inclusive practice is associated with more frequent visiting, which substantially increases a child's chances for reunification.

Additional research will be needed to assess whether encouraging inclusive practice would increase visiting and rates of reunification. The findings from this study support further exploration of the use of inclusive practice. Children whose parents participated in inclusive practice did not appear to have better adaptation to care than children who experienced traditional practice. However, there was also no evidence of any negative effects that would preclude the development of inclusive services focused on increasing rates of reunification. Barriers to increasing inclusive practice might include foster parent and agency resistance. Foster parents are generally paid only enough to meet the basic needs of their foster children. To expect them to interact with birthparents on a regular basis would shift their roles substantially. For example, for visiting in foster homes to be effective, foster parents would need to provide supervision, structure, and role modeling during visits (Loar,1998).

They would also need to convey a respectful and caring attitude toward birthparents. This might be difficult for foster parents who have strong feelings about how their foster children were previously cared for by their parents (Palmer, 1995). Agencies would need to train and adequately compensate foster parents to perform this new role. Although many barriers to developing programs that promote inclusive practice exist, success in developing such programs has been reported (Gillespie, Byrne, & Workman, 1995; Landy &Munro, 1998; Palmer, 1996). Given the shortened time frame for reunification that is imposed by ASFA, the importance of understanding the types of service that are most effective in increasing rates of reunification is heightened. It is hoped that child welfare agencies will consider the use of inclusive practice and participate in testing its effectiveness in future research.

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Exhibit 25

MAKING THE MOST OF VISITATION BETWEEN CHILDREN AND THEIR FAMILIES

An Excerpt from "Practice Notes" From the North Carolina Division of Social Services and the Family and Children's Resource Program
Volume 5 No. 4

Visit Frequency Counts

The frequency of parent-child visits has a lot to do with how children view their parents, how well they adapt to foster care, and how long they are in care.

Perceptions of Birth Parents. Researchers Kufeldt and Armstrong (1995) found that the foster children whose birth parents visited at least once a week tended to rate their parents as normal or healthy. In contrast, this same study found that children who were deprived of contact with their birth parents and wanted additional visits rated their parents as problematic. Children who saw their parents less than once a month felt they suffered as a result of not maintaining contact with their birth parents (Kufeldt & Armstrong, 1995).

Adapting to Foster Care. The frequency with which they visit their parents also seems to affect foster children's behavior. Researchers Cantos and Gries (1997) studied 49 foster children and found that children who were visited frequently (either once a week or once every two weeks) exhibited fewer behavioral problems than children who were visited infrequently (once a month or less) or not at all. Overall, children who had frequent contact with their parents showed less anxiety and depression than children whose parents' visits were either infrequent or nonexistent (Cantos & Gries, 1997).

Permanency Outcomes. Frequency of visits also appears to affect what ultimately happens to families. White and colleagues (1996) examined 41 closed case records of children under 10 years of age who had been in custody of the Nevada Division of Child and Family Services. The study examined visit frequency, location, and social worker activity for each of the cases. White and colleagues found that children in care for less than 20 months received twice as many visits from their parents than children who were in care over 20 months. This suggests that more frequent parent-child visitation may be associated with shorter foster care stays.

Parent-Social Worker Contact. White and colleagues also found an interesting relationship between the frequency of contacts social workers had with parents and how often parents saw their children. Parents of children in care less than 20 months had 2.49 contacts with their social worker per month, compared to 1.55 contacts per month for parents of children in care greater than 20 months. This seems to suggest that social workers have some influence over visitation patterns and, indirectly, family outcomes.

Facilitating Visits

Many agencies are well-equipped to establish and facilitate visitation programs. However, some are not. Following are some suggestions for assessing and enhancing visitation in your agency and practice.

The foundation of a successful visitation program is the people who establish and monitor visits—these individuals must be properly informed about the benefits of visitation and trained about visitation procedures (Perkins & Ansay, 1998).

The first step in facilitating visitation should be to set up a regular, written visitation schedule. Written schedules encourage birth parents to adhere to the visitation plan and often lead to more visits (Perkins & Ansay, 1998). Since they are essential to visits, birth and foster parents should be directly involved in setting up visitation schedules. Involving them and respecting their preferences for visit times and locations demonstrates to parents that they are important members of the team.

Increasing evidence also suggests that when the first visit is held immediately following placement (within 48 hours), birth parents may be more likely to show up for visits and more inclined to see their value (Gallimore, 2000).

Successful visitation also relies on accurate assessment of birth parents' strengths and needs. In *Making Visits Work*, Loar (1998) points out that most visitation plans assume that birth parents understand what their child goes through if they don't show up for a

visit, and that parents have leisure and recreation skills independent of drugs, alcohol, sex, danger, and violence. Other common assumptions are that birth parents know how to:

- Play with their children
- Talk politely with their children
- Enjoy their children's company
- Separate from the visit their frustration, shame, and humiliation over losing custody
- Read to children or read and understand court reports, contracts, priorities, major and minor requirements

Yet these assumptions do not always hold true. By overestimating parents' abilities, visitation planners can unwittingly undermine family reunification (Loar, 1998).

Another important step is communicating about the visitation plan to all interested parties. This includes ensuring foster parents know the visitation schedule and what is expected of them, explaining visitation procedures and activities to birth parents, and informing foster children that visits will be only temporary reunions with family (Kessler & Greene, 1999).

Finally, merely providing families with an empty office in which to meet is seldom enough. At the very least, visiting rooms should contain comfortable furniture, games, and toys. Loar (1998) suggests tailoring visitation plans to the interests of children and birth parents; they may have common activities/interests that facilitate positive interactions (Loar, 1998).

Documenting Visits

Regardless of how they go, it is important to comprehensively document visits. "Accurate and descriptive documentation of visitation patterns and progress serves the dual purpose of providing clear evidence for discharge or termination of parental rights" (Wattenberg, 1997).

Flick (1999) suggests visit documentation should include information about:

- Who participated and what activities took place
- The time the parent arrived and the length of the visit
- The interactions between the participants (level of affection)
- The extent to which the parent exercised his or her role (setting limits, disciplining child, paying attention to child)
- Whether the social worker needed to intervene
- How parent and child separated
- What happened after the visit (parent's or child's reactions)

Conditions That Optimize Visiting

- Social worker is committed to visiting
- Social worker has empathy for parents
- Foster parents/kin are committed to visiting
- Agency requires written plans for frequent visits
- Agency resources promote visiting; this includes a room with comfortable furniture and games or other activities for families

(Hess & Proch, 1988)

Influencing The Frequency of Visits

Social workers can do three things to promote frequent parent-child visits. The first is to try to schedule visits for times and

locations that work for all the parties involved—the birth parents, foster parents, children, and, if applicable, the social worker or person monitoring the visit.

When setting up the visitation schedule for families, try to schedule as many visits as the parents and other parties can reasonably attend. Because it places emphasis on making a case decision within one year, concurrent planning generates more urgency about scheduling frequent visits.

The second thing social workers can do to promote visitation is to strategically recruit, select, and train a pool of foster parents who can support the goals and tolerate the uncertainties of concurrent planning. During training and when children are placed in their homes, social workers can help support foster/adopt families by having open, honest discussions with them about the risk they are taking by agreeing to be "Plan B" (adoptive parents, guardians, or custodians) when "Plan A" (reunification) has not been ruled out.

Social workers should emphasize that the level of "risk" for the relatives or foster parents is not quantifiable. They should also make certain foster parents understand how visits fit with concurrent planning and why they are important. Without foster parent support, visits (and therefore concurrent planning itself) may be less successful.

The third thing social workers can do to promote visitation is to have frequent and quality contact with the birth parents. In *Factors in Length of Foster Care: Worker Activities and Parent-Child Visitation*, White, Albers, and Bitonti (1996) found a link between how often social workers saw birth parents and how often those parents saw their children. This same study also found a link between the frequency of visits and the length of time children spent in foster care: frequent visits seem to be tied to shorter stays in out-of-home care.

Supervisors can support social workers in their efforts to promote visitation by helping them examine their personal experiences and biases toward visit planning. Supervisors can also help social workers ensure "that visiting plans are individualized and that the opportunities provided for parent-child contact exceed the minimum required whenever indicated" (Hess, 1988). With their social workers, supervisors should carefully explore any plans for using visits "to reward parent progress or to test parental interest" (Hess, 1988).

In addition to monitoring the activities of individual workers, supervisors should assess whether their agency as a whole systematically promotes frequent visitation (White, Albers, & Bitonti, 1996).

Although social workers' and supervisors' roles in visitation cannot be underestimated, they are not the only ones who affect the frequency of visits. Courts also exert considerable influence in this area. For example, the courts in Santa Clara County, California order that parents visit their children two to three times a week in order to maintain bonds. This puts considerable pressure on the social workers and foster parents to keep up with the visitation pace (Wattenberg, 1997).

What to Watch for

In order to practice concurrent planning in a legal, honest, fair, and effective manner, certain mistakes related to visitation must be avoided:

1. Equating concurrent planning with adoption and therefore minimizing reunification efforts. This can lead caseworkers to schedule fewer visits.
2. Assuming assessment tools will infallibly predict case outcomes. This may lead to minimizing reunification efforts and decreasing visitations. Ultimately, the child's parents will support or prove wrong the assessed placement outcome.
3. Investing in a particular outcome. Allow the case to evolve from the family's decisions and actions.
4. Designing case plans that are not family-centered. Put another way, the agency takes on responsibility for things the parents should be doing. Parents have both rights and responsibilities. Concurrent planning supports their active role in visitation, engaging in services, and planning for their child's future.
5. Offering foster parents and relatives an estimate of "legal risk." Let the adults take the risks, not the children. Acknowledge that foster/adopt parents are taking on the role of "Plan B" and still supporting parental visitation. This is not easy. Encourage foster/adopt parents to

become involved in parent-child visits to promote more supportive relationships with biological parents.

6. Interpreting 12 months as an absolute limit on reunification, regardless of parental progress. "There is a fine line between the judicious use of time limits to prevent foster care drift, and a rote enforcement that ignores the full picture of parental motivation, effort, incremental progress, and a foreseeable reunification" (Katz, 1999).

Conclusion

When properly planned, facilitated, and documented, frequent visits between foster children and their parents can be positive experiences that result in equally positive outcomes.

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Exhibit 26

VISITATION SUPERVISION CONTINUUM

Research indicates a positive correlation between family contact and family reunification. For this reason, visitation is an important part of Reasonable Efforts when children must be placed in out-of-home care. Beyond this concern, the agency orientation is towards family reunification as quickly as possible.

Visitation takes on different characteristics as the case moves through the system and the child is getting closer to reunification.

Initial placement phase: In most cases, visitation is initially supervised, but in the most natural, family-like setting possible. This way it is easier to observe and collect assessment information, support the parent during the process of interacting with their child and at the same time ensuring the child s safety.

Visitation should focus on allowing natural parent-child interactions such as cooking and eating a meal together, reading stories, cleaning a room, playing a game, etc.

Central phase: Visits are planned to achieve case plan goals; and are planned to occur often and increasing over time in frequency and duration. The reunification phase should be initiated when the family has successfully experienced both unsupervised and overnight visits.

Reunification phase: Emphasis in visitation planning is on assuring a smooth transition home and assessing services needed to support the family following reunification. During this period, visits should provide maximum opportunity for parent-child contact and for parental responsibility for the child, particularly in areas where problems may have previously occurred. This is also an opportunity for the CPS Specialist to evaluate stress points in the relationship between the child and family and to plan for services to help alleviate these stressors.

Child-Parent Visitation

Carefully planned visitation between parents and their children in temporary care is a powerful family reunification intervention tool. Visitation can help implement many essential family reunification goals, including maintaining the parent/child/sibling relationships; enhancing child and parent self-images; promoting partnership between parents and foster parents; learning and practicing parenting skills; helping family members confront reality; and documenting progress towards reunification goals.

In developing and implementing a visitation plan, the following principles should be followed:

1. The must develop a plan that allows children to have frequent and consistent contact with their parents, siblings, and others who cared for them prior to placement. **Visitation should occur no less than weekly. In most cases, as much visitation as feasible is appropriate**.

VISITATION IS THE RIGHT OF A CHILD.

2. Family members should be actively involved in developing visitation plans. Not only does this increase the probability that family members understand and will comply with the plan, but it also assures that visit plans take into account the family members' needs, resources, and concerns.

3. Agency efforts shall be directed toward determining a visitation plan in each case that will best meet individual children's and parents' needs and will closely parallel the case plan goals. Visitation plans should address visit frequency, length, location, supervision (if required) supportive services, tasks and activities that allow for the most natural interaction between parents and children as possible. It should be expected that visitation plans may need alterations depending upon changes in the individual case.

4. Visitation plans shall consider information provided by service providers and foster parents concerning the progress of parents and the specific needs of the children.

5. **Visitation plans must never be used as a reward or as a punishment.** Changes in visitation arrangements shall be directly related to the ongoing risk and family assessment.

6. All parties involved shall be made aware of the visitation plans through the development and implementation of a written visitation plan. (See Visitation window)

7. Conflicts in determining the appropriate visitation plan are inevitable. Consideration should be given to the following:

a. Visitation conflicts involving realistic concerns for a child's safety and security should be resolved through weighing this concern more heavily than any other and adapting agency resources to address this concern.

b. When the **family members' right** to contact conflicts with the needs or preferences of substitute caregivers or service providers, the conflict should be resolved in a way

that protects and assures the family members' right to contact.

c. When visitation plan options offer varying degrees of support to the case plan, for example with regard to visit length or visit site, weight should be given to the visitation plan that best supports the case plan even when the visitation plan is less convenient or requires additional agency resources.

d. When expectations as to who should be included in visits differ, the child's and the parents' preferences should be given priority over those of temporary caregivers or **extended family members**.

e. When limited resources create a conflict with any aspect of the visitation plan, every effort should be made to develop or access resources in order to carry out the plan.

8. Reunification should be recommended when the child has safely completed unsupervised visits in the family's home; overnight visits; weekend visits (or visits lasting several weekdays); and, if at all possible, extended visits (longer than one week). These visits assist the CPS Specialist and the family to jointly assess if the changes that needed to occur have actually occurred. .

While we know visitation is critical we also must bear in mind our commitment to child safety. In instances when child safety during a visit is in question, one of the following will occur

- **Highly Structured/Strict Supervision Because the Family Needs Support and Assistance in Caring for Their Child Safely**
- **Moderate Supervision**
- **Relaxed or Intermittent Supervision**

Visitation Guidelines for "Highly Structured/Strict Supervision"

Presence of Facilitator: The child may not be removed from the presence of (sight or hearing) the person supporting the visitation. The individual supporting the visitation must be proficient in the language used at the visit; no whispering, no notes, etc. Parent remains in the visit room, while supervisor escorts child to the bathroom, drinking fountain, etc..

*Visit Site***:** Must be held in the CPS office or in the therapist's office or in another safe environment.

*Persons Who May be Present at Visits***:** Parents, grandparents and siblings only.

*Length of Visit***:** 1 Hour Only unless the visit is going well and then it can go longer depending upon the safety assessment of the individual supervising the visit.

Late Arrivals: If parent is a few minutes late, consider the reason and seek to find ways to provide the child and parent maximum time together. If parent does not show or call within 15 minutes, child will be returned to foster home. If child arrives late, ensure that the parent is provided the full visit time.

BEST PRACTICE TIP:
Of course it is important that children and CPS Specialists do not wait for extremely long periods of time for the parents to attend a visit. However, ***visits are not and should never be used as a punishment for the child or the parents.***

*Alcohol and Drugs***:** If parent's behavior indicates that the parent is intoxicated/"high", the visit is immediately cancelled.

CPS Specialist Fears Parent May Attempt Abduction: Prior to visit, the CPS Specialist alerts visit facilitator and back up (unit supervisor, law enforcement, etc.) Explains consequences to parent(s).

Parent Attempts Abduction: Alert back-up for assistance. Do not get into a tug of war with the parent over the child. Call 911, if needed.

Parent Successfully Abducts: Call 911 and CPS.

*Loss of Emotional Control by Parent, Upsets Child***:** Remove child; try to calm down and give parent another chance; if behavior persists; end visit.

BEST PRACTICE TIP
This is a complicated call because it is important for the child to see the loss and grief the parent is experiencing as a result of their being removed. Children need to know that their parents hurt too.

Inappropriate Parent Behavior: (Interrogates child, threatens/harasses child; demeans child/ spouse/relatives/foster parents/CPS; pumps for information re: other parent/foster home/school location; attempts to discuss case return home, charges, court etc.; extensive use of vulgar language.) Remove parent from room; give verbal warning or stop visit.

BEST PRACTICE TIP:
While the questions the parents ask the child may seem inappropriate it is possible that the

parent is concerned about the child and this is the only way the parent knows to ensure that the child is safe. Use this as an opportunity to help the parent understand how this behavior may be impacting their child.

Visitation Guidelines for "Moderate Supervision"

*Presence of Facilitator***:** CPS Specialist may delineate degree and specific type of supervisor activity for each individual case.

Visit Site: Designated sites outside the office may be recommended. Child must ride with the supervisor, not with parent.

Persons Who May be Present at Visits: Parent and others who are designated in writing by the CPS Specialist The total number of visitors should be agreed upon prior to the visit.

Length of Visit: Minimum 1 hour.

BEST PRACTICE TIP:
Sometimes it takes quite a while for the parent and the child to re-connect and feel comfortable with one another. As such, it is important to seek to make the visits as long as possible to allow this re-connection to occur.

Late Arrivals: If parent is a few minutes late, visit will end at designated time. If parent does not show or call within 15 minutes, child will be returned to the foster home. If child arrives late, every effort will be made to provide the full visit time.

*Alcohol and Drugs***:** If parent's behavior indicates that the parent is intoxicated/"high", the visit is immediately cancelled.

CPS Specialist Fears Parent May Attempt Abduction: Prior to visit, the CPS Specialist alerts visit facilitator and back up (unit supervisor, law enforcement, etc.) Explains consequences to parent(s).

Parent Attempts Abduction: Alert back-up for assistance. Do not get into a tug of war with the parent over the child. Call 911, if needed.

Parent Successfully Abducts: Call 911 and CPS

Loss of Emotional Control by Parent, Upsets Child: Remove child; try to calm down and give parent another chance; if behavior persists; end visit.

*Inappropriate Parent Behavior***:** (Interrogates child, threatens/harasses child; demeans child/ spouse/relatives/foster parents/CPS; pumps for information re: other parent/foster home/school location; attempts to discuss case return home, charges, courts etc.; extensive use of vulgar language.) Remove parent from room; give verbal warning or stop visit.

Visitation Guidelines for Relaxed and/or Intermittent Supervision, Includes Overnight Visits

*Presence of Facilitator***:** Supervisor may be present for portion of visit.

Visit Site: Site is usually the parent's home or other places the parent wishes. Child may usually ride with parent.

Persons Who May be Present at Visits: Any person may be present, except those disallowed by CPS.

Length Of Visit: 1-2 hours (for the supervised portion).

*Late Arrivals***:** If parent is not home or at designated visit site, the Parent Aide/Supervisor shall wait 15 minutes at least, then return child to foster home.

Alcohol and Drugs: If parent's behavior indicates that the parent is intoxicated/"high", the visit is immediately cancelled.

CPS Specialist Fears Parent May Attempt Abduction: Prior to visit, the CPS Specialist alerts visit facilitator and back up (unit supervisor, law enforcement, etc.) Explains consequences to parent(s).

*Parent Attempts Abduction***:** If parent is more than 15 minutes late in returning child to Parent Aide/foster parent, then the latter will notify CPS.

BEST PRACTICE TIPS
In this phase, it is important to consider other factors that might be impacting a late arrival other than abduction. If the parents have been actively involved in visits and in working with the child welfare system then the parent aide or caregiver should not over react to a late return.

Parent Successfully Abducts: Call 911 and CPS

*Loss Of Emotional Control by Parent, Upsets Child***:** Remove child; try to calm down and give

parent another chance; if behavior persists; end visit.

Inappropriate Parent Behavior: (Interrogates child, threatens/harasses child; demeans child/ spouse/relatives/foster parents/CPS; pumps for information re: other parent/foster home/school location; attempts to discuss case return home, charges, courts etc.; extensive use of vulgar language.) Remove parent from room; give verbal warning or stop visit.

Sibling Visitation

One of the biggest losses to a child in out-of-home care is the loss of shared history with other family members. Siblings who are placed together are often better able to adjust to placement and be realistic about reunification. If a child is not placed with siblings, all efforts must be made for maintaining these relationships. Structured interviews with more than one sibling as well as unstructured visitation times can aid the children with reunification.

If children are separated, the CPS Specialist can ensure that relationships are maintained by arranging frequent visits and shared experiences. With the younger child, more frequent physical contact is recommended. For the older child, less face to face contact may be needed but telephone contact and informal visits should occur on a regular basis. Siblings are to be encouraged to provide mutual support to each other.

Foster parents should bring siblings together for visits, therapy, vacations, etc. The sharing of history maintains consistency and support for the children. This assists in adjustment to transitions and in maintaining relationships.

I deserve to have the same memories as my brothers and my sisters&

Jessica
A Former Foster Child

Case-Specific Considerations: The Children

Children s chronological and developmental age:

- How frequently does this child need to have parental contact to sustain the relationship?
- What is the child's capacity-for self-care and self protection?
- How vulnerable is this child to potentially harmful situations?
- How able is this child to structure his or her own activities?

Children's Request:

What is the child requesting in terms of visits?

Children's Reactions to Visits:

- § Is the reaction appropriate given the stresses of placement?
- § Does the reaction reflect distress related to conflicting loyalties, such as between parents and foster parents?
- § Does the reaction reveal problems in the visitation situation?
- § Does the reaction reveal problems in the parent-child relationship?

Children's Developmental Tasks:

How can visits facilitate parent-child interaction related to the child's current developmental tasks?

Children's Therapeutic Needs:

How can visits facilitate children's progress on therapeutic tasks?

Children's Schedules:

How can visits facilitate parents' involvement in children's daily routines and in special events?

Case-Specific Considerations: Parent and Family Relationships

Parents' Behaviors and Abilities Related to Reason for Placement:

- § How can visits promote and support changes necessary for the child to be safe in the parents' home?
- § How can visits facilitate assessment of the child's safety in the home?
- § How can visits provide an opportunity for the parent to practice/apply appropriate parenting skills?

Parents' Compliance With Visitation Plans:

- § To what extent have parents complied with visitation plans?
- § What is the meaning of non-compliant visitation behaviors? Are the parents fearful that they will not have their children returned and as such are pulling away?
- § Are there barriers to visitation that can be eliminated?

Parents' Past Endangering Behaviors:

- § Is there a history of attempted abduction?
- § Have the parents ever attempted to deceive the CPS Specialist about an injury that may have occurred during a visit?
- § Have the parents ever threatened or attempted harm to child, staff, caregivers, or others during a visit?

Parents' Request:

What visitation arrangements are parents requesting?

Parents' Reactions to Visits:

- § What reactions -- positive and negative -- are parents experiencing during visitation?
- § Are parents able to refrain from expressing their reactions inappropriately in the presence of their children?

Parents' Schedules and Accessibility:

How can parents' access to visits reasonably be accommodated?

Family Relationships and Interactions:

- § Who does the child define as family?
- § What relationships are important to maintain or build through visitation?
- § What arrangements will minimize stress and conflict among family members during visitation?
- § What arrangements will maximize parent-child interaction (as contrasted with parent interaction with others visiting)?
- § How can visitation arrangements tap and build upon the family's social support network?

Case-Specific Considerations: The Foster Parents/Out-of-Home Caregivers

Agency Support of Foster Parents Involvement in Visiting:

- § What expectations do foster parents have regarding their involvement in visitation based on agency training, the licensing process, and expectations discussed with the CPS Specialist?

§ What supportive services does the agency provide to foster parents involved in visitation? (i.e.: reimbursement for transportation, support groups for problem solving, emotional support)?

Foster Parents' Capacity to Support Visitation and Reunification:

§ What are the foster parents' attitudes towards family relationships?
§ Do the foster parents value the child/parent relationship?
§ Can the foster parents appropriately engage in a relationships with the child's parents?
§ Are the foster parents able to supervise and support the visits?
§ Will the foster parents intervene appropriately and encourage positive parent-child interaction during the visits?
§ Are foster parents willing to allow visits in their home?
§ Are foster parents willing to supervise visits in their home or elsewhere and document what occurs as requested?
§ Are foster parents willing to teach a parent how to provide care for the child?
§ Are foster parents willing to transport?

If unwilling to assist with visiting, will foster parents be supportive of other reunification efforts and in what ways?

Foster Family's Schedule:

How can visitation arrangements minimize disruption to the foster family's schedule?

Impact of Visitation on Other Children in the Placement:

How distressing are one child's visits to other children in the home? Does the foster parents' support of one child's visitation result in the neglect of other children in the home?

Developmentally Related Visit Activities*

Age	**Developmental Tasks**	**Developmentally Related Visit Activities**

Infancy (0-12 mos)	Develop primary attachment	Meet basic needs (feeding, cuddling, bathing, protecting)
	Develop object permanence	Play peek a boo games
	Basic motor development	Help with standing, walking by holding hand, play come to me games
	Word Recognition	Name objects, repeat name games, read to child
	Begin exploration and master of environment	Encourage exploration; child proof home; take walks; play together with colorful, noisy, moving items
Toddler (1-3 yrs)	Develop impulse control	Make and consistently enforce appropriate rules
	Language development	Talk together, read simple stories, play word games
	Imitation, fantasy play	Play let s pretend games; encourage imitative play by doing things together such as clean house go to the store
	Large motor coordination	Play together at a park; assist in learning to ride a tricycle, dance together to music
	Small motor coordination	Draw and color together; string beads together
	Develop basic sense of time	Discuss visits and visit activities in terms of after lunch or before supper

	Identify and assert preferences, sense of self	Allow choices in foods eaten, activities, clothes worn
Preschool/Early school (4-7 years)	Gender identification	Be open to discuss boy-girl physical differences. Be open to discuss child s perception of gender roles;
	Continue development of conscience	Make and enforce rules; discuss consequences of behavior
	Develop ability to solve problems	Encourage choices; discuss problems together
	Learn cause-effect relationships	Point out cause-effect and logical consequences of actions
	Task completion and order	Plan activities with beginning, middle, end (as prepare, make cake, clean up). Play simple games such as Candyland, Go Fish
	School entry and adjustment	Shop for school supplies and clothes together; provide birth certificate, medical record for school entry, go with child to visit school prior to first day, talk with child about school experiences, attend school activities and conferences with teachers

School-age practice (8-12 yrs) demonstrate	Skill development (school), sports, special interest	Help with homework, sports, together, support of child's special interests, such as help with collections; attend school conferences and activities; work on household, yard task together
	Peer group development and attend team play	Involve peers in visits, team activities with child (or observe child s team together)
	Development of self awareness	Talk with child about child s feelings
	Preparation for puberty	Discuss physical changes expected; answer questions openly
Early Adolescence (13-16 yrs)	Cope with physical changes	Provide information re: physical changed; be positive about and help with personal appearance such as teaching about shaving, hair care, make up
	Develop abstract thinking	Plan and discuss future what if
	Development of relationship	Be open to discussing relationships; problems with friends; set clear expectations
	Become more independent of parents	Help learn to drive; assist in finding part-time job and handling money; support school completion

	Changes in peer group association	Transport to peer activities; include peers in visits
Late Adolescence (17-22 yrs)	Separation from family	Encourage independence through helping find an apartment, apply for jobs, think through choices. Tolerate mixed feelings about separation
	Develop life goals, rework identity	Be open to discuss options, think through together; share own experiences as young adults, both successes and mistakes.
	Develop intimate relationships	Be open to discuss feelings, problems and plans.

*Adapted from Family Visiting in Out-of-Home Care: A Guide to Practice, Peg McCartt - Hess and Kathleen Ohman Proch, Washington, D.C.: Child Welfare League of America, 1988.

Exhibit 27

ENSURING A MEETING WITH THE FAMILY IS FAMILY CENTERED

Description of Family-Centered Meetings

"Family-centered meeting" is a broad term used in child welfare to describe a planning and decision-making process that includes parents, caregivers, children, CPS Specialists and other service providers, and it may include extended family, friends, members of community groups, and other community partners. Once the investigation or the initial assessment is completed, a family-centered meeting can be convened. It can be called at any time in the life of case when there are important issues to address that require input and planning from both family members and professionals.

Purpose of Family-Centered Meetings

The purpose of FCMs is to (a) reach agreement on the issues to be addressed, (b) get the best thinking of family and service providers in developing plans that offer solutions, and (c) help these partners work together in carrying out the plans.

A family-centered meeting (FCM) in child welfare is held not simply to demonstrate respect or be "nice" to families. Nor is a FCM intended as a way for Social Services to give over its responsibility for protecting children at risk to the family. Social Services departments make the case decision on whether or not services are needed. This decision is not made with the family. Once Social Services makes the case decision, then the family and community are involved in the decision making on how to ensure the children's safety and wellbeing.

Principles of Family-Centered Meetings

The following table identifies the principles of family-centered practice and how each of these principles is applied in a FCM.

Principles of family-centered practice	Application in family-centered meetings
"The principles of family-centered practice reflect the belief that the family is its own primary source of intervention and determines who its members are."	The caregivers of the children decide with the CPS Specialist which family members and friends will be invited to the meeting. At most family-centered meetings, the number of family members and informal supports is greater than the number of service providers.

"The family is viewed as a system within a larger social and environmental context. As a result, interventions focus on accessing the family's immediate and extended community in needs assessment, resource identification and service delivery."	The CPS Specialist and the family work hard to widen the circle of support for the children and family by preparing for the meeting and making sure the right people are invited. This may include relatives and other close supports such as friends, pastors, and neighbors. At the meeting, the family and their close supports are encouraged to share their concerns, identify the needs and resources as they see them, and come up with a plan that meets needs and utilizes informal and formal resources.
"Family-centered practice respects the family's right of self-control and capabilities; and, assumes they have the capacity to grow and change when provided the proper supportive interventions."	Although the CPS Specialist must approve the plan and make sure that it meets the safety and well-being needs of the child, the family is encouraged to create the plan themselves. This is accomplished by the professionals first encouraging and considering the family's solutions prior to making their own recommendations. Depending on safety needs, private family time may be used to encourage the family's development and "ownership" of the plan. CPS Specialists employ a strategy of asking for the family's input rather than telling them what to do.
"Family-centered practice extends into the provision of placement services by involving the family in developing and implementing a plan for reunification, partnering with the foster family in temporary placement; and if necessary, working to preserve the child's placement in a new, permanent adoptive family."	Family-centered meetings include all of the people important in the life of the child. This brings together biological, foster, and adoptive family members.
"Family-centered practice develops strengths, enhances potential, and empowers families to identify and resolve their own problems."	Family-centered meetings focus on and identify the strengths of the children and family. This shows respect for the family and makes it possible to develop plans that will work. Families are encouraged to identify their own solutions because it is assumed that they are their own best experts. Although the family identifies solutions and plans, the CPS Specialist must share the critical concerns and make sure the plan meets the child's safety and well-being needs.

Overall Process of Family-Centered Meetings

The CPS Specialist talks with the key family members about having a meeting. It is essential that this process begins very early in the CPS Specialist's contacts with the family. The group decision-making approach may be new to both family and worker, so it can take some time to achieve trust in and understanding of the process. In order for the family-centered meeting to be effective, it requires the full support and participation of the family and worker.

Sometimes parents/caregivers are reluctant to include other members of their family/community network in a family meeting. This may be because of the desire for privacy, embarrassment, self-protection, safety, damaged relationships, prior abuse, or any number of reasons. FCMs are essentially voluntary processes. Participants, including parents, ultimately decide the level of their participation.

While parental wishes about who is invited/not invited should be honored and respected, it is also imperative that the CPS Specialist uses diligence in expanding the circle of support for the child and family as widely as possible. A broad and comprehensive circle of support is more likely to keep the child and family safe. Widening the circle involves a great deal of skill in working with resistance. When parents/caregivers are reluctant to hold a family meeting, CPS Specialists must seek to understand what this reluctance is about and how the safety and comfort of the parents/ caregivers can be achieved.

Preparing for Family-Centered Meetings

The preparation phase of all FCMs will determine in large part the success of the meeting's outcomes. Adequate preparation helps to ensure participant safety and support of the process. Safety and support for the process are what allow participants to engage in planning and decision making that is effective, creative, and long lasting. Preparation for a FCM is usually the responsibility of the CPS Specialist, although it should be done in partnership with the supervisor, facilitator, other professionals, and family members. Organizing FCMs usually happens over a period of time, depending on the case, and can usually begin with the very first contacts with the family. The following is a list of issues that must be addressed during the preparation phase of a FCM, prior to the meeting itself.

- Purpose – clearly defined and agreed upon
- Invitations – who is invited, making sure the right people are there, extending the invitation, and sometimes sending written notices or making telephone reminders
- Where and when – a place and time conducive to getting the right people there, usually not at the DSS agency
- Safety – both physical and emotional, for all participants
- Ground rules – guidelines for behavior at the meetings so that everyone is safe, comfortable, and able to participate effectively

- Confidentiality and informed consent – family members understand their rights to privacy and the limits of confidentiality, participants understand what will be discussed and consent to the purpose and the process
- Supports – people feeling at risk, particularly victims, have adequate emotional support both during and after the meeting
- Roles – all participants understand their roles and what is expected of them and others
- Views of the child – if children cannot attend the meeting, plans are made for ensuring that their views are heard and considered
- Interpreters – language barriers are addressed and planned for
- Special needs – making sure that no one's participation is inhibited by barriers involving mobility, literacy, developmental challenges, etc., arranging a telephone hook-up of people in detention or unable to travel
- Guest speakers – anticipating service needs and with the family's permission, inviting people who are not already involved in the case to attend part of the meeting to speak about possible resources to include in the plan
- Food – beverages, snacks, or meals that help set a tone of hospitality and comfort, encouraging full participation and respectful exchange
- Family traditions – starting, ending, and/or conducting the meeting in ways that honor and fit the family's culture; examples are a song or prayer of the family's selection
- Travel/transportation – ensuring that barriers of distance or lack of transportation do not inhibit the involvement of people crucial to the meeting's success
- Childcare – plans for children's attendance and/or care made ahead of time

Roles at Family-Centered Meetings

Each participant at a FCM is a valued partner working toward child and family safety and wellbeing. Each participant also has a distinct role and function.

Family members contribute knowledge and wisdom about family resources, concerns, history, relationships, and culture. They provide long-term involvement. Their role at a family-centered meeting is to create a plan for safety and wellbeing that works for them and can be approved of by the child protection agency.

Children are the focus of the family-centered meeting and should be closely involved in the process. The following questions will help the family members and CPS Specialist make decisions about how the child should be involved:

- How old is the child?
- How does the child want to participate?

- What special needs are there to consider about the child's involvement (cognitive, behavioral, developmental, emotional)?
- How does the family want the child to participate?
- Is there potential for the process to be helpful for the child?
- What kinds of supports need to be put in place for the child to participate safely?

Children should be present at the meetings whenever possible. If it is decided that children will not attend the whole meeting or part of it, the following are some options for ensuring that their views are heard:

- Audio/video tapes
- Designating a spokesperson for the child
- Conference calls
- Writing letters/drawing pictures ahead of time
- Participating in only parts of the meeting
- Having pictures of the child at the meeting
- Empty chair technique to remind the group of the child

Extended family, friends, and close supports also contribute knowledge and wisdom about family resources, concerns, history, relationships, and culture. They provide long-term involvement. Their role at a FCM is to help create and resource a plan for safety and wellbeing that works for the family and can be authorized by the child protection agency. The family members, CPS Specialist, and facilitator will decide together which extended family, friends, and close supports should be included in the FCM.

The case-carrying CPS Specialists contribute knowledge about agency and community resources and relays both the strengths that they see in the family system and the critical concerns that must be addressed in the family's plan. The CPS Specialist may be called upon to answer questions about agency interventions or provide information. Most importantly, the CPS Specialist must approve and support any plan that goes forward from the FCM. The workers must approve the plan in terms of meeting children's needs for safety and wellbeing and authorizing agency resources to carry out the course of action.

Other service providers inside Social Services and in the community also contribute knowledge about resources and relay both the strengths they see in the family system and concerns they may have for family members. They are encouraged to provide information and options for the family to consider rather than make recommendations.

Exhibit 28

Reunification Prognosis Assessment Guide

Instructions: In consultation with the unit supervisor, consider each poor prognosis indicator and each strength and mark those that describe the family being assessed. Identify and consider any additional poor prognosis indicators and family strengths that are not included in the checklist. Compare the poor prognosis indicators to the strengths, considering whether the family's strengths mitigate the poor prognosis indicators. Consult with an Assistant Program Manager, Psychological consultant or another supervisor if needed. If the poor prognostic indicators significantly outweigh the strengths, then prognosis appears low. Proceed with concurrent permanency planning.

Poor Prognosis Indicators:

- [ ] Has the parent repeatedly and with premeditation abused the child or another child of the parent?
- [ ] Has the child experienced physical or sexual abuse in infancy by the parent or due to the parent's failure to protect?
- [ ] Is the parent's only visible support system and only visible means of financial support found in illegal drugs, prostitution, and street life?
- [ ] Is there evidence the parent is chronically addicted to debilitating illegal drugs or alcohol? Examples of such evidence may include repeated drug related arrests or conviction, or abuse of drugs or alcohol during pregnancy.
- [ ] Is there a pattern of documented domestic violence of one year or longer that placed the child at harm or risk of harm, with inability to correct the situation?
- [ ] Does the parent have a recent history of serious criminal activity or repeated detentions or incarcerations?
- [ ] Has the child suffered more than one form of abuse including sexual abuse, or neglect; or have there been three or more CPS interventions for serious abuse or neglect; or has there been a pattern of cumulative or chronic harm from abuse or neglect?
- [ ] Have other children been placed in foster care or with relatives for periods of six months or longer or had repeated placements with CPS intervention?
- [ ] Has the parent abandoned the child with friends, relatives, hospital, or in foster care; or once the child is placed in substitute care, has the parent not visited of his/her own accord?
- [ ] Have CPS preventive measures failed to keep the child with the parent?
- [ ] Does the minor parent have no parenting support systems, and placement of the child and parent together has failed due to the parent's behavior?
- [ ] Has the parent asked to relinquish the child on more than one occasion?
- [ ] Has the parent's rights to another child been terminated?

[ ] Is the parent intellectually or mentally impaired showing significant self-care deficits **and** lacking a support system able to share parenting?

Strengths In Families

[ ] Parent responds appropriately to the child's verbal and non-verbal signals.
[ ] When they are together, the child shows comfort in the parent's presence.
[ ] The parent has raised the child for a significant period of time.
[ ] In the past, the parent has met the child's physical, emotional, and medical needs.
[ ] Parent accepts responsibility for the problems that brought the child into care and is taking steps toward change.
[ ] Is there at least one parent or guardian to which the poor prognosis indicators do not apply and who is willing and able to parent and protect the child?
[ ] The parent has a meaningful support system who seem free of overt pathology that can help him/her now (church, job, friends, AA/NA sponsor, parents, partners, friends, relatives).
[ ] Extended family and/or significant adults come forward to offer help when the child needed placement and has followed through on commitments in the past.
[ ] The parent's own history shows consistency of parental caretaker.
[ ] The parent's history shows evidence of his/her childhood needs being met adequately.
[ ] Parent's general health is good and parent accesses available medical care for self appropriately.
[ ] Parent has a history of stability in housing.
[ ] Parent has a stable employment history and/or employable skills.
[ ] Child shows age-appropriate cognitive abilities.
[ ] Child is able to attend to tasks at an age-appropriate level.
[ ] Child shows evidence of conscience development.
[ ] Child has appropriate social skills.

Exhibit 29

Standards for Timeliness of Behavioral Health Services

DBHS/RBHAs Time Frames:

All RBHAs have to ensure that eligible and enrolled persons have timely access to services. The following are the DBHS and RBHA established standards for the timeliness of behavioral health services.

Non-acute services

- § RBHA shall accept referrals 24 hours a day, seven days a week from all sources
- If the RBHA doesn't have centralized intake process, a directory of providers who perform intakes /initial evaluations shall be provided to referral source
- § Initial evaluation within 7 calendar days of referral or request for Title XIX services
- § The first behavioral health service appointment shall be provided within 23 days
- § Routine Psychiatric visit within 30 days of determination of need for a psychiatric appointment
- § Waiting time for appointments shall not exceed 45 minutes
- § Individual Service Plan (ISP)
- Non-acute service needs
- Individual Service Plan developed within 2 weeks of completion of the evaluation
- Acute service needs
- An interim service plan to be developed within 24 hours of the screening and or evaluation

Crisis services

- § By face to face or telephonically for assessment of acuity of situation
- § If assessment indicates the need for crisis services, face-to-face crisis services shall be provided:
  - In the metro Phoenix & Tucson areas within 1 hour
  - Other areas, face to face within 2 hours

Utilization review

- § Inpatient hospitalization -- Within first 72 hours from admission, and not more than every 7 days thereafter.
- § Out-of-Home Placements - At least every 30 days
- § Outpatient treatment - At least every 90 days

Notice requirements

Denial of a Request for Prior Authorization of a New Title XIX service

§ RBHA or subcontracted provider sends a notice not later than 3 business days from the date of a denial of a request for new services

§ Form "Notice of Our Decision about Your Request for Behavioral Health Services" for denial will be sent to the case manager

Reduction, Suspension or Termination of an Existing Title XIX service

§ Notice must be sent 10 days prior to the date of action for Children, Substance Abuse, General Mental Health

§ 30 days for SMI services

§ Form "Notice of Our Decision To Change Your Behavioral Health Services" will be sent to the case manager.

Exhibit 30

Issue Resolution Information Sheet

SOURCE INFORMATION **DATE:**

Mental Health Specialist Last Name: First Name:

Tel# : District: 1 2 3 4 5 6

Fax# :

Type of issue: **Type of Service:**

Denial TGH

Suspension RTC

Termination Hospitalization

Reduction Counseling

Timeliness Other

Service not available

CLIENT INFORMATION:

Child Last Name: First Name:

Client TXIX eligible: yes no RBHA enrolled: yes no

CPS SPECIALIST INFORMATION

Last Name: First Name:

Tel# : Supervisor:

RBHA INFORMATION:

RBHA Name: Network: (if applicable)

Customer service representative: Tel# :

RBHA Case manager:

ISSUE DESCRIPTION:

STEPS TAKEN TO RESOLVE ISSUE:

RESOLUTION DESIRED:

DBHS TEL# : 602-364-4620 (as for Children's Bureau Person available 8-5 pm)

DBHS FAX # : 602-364-4767

Central Office DCYF/ACYF - FAX # : 602-542-3330

Please fax to DBHS Customer Service Dept and Randy Grover at Central Office

Exhibit 31

Issue Resolution Process

LEVELS	EXAMPLE NONCRITICAL ISSUES STATE WIDE PROCESS	EXAMPLE CRITICAL ISSUES STATE WIDE PROCESS
	TYPES OF ISSUES - Reduction, termination, suspension, denial, and/or lack of timeliness in services	TYPES OF ISSUES - Reduction, termination, suspension, denial, and/or lack of timeliness in crisis or urgent services
	Examples § Time Frames: o Initial evaluation within 7 days o First service within 30 days of intake or request of service § Routine Psychiatric visit within 30 days of determination of need § Waiting time for appoints shall not exceed 45 min. § Individual Service Plan (non-acute service needs) developed w/in 2 weeks of screening § CFT issues o Recommendations should be followed unless the service requested requires prior auth o Should follow the DBHS CFT PIP & TAD docs o Written plans given at the end of the meeting o Effort made to arrive at consensus § Specialized services – services should meet the unique needs of CPS involved children and families o See the Unique Needs Document and PIP	**Examples** § Out of home placements § Discontinuation of medication § Court ordered services- when unable to meet time frames Time Frames -- § Crisis service - by face or telephonically for assessment of acuity of situation service, if assessment indicates the need for crisis services shall be provided in Phx & Tucson within 1 hour; other areas, face to face within 2 hours § Urgent care - initial screening or triage by tel. or face to face within 2 hours § If urgent care initial screening indicates the need for urgent services, face to fac e urgent services shall be provided within 24 hours
LEVEL 1	CPS Supervisor or Designee contacts provider case manager/ therapist	CPS Supervisor or Designee contacts provider case manager/ therapist
	No local resolution - GO TO LEVEL 2	
LEVEL 2	CPS Supervisor or Mental Health Specialist calls or faxes DBHS and completes issue resolution information sheet and sends a copy to Central Office	CPS Supervisor or Mental Health Specialist calls or faxes DBHS and completes issue resolution information sheet and sends a copy to Central Office

§ CPS Supervisor or Mental Health Specialist receive Priority Response

§ Requires a response indicating actions to be taken by RBHA or TRBHA sent to DBHS within 24 hours

§ DBHS will review the disposition information provided to them by RBHA/TRBHA contact person

§ DBHS will track the issue until implementation of the RBHA plan for resolution

§ DBHS will contact RBHA/TRBHA of closure for resolution

§ DBHS will respond to caller (CPS Supervisor or Mental Health Specialist) on resolution

§ CPS Supervisor or Mental Health Specialist receive Priority Response

§ Requires a response indicating actions to be taken by RBHA or TRBHA sent to DBHS within 24 hours

§ DBHS will review the disposition information provided to them by RBHA/TRBHA contact person

§ DBHS will track the issue until implementation of the RBHA plan for resolution

§ DBHS will contact RBHA/TRBHA of closure for resolution

§ DBHS will respond to caller (CPS Supervisor or Mental Health Specialist) on resolution

Exhibit 32

PSYCHOLOGICAL ASSESSMENT LEVELS

1. PSYCHOLOGICAL ASSESSMENT LEVELS

A. **Interview** (1-2 hours, including report preparation)

§ Evaluations in this level will include a written statement of individual and/or family assets and liabilities based on one or more intensive interviews with the individual and/or family members. Based on assessment, the statement must also contain a prescription for an appropriate treatment plan. Diagnostic descriptions shall be according to DSM-IV.

§ This level of evaluation may include review of previous evaluations or previously completed psychological tests.

B. **Interview(s) and Limited Testing** (3-4 hours, including report preparation)

§ Evaluations in this level will include a written statement of individual and/or family assets and liabilities based upon a) intensive interviews with the individual and/or family members, and b) tests including at least an individual intellectual performance and personality test. Whenever possible, previously completed test scores and profiles shall be used. A prescribed goal-oriented, time-limited treatment plan based on the evaluation shall be part of the written statement.

§ Diagnostic descriptions shall be according to DSM-IV.

C. **Interview(s) and Comprehensive Testing** (6-8 hours, including report preparation)

§ Evaluations in this level will include a written statement providing a comprehensive description of individual and/or family assets and liabilities. This statement shall be based on a) intensive interviews with the individual and/or family members and b) a full range personality, individual and intelligence test; educational performance evaluation; organic dysfunction and projective techniques. Wherever possible, previously obtained test scores and profiles shall be used. The statement shall contain a prescription of a goal oriented, time-limited treatment plan.

2. Diagnostic descriptions shall be according to DSM-IV- Psychological Assessment Behavioral Indicators

A. **Interview:** A basic psychological evaluation may be utilized to assess the nature of the problem(s) that brings the child and family to ACYF's attention, to assist in identifying treatment needs, and to help determine what services might best be utilized to address the child's and/or family's problems. This level of assessment may also be utilized to help determine and evaluate the child's and/or family's perception of problem areas and to identify areas where they want to receive help.

B. **Interview(s) and Limited Testing:** A more in-depth psychological evaluation (including limited testing) may be desirable when parents and/or children:

- § Display evidence of dysfunction which could include symptoms of anxiety and/or depression, aggressiveness toward others, disruption of school or work performance, poor social or interpersonal relationships, substance abuse or other forms of self abuse, (e.g., threats of suicide, running away, etc.).
- § Exhibit deviant physical characteristics or functions such as problems in balance, gait, speech, or hand-eye coordination. In addition, this level would be appropriate when children appear developmentally delayed.
- § Have been sexually abused or sexually abusing others.

C. **Interview(s) and Comprehensive Testing:** An in-depth psychological evaluation which includes comprehensive (projective and intelligence) testing may be necessary when parents and/or children:

- § Display evidence of severe maladjustment and dysfunction which may be demonstrated by more serious manifestation of the symptoms described in 2 above.
- § Exhibit behaviors which are extremely inappropriate for the situation or their age, including bizarre behaviors (e.g., delusions, hallucinations, or inadequate relationships with reality) or social withdrawal.

Exhibit 33

What CPS Specialists Need to Know About Substance Abuse Confidentiality

Federal Laws 42 CFR, Part 2 Confidentiality of Alcohol and Drug Abuse protect the confidentiality of alcohol and drug abuse participant records. This Federal law also severely restricts communications about identifiable individuals by programs that provide substance abuse diagnosis, treatment or referral for treatment.

Disclosure of client substance abuse information, including diagnosis and treatment, is permissible if a participant has signed a valid consent form which is not expired or been revoked by the patient.

Federal law prohibits unauthorized disclosure. This applies whether or not the person seeking information already has the information, has other means of obtaining it, has official status, has obtained a subpoena or warrant, or is authorized by state law.

The following apply to the prohibition on disclosure of records:

- Disclosure means any communication or information about a participant that would identify someone as a participant, or as a drug or alcohol abuser, including verification of information that is already known by the person making the inquiry.
- Participant means any person who has applied for, participated in or received an interview, counseling, or any other service from an agency, including Arizona Families F.I.R.S.T.
- Records protected from unauthorized disclosure include any information acquired about a participant, including the participant's identity, address, medical or treatment information, and all communication made by the participant to program staff, whether in writing or recorded in some other form.
- Participant identifying information is any information that will identify a participant as an alcohol or drug abuser, either directly or indirectly.
- Disclosure is permissible if a participant has signed a valid consent that contains specified items and is not expired or been revoked by the client. The consent/Authorization to Release Substance Abuse Assessment and/or Treatment Information meets this standard.

A State or Federal Court may issue an order permitting disclosure about a client that would otherwise be forbidden. The Court may issue the order only after it follows special procedures and makes particular determinations required by the regulations. The Court may order disclosure of confidential communications only if the disclosure is:

- Necessary to protect against threat to life or serious bodily injury.
- Necessary to investigate or prosecute an extremely serious crime (including child abuse).
- Connected with a proceeding at which the client has already presented evidence concerning confidential communications.

The federal confidentiality regulations prohibit the person receiving the protected information from making further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulations. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

If a participant is a minor, the minor must sign the consent and the parent, guardian or other person, or entity legally responsible for the minor, must also sign the consent.

If a participant is adjudicated, the participant's legal guardian may consent.

Prior to sharing a parent's substance abuse treatment information with the court or any party (including substance abuse treatment information in the court report) the parent must sign consent or there must be a specific court order. A consent is the preferred practice. Information may be shared with the Court when the parent is self reporting to CPS about their substance abuse problems or treatment history.

Obtain consent to document that the client has agreed to the exchange of information between CPS, the provider and any other party reflected in the consent. At the time consent is being required of the client, inform the client of the importance of the "service team" receiving accurate information regarding their progress.

This consent limits the information released to compliance information and is not a full disclosure of the therapeutic record. Information such as therapeutic notes would not be included; however information regarding client progress in treatment is available to assist the case manager in making determinations regarding permanency and case planning.

Without the consent, information cannot be shared with CPS or any other party without a court order.

Submit a signed consent with the referral to AFF or any other substance abuse provider to ensure communication and sharing information will occur regarding the clients progress in services.

Retain a copy of the consent in the hard copy case record.

Exhibit 34

DEPARTMENT OF HEALTH SERVICES
CHILDREN'S BEHAVIORAL HEALTH INTERGOVERNMENTAL AGREEMENT
CASE MANAGEMENT HIERARCHY

Primary responsibility for case management functions is as follows:

Characteristics of the Child/Youth	Case Management Responsibility
Category #1	
If the child is developmentally disabled: and receiving services from DES/ DDD	Division of Developmental Disabilities – DES is Primary
If the child above is also dependent and/or on probation:	DES/DDD is primary DES/ACYF and/or JPO are secondary.
Category #2	
If the child has been adjudicated to ADYTR and the child is also a dependent	DYTR is Primary DES is Secondary
If the child above is also on probation	Juvenile Probation is Secondary
Category #3	
If the child is dependent:	DES -Division of Children & Family Services is Primary
If the child is also in detention	Juvenile Probation is responsible for case coordination due to having the over riding legal jurisdiction.

If the child is also on probation	DES/ACYF is Primary Juvenile Probation is secondary
Category #4	
If the child is on probation	Juvenile Probation is primary

Exhibit 35

STATE OF ARIZONA
Division of Children, Youth and Families

Supervisor s Guide To Implementing Family Centered Practice

Table of Contents

Background and Position Statement Regarding Family Centered Practice 3

Use of This Document A Note to Supervisors 5

Helping Workers Develop Their Critical Thinking Skills With a Family Centered Lens 8

Best Practice Flow 9

Supervising to Family Centered Practice Along the Case Flow 12

Addendum 27

Background and Position Statement Regarding Family Centered Practice

Arizona DCYF has made a decision that Family Centered Practice will guide the standards of practice, supervisory activities and the day to day interaction between families, social workers and the community of caregivers and providers.

We have sought to craft a practice framework that is meaningful to the field. Housed within the framework are actual how tos for carrying out the complicated work of child welfare in a family centered way. These practices are interrelated, working together in a dynamic, synergistic way.

This practice framework will challenge every member of Arizona DCYF to work, to varying degrees, differently than we have in the past. We believe that the practice of these principles will over time, safely reduce the number of children entering the system as well as improve the care of those that do. It will require strong teamwork between the various units of the agency, and a willingness to look at biases, and personal values that may get in the way of effectively serving families.

While not intended to be prescriptive, this practice framework is expected to be the litmus test against which we measure the quality of our work.

Ensuring child safety, permanence and well being are foundational to the practice of child welfare we believe that family centered practice is a way of ensuring these outcomes.

How Does Family Centered Practice Improve Outcomes for Children?

Family Is Our Foundation

- In America, the family is a foundational institution we expect parents to be responsible for taking care of their children and when families need our help we have a responsibility to assist them. If the birth parents cannot assume a full-time caregiving role we need to find a family for the child who can while at the same time finding ways to keep the child connected to his or her history.
- Children tell us over and over again that they are better off if they can grow up in their own families

safely and stay *connected to their roots.* This provides a continuity of relationship and history. This is better for the child both in the short term and as they evolve into adults. We *owe it to every child* to give them an opportunity to grow up with their family.

- 80% of children who age out of foster care in this country are home by the time they are 21 years of age.

- Termination of Parental Rights, while necessary in some instances is a legal distinction, not an emotional one for either the child or their family.

Engaging families and practicing in a family centered way keeps children safer.

- The State of Minnesota found that safety of children was not compromised by engaging families and giving them more control over case decisions.
  - Moreover, there was evidence in Minnesota that child safety actually improved when the family is connected strongly to the community and not the child welfare system.
  - Cooperation between families and the child welfare agency increased. Family flight (leaving the town or disengaging from their children decreased).
    - because of the more positive and supportive orientation
  - When focusing more on engaging the families during the safety assessment (investigative) process services were more targeted and results more successful Families who are engaged early in the process felt they had greater involvement in decision making, were more satisfied with the experience and were better able to care for their children. [1]
  - With five complete years of data, families continued to have lower rates of recurrence.
- Children s long term mental health is damaged by losing consistent connections and stable living with an adult who loves and unconditionally cares about them.
  - **21% of children who are adopted from the child welfare system have significant medical/psychiatric or emotional conditions. [2]**
  - A 1990 study found that the incidence of emotional, behavioral, and developmental problems among children in traditional foster care (including depression, conduct disorders, difficulties in school, and impaired social relationships) was three to six times greater than the incidence of these problems among children not in out-of-home care. [3]
- By watching a family work through issues the child is learning about how to resolve problems in life.
- Frequent and consistent parent-child interaction teaches the child why they cannot live with their family (if they cannot) and at the same time allows for optimal connection.

Use of This Document: Note to the Supervisors

The intent of this document is to support you in your process of developing and supporting your staff to be family centered in their work. This document should serve as a support to helping workers integrate family centered practice in all aspects of assessment, case planning and service delivery. We suggest that you use this document during the teachable moments of case staffing and case review.

Keep this tool nearby and when interacting with a case worker. Ask the worker questions that are posed in the document. Reflect on some of the practice issues identified. Create experiences and opportunities for the worker and the entire unit to think about the art of social work practice and why they entered the field in the first place.

"It is the responsibility of the supervisor as a case consultant to the worker, to prevent the premature commitment to a position, point of view, judgment and prevent staff from becoming unwilling to consider alternative interpretations based on further information."
Gambrill, 1990

This document will assist you as a supervisor in remembering how important it is to ensure that **the way that you interact with the social worker is a role model for how the worker will interact with the family**. Pay attention to body language, verbiage, ways that you ask for information, ways that you redirect. The words that we use reflect our thoughts and feelings about families.

Critical components to strong supervision include the following and they are under your control!

- Controlled; non-random supervision
- Use a standardized process and criteria during consultative supervision
- Focus attention on the decision-making process of the worker what guided their thinking?
- Seek to reduce the influence of irrelevant information
- Know what you don t know
- Balance contradictory information and seek rationale
- Consider alternative explanations

Your specific tasks as supervisors include:

- To encourage and facilitate effective information collection that ultimately leads to child safety, permanency and well being;
- To help workers analyze case information and correctly identify threats to child safety;
- To assist in identifying difficulties in establishing sufficient safety/case plans;
- To increase worker competence; and
- To locate and address a worker s professional and personal characteristics associated with competence that limit effective child protective work.

The document is comprised of both narrative and a visual aide. The visual aide is a flow chart depicting best practice from the point of the referral call, to case closure.

Each practice section includes:

F A narrative which describes each practice and how this practice looks in the day to day life of a social worker. Each narrative statement has a star with a number reflecting where on the flow chart this practice can be found. The flow chart was created to assist the social worker in identifying how and when these practices are utilized while serving the child and family.

F Supervisory suggestions and reminders that address how to help your staff implement this practice area.

F References to Tools and Tips for Best Practice located in the Addendum as well as case examples that might be helpful as teaching tools.

Helping Workers Develop Their Critical Thinking Skills With a Family Centered Lens

Part of your task is to support the workers in improving their critical decision making skills. Below are Characteristics of a Good Critical Thinker by Nickerson (1987).

F Uses information skillfully and impartially remembering that you are always assessing and using information as a basis for helping support children and families.

F Organizes thoughts and articulates them concisely and coherently being fully transparent to families practicing full disclosure.

F Attempts to anticipate the probable consequences of alternate actions before choosing among them there is no magic bullet in child welfare every decision has tremendous implications for children and their families both in the short and long term.

F Has a sense of the value and cost of information, knows how to seek information, and does so when it makes sense understanding that the way that we ask questions is directly related to the quality of the information received.

F Listens carefully to other people s ideas families are the experts in their own lives and hold the solutions to many of their problems.

F Recognizes that most real-world problems have more than one possible solution and that those solutions may differ in numerous respects and may be difficult to compare in terms of a single figure of merit.

F Looks for unusual approaches to complex problems and builds on the times when the family was successful in the past what were they doing at that time?

F Can respect differing viewpoints without distortion, exaggeration, or characterization remembering that families come from diverse cultures we need to become very curious about why families do what they do.

F Is aware of the fact that one s understanding is always limited so be curious!

F Recognizes the fallibility of one s own opinions, the probability of bias in those opinions, and the danger of differentially weighting evidence according to personal preferences

F Can strip a verbal argument of irrelevancies and phrase it in terms of its essentials inside the family s story they are telling you things about what they feel, believe and want out of life.

BEST PRACTICE FLOW

1

The Call Comes Into CPS Hotline

2

Begin the practice of Full Disclosure where everyone Knows what everyone knows

3

Conduct a **safety assessment** –we seek to learn if safety issues exist in the family system. If so we seek to determine how the family can stay together safely—and if not who within the family can provide temporary care.

As we complete the safety assessment it is our task to let the family know that we are there to help—not to take away their children.

If the safety issues are such that the child is in immediate danger—and we cannot mitigate the danger by adding supports we must place the child. During the safety assessment we learn about kin.

Safety Assessment in the home

4

Refer to community agencies for support and services

5

Decision made as to the safety and risk issues. We meet with **families** whenever possible prior to placement to learn about kin. We carefully plan for these meetings to ensure that the voice of the family has optimal chance of being heard.

Child stays in the home

Child is placed

6

The **initial safety plan** allows the child to stay in the home with supports.

7

If a child has to be removed we pay close attention to the fact that this is painful to the child and the family---and we work with the child and family accordingly. We seek to put ourselves in the shoes of the children and families.

8

Court Hearing—seek to engage the family in kin identification

Whether the child has to be removed, or not we learn about the family's needs through a **comprehensive Strengths and Risk Assessment.**

9

10

When a child is placed in care the **birth family and the resource family work together closely** to support the reunification efforts. Children need to be involved in all case planning about their lives—age determines the level of involvement.

Part of the assessment process means that we understand the culture, ethnicity and rituals of the family. This helps inform our case plan development. **We start to learn during the initial contact when completing the safety assessment, learn more through the Strengths and Risk Assessment** and continue throughout the time of serving the family.

If a child cannot be placed with siblings (and this should be rare) ensure frequent sibling visitation.

12

11

Within 60 days initial Case Plan for both the child and family is complete. This is done in conjunction with the family.

Case Plan

1. Success is defined by the reason the agency is in the home--

2. We co-identify what success looks like (in the area that caused us to be in the home) ---

3.Family Strengths are explicitly tied to action steps

4. Prioritize the specific services and activities (in concert with the families) that are critical to achieving success – there must be an explicit link.

11

5. Engage community partners in the process – so that families have connections to the community AFTER we are no longer involved.

5. Ensure that every member of the team has a copy of the case plan – and understands their roles in carrying out the plan.

Worker and Family Visitation: Reviewing the progress of the family on an ongoing basis Families need to know what we are thinking.

13

We need to create positive visitation experiences by attending to location, timing and the way that we create opportunities for frequent and normal **parent-child interaction.**

Visitation in the birth family home

We Also Need to Ensure that children visit relatives and others who matter to them...teachers, best friends, grandparents

12

Frequent review of service plan. Required every 6 months but can occur more frequently. Look for Success—not necessarily compliance. Fully involve family in assessing success.

13

If the plan is not working--don't keep doing the same things...CHANGE THE PLAN!

13

Permanency Decisions must occur within ASFA timeframes.

Permanency Decisions—children And youth -the CFSR requires children as young as age 6—voice is strongly heard.

14

We also look for ways That the child can maintain optimal connection with birth family—regardless of final permanency plan.

of final permanency plan.

Supervising to Family Centered Practice Along the Case Flow

About this Section:

Supervisors can use this section of the document in many ways. It allows you to continually refer to the family centered practice framework along the flow of serving a family. The stars indicate where the best practice statement is relevant along the case flow. The supervisory tips provide considerations for how to move your supervisees to a new level of awareness in their practice.

Practice Statement #1

Family Centered Practice seeks to engage the family as partners in the identification of need, planning for services and assessment of service efficacy. Families must be included in every aspect of the assessment and service delivery process, from the initial involvement to the point where the child s safety, permanency and well being is secured

Intake and Safety Assessment Process

- During the intake call we find out from the caller what the family s strengths and resources are. We also ask the caller about kin people who care about the family.
- During the safety assessment we are honest with families we practice full disclosure we let the family know why they are involved, what needs to happen, and consequences if they do not achieve goals.
    - Everybody knows what everybody knows&we don t hide behind the myth of confidentiality.
- During the safety assessment we meet families where they are at. Workers need to ask families:
    - Why do you think that I am here?
    - Do you think that you have any issues that jeopardize the safety of your children?
- During the safety assessment we learn about how the family interacts, who matters to them, what are their supports, what is it that they see they need help with, how they solve simple problems. We do this in the process of learning if there are any immediate safety issues for the child. We are

assessing both for safety and looking for ways to mitigate safety concerns.

- Some of the ways that we learn about family supports is to ask open ended questions like the following:
    - Who do you go to in times of need?
    - Are there places in the community you go to for help?
    - If we have identified safety concerns we discover family connections and use the information compiled in setting up the Family Team Meeting and in case planning.
- During the safety process we seek to understand the family s decisions about parenting.
- Throughout the safety assessment it is our task to ensure that families **know that we are there to help** not to take away their children.

- If we do identify safety concerns, we craft an immediate safety plan for the family.

- Family Meetings are very helpful vehicles for crafting a safety plan and for learning about kin who can support the family.

Meetings With Families (See Addendum #1: Guide to Family Meetings)

Meetings with families occur throughout the entire process. When we hold a meeting with families PRIOR to placement the intent is as follows:

- Prevent removal if possible by identifying the natural supports that the family has available, or services that can be utilized and wrapped around the family to create safety.
- Establish a relationship between the worker, the family and kin.
- Learn about any family progress since the safety assessment:
    - *Reinforce and celebrate any steps that the family has taken to mitigate the reasons we are involved in the system*
- Engage the family and secure an investment in working together.
- Ensure a common definition of success.
- Explore family needs and appropriate services to address those needs relating to the reason the family is involved in the system.
- Learn about family existing strengths, resources, and protective capacities.
- Identify roles and responsibilities for each member of the team
- Provide sample documents so that the families understand what is required by the court.

- Identifying a member of the team that will stay connected to the family and help the team assess progress toward to agreed upon definition of success.

Meetings with families also occur FOLLOWING placement. The intent of those meetings is as follows:

- Establish a relationship between the resource family and the birth family, or address any issues between birth family and kin.
- Address the predictable tension that can exist between a resource family (including kin) and a birth family and talk about how to resolve the tension be very transparent.
- Have the birth family share their knowledge about the child s needs, likes, dislikes, sleeping schedules, napping, favorite food, medical history, etc.
- Discuss ongoing interaction between the child and their family the role of each in making sure the child stays connected to those who matter to him/her (this can include teachers, best friend, neighbor grandparents/relatives on either side)
- Be very specific about the process and the timeframes create a visual aide to show the flow of the case through the system. FULL DISCLOSURE!

Family Centered Strengths and Risk Assessment Process

§ During the Family Centered Strengths and Risk Assessment is the art of using our skills, compassion and empathy to have the family tell their story.

§ We ask open ended, **strength-focused questions** that help us to understand how the family functions, where they have strengths, resources and capacities, where they have succeeded in the past and how we can tap into those strengths so that they can again experience success.

§ It is important to note that change NEVER occurs from a position of deficit if change is to occur it comes from a place of hope and confidence. Engage the family and provide the family with hope that things can get better.

§ Within the ***Guide to Conducting A Family Centered Strengths and Risk Assessment*** there are questions that may be helpful in learning about the following key assessment areas:

These questions are designed to engage the family. We seek to be fully transparent so that the family understands why we are asking the questions and how their responses will assist in developing the case plan.

- The Family Perspective of the Issues (Family Story)
- Basic Needs: Food, Housing, Clothing
- Day to Day Parenting
- Family Fears
- Family Connections Support System
- Child Mental Health
- Parent Mental Health
- Parent/Child Substance Abuse
- Domestic Violence
- Employment/Vocational Status
- Medical/Dental Needs

Case planning and Case Plan Review

- Engaging the family in the case planning process means that we NEVER develop the plan and then bring it to the family.

- We look for explicit ways to engage the family in the process of planning for their own lives. Family meetings are vehicles for Case Planning families most often know what is best for them what will work.
- Family Centered Practice means that we look to the family to find solutions for their problems.
- We ensure that the family knows we are interested in their success NOT simply in their compliance.

Some of the skills necessary to develop collaborative/engaging relationships with families include:

- **Following the parent s lead**
  - The worker purposely nurtures a collaborative relationship with the family, while avoiding being controlling. Alliance building by letting the parent tell his/her own story may take more time than interviews directed by the worker, but it is a worthwhile investment.

- **Empathic listening**
  - The worker pays attention to the parent s worries about the child and voices an appreciation of what the parent is coping with.

- **Recognizing the parent s and child s strengths**
  - The worker talks about what the parent has done well, empowering the parent.

- **Finding common ground**
  - Differences between the worker and family make building collaboration hard work, but

usually they can agree on at least some of the child s needs.

§ **Not taking the family s behavior personally**
  - o Recognizing that the family has reasons not to trust, the worker avoids reacting to behavior that seems uncooperative but is driven by past victimization.

§ **•Immediate response**
  - o The worker builds trust by finding something the parent wants assistance with that he/she can provide or arrange.

Supervising to Family Engagement:

Supervisors Did You?

þ Talk to social workers about power imbalance if social workers are to really engage families, they must first admit that there is a power imbalance admitting that families have legitimate reasons to feel scared and lacking in trust of the system.

þ Challenge workers who approach families with a we know best or an "I am in charge" approach. If supervisors do perceive these kinds of approaches are being used they must confront and redirect staff.

þ Help workers see that we do not develop collaborative relationships with families by taking on a law enforcement role we are social workers and supervisors have to assist staff in identifying with the social work profession not the law enforcement profession. Use the scaling question On a scale of 1-10 with 1 being law enforcement and 10 being social where would you plot your professional identity?

þ Help workers conducting the safety assessment understand that while they have to compile information they need to do so in such as way that they do NOT alienate families and that the next worker in the system who works with the family does not have to undo the relationship damage that was done.

þ Help workers focus on the entire family as an entity that needs support to stay together safely. Those conducting the safety assessment need to look for ways that the family can stay together safely!

þ Attend to how the social worker s values, biases and experiences may be influencing family engagement. How do your past experiences impact how you are engaging the family?

þ Listen as the worker talks about the family what is your sense of how they feel about the family do they respect them or do they judge them pretty harshly or somewhere in between.

Practice Statement #2

Family Centered Practice requires that we build on the strengths and the capacities and resources of the family system. Strength focused work looks to the family to identify the solutions to their problems believing that the solution lies within the family system.

§ Families and workers need to define success in the same way otherwise how can the family know and understand where they are going?

§ Families most often have the information needed to make decisions affecting them. We need to ask the families what they think&and they should, in most cases, be the core decision-makers.

- We need to find ways to help parents rear their children we look for ways for families to stay together safely.
    - We give families back the power to make decisions about their lives.
- The plan that we develop is an ongoing living document we craft it and revisit it frequently. So each time we visit with the family we see if the plan is still a good plan for success.
- The initial safety plan, the five day plan and the case plan are directly related to the reason that we are in the home.
    - We use the strengths as a foundation for actual case planning.
    - We identify what success looks like (in the area that caused us to be in the home) ---and then we prioritize the specific services and activities that are **critical to mitigating the need**.
    - The family tells us what they need most.
- The team every member has a copy of the case plan---and each has their role in assessing the efficacy of the plan. Anyone can call a team meeting to change the plan.
- Children need to be involved in all case planning about their lives age determines the level of involvement. The CFSR standard expects that children as young as 6 have a voice in planning for their own lives we need to seek to understand their thoughts and feelings and keep them informed about the choices to be made in a language that they can understand.
- When workers visit birth families, children and resource families the meetings have a purpose assessing if the plan is accomplishing what it was intended assessment of progress explicitly linked to the reason that the children are in care.

- These are the kinds of occurrences that result in a case plan review meeting:
  - *Any move of the child*
  - *Resource family (including kin) asks for a meeting as they are struggling with the child and do not want the placement to disrupt*
  - *The family is not making progress toward the definition of success*
  - *The family is making progress and the services are no longer needed*
  - *The family asks for a meeting*
  - *The child asks for a meeting to talk about their lives*

Supervising to Inclusion and Ensuring We Hear the Family Voice
Did you?

þ Review the file to ensure that the family has told their story, in their words.

þ Notice if the language of the worker (written and verbal) reflect an understanding of the family *not judgmental, reframes the family struggles, reflects the family's ideas about what might work, written in the family s voice it is a less directive, clearly depicts a collaboration between the worker and the family.*

þ Help the worker translate the family s strengths into protective capacities?

þ Ensure that the worker identified supports within the family network and found ways to build on these family supports as a way to keep the children safe?

þ In case planning, what are the ways that the worker is explicitly engaging the family?

þ How do you ensure that the worker and the family have a common definition of what success looks like so that services provided have optimal chance for success?

þ Ensure that the children/youth are active participants in planning for their own lives?

þ Ensure that the services being provided to meet the needs of the children, parents, and caregivers are culturally sensitive, responsive to family s needs and accessible?

þ Ensure that the worker has asked the family if they are satisfied with the services being provided?

þ Ensure that the educational, physical and mental health needs of the child(ren) have been assessed? Has the family s voice been active in this conversation. Families are experts regarding their needs if we let them have a voice.

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Practice Statement #3

Family Centered Practice honors the importance of a child s emotional and spiritual attachments to his/her culture.

- DCYF and its partners will ensure that our practice reflects cultural norms of families served.
  - If a child is in out of home placement, it is our responsibility to communicate information about the child s culture to the caregiver.
  - Part of the task of learning about the culture/religion/ethnic background of a family is to understand the family s views on: discipline; cleanliness; housing standards and to assess how these beliefs/practices impact child safety.
  - We need to acknowledge that there are differences in beliefs due to where children are raised and the economic status of the families and incorporate this understanding into our assessment of child safety.
  - We make certain that the child maintains cultural connections and practices (religious, tribal, etc.)
- **Remember&every time we interact with a family, we are entering their culture.**
- Resource families and social workers must be encouraged to learn about and then celebrate the child and family s culture and ethnic rituals.
- Child welfare services involves entering into the culture of another person and making decisions that impact generations to come.

Supervising to Culturally Sensitive and Responsive Practice
Did you?

þ Ensure that the worker discussed family rituals such as how the family celebrates holidays and if a child is placed help the worker to ensure that the child does not lose these rituals.

þ Ensure that workers communicate information learned about family rituals to resource families. Supervisors encourage meetings between resource families and birth families where this information is shared.

þ Explore with their staff the awareness of cultural differences and how these differences impact parenting, housing standards, etc. Where is it in your process of learning about the family that you learn about the family s culture?"

þ Ensure that the family s culture is reflected in the case plan and services provided. For example, if the family s culture is strongly male dominated then ensure that the role of the father in the family is central in the case plan. Or, if is part of the family s culture that extended family are in an out of the family s home build this into the case plan use this as a strength. Or, if the family s culture has a strong spiritual orientation find ways to engage the spiritual leader in the case planning process.

þ Ask the workers How did you enter into the culture of the family you are serving?

Practice Statement #4

Family Centered Practice honors the importance of a child s emotional and spiritual attachments to his/her birth family even if the permanent plan is not reunification. Maintaining these connections is critical to long term child health.

- Placement is our very last resort. If there is a way that we can help the family stay together safely we do so. During the safety assessment (investigation) we look for ways to wrap services and supports around the family so that the children do not have to leave.
- We believe that when we remove a child pain and damage always occurs. It is not a quick fix &and there are a whole new set of issues to address. Do if we must remove a child, we do it planfully and attend to the child s pain.
- During the safety assessment and throughout the life of the case we learn about kin so that we can engage kin in helping the family stay together or if the child has to be placed they are placed with people the child knows or is connected to. If a child has to be placed we must make certain that children have access to relatives and others who matter to them! Find ways that children do not lose connections as a result of being placed!
    - We need to continually ask birth families about maternal and paternal kin (and connections)
    - We need to ask the ***children*** about maternal and paternal kin (as well as others who are not relatives but they are kin on an ongoing basis.
    - We need to find ways to help the family navigate these roles and the emotions associated

that have now changed in the kinship caregiving arrangement.

- When children are placed the birth families and resource families are partners in shared parenting and resource families serve as a support and role model to the birth family.
    - A meeting between the birth family and the resource family should occur ***as close to placement as possible.***
    - Intent of the meeting is to:
        - *Establish a relationship*
        - *Begin to craft the individualized case plan,*
        - *Have the birth family share their knowledge about the child s needs, likes, dislikes, sleeping schedules, napping, favorite food*
        - *To discuss ongoing interaction the role of each in making sure the child stays connected to his kin*
- Resource families are expected to assist the worker in ensuring that the child maintains connections to those that matter to him/her workers should engage the resource family in helping the child maintain connections.
- Family-centered practice will reflect a sense of urgency to achieve timely permanency for children in foster care, reflecting their need for the security and stability of being with a family.
- If a child cannot live with their birth family on a full time, permanent basis we explore optimal connection:
    - Letters
    - Photos
    - Annual (or more frequent visits)
    - Holidays
    - Birthdays
    - Whatever else can be defined by the child, family and the permanent caregiver
    - Relationships with extended family do not have to end

- If a child is placed outside the home, ***frequent and consistent*** parent-child and child-sibling interaction occurs. Workers need to engage other members of the team in ensuring that these visitations occur.
- Visitation should occur in settings that are most conducive to bonding and family members enjoying one another. This means that the visits do not happen in the office unless absolutely necessary!

Supervising to Maintaining and Creating Life Long Connections While Striving to Achieve Permanency in the ASFA Timeframes

Did you?

- Ensure that the worker asked the family to define who they think about as family ?

- Help the social worker to work through any value issues that they may have about Dad especially if Dad is incarcerated. How do worker s personal opinions impact visitation in prison?

- Ask the worker how the permanency plan ensures optimal connection to the child s birth family?

- Ask the worker the direct link between the service being provided and the permanency goal?

- Help workers address any value issues that may be reflected in sayings like The apple does not fall far from the tree! These words reflect a disrespect of families that need to be challenged during supervision.

- Ensure that the worker identify kin during the safety and the strengths and risk assessment processes?

- Ensure that the worker learned about the supports on which the family relies?

- Ensure that if a child had to be placed&the worker asked the child/youth who matters to them? Did the worker ask the resource family to assist us in maintaining these important connections?

- If siblings had to be removed from care---did the worker seek to place the children together? If not, is there a specific plan for maintaining consistent and meaningful contact?

- If a child has been in a foster home for a long time and moves to another permanent home how is the worker helping the child maintain connection with the original resource family? We cannot be the reason that the child experiences another loss!

Practice Statement #5

Family Centered Practice ensures that we seek to meet the *diverse needs* of the family and not solely focus on diagnosis and treatment . Many of the families that come to the attention of the child welfare system simply need community resources to help meet their basic needs to safely care for their children. This requires that we see the family in the context of their community. The child welfare system will not be in the family s life forever. By identifying and or creating supportive connections to the community, the family will be able to get their needs met after the system s involvement.

- At the point of the intake call we ask the caller what they are willing to do to support and help the family as a means to engage the community in child protection.

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- The safety and comprehensive family assessment (using the Strengths/Risk Assessment Tool) is an excellent tool for understanding family s basic needs. The questions posed allow the family to describe their needs in an honest and real way.

- We cannot be all things to all people we must share the workload with the broader community to include providers, faith based organizations, community service entities, etc.

- We strive to create a common philosophy about the work that we do. This means that we are all educators about the importance of 1) helping families be the protectors of their own children, 2) community agencies being responsive and non-judgmental of families in need, 3) community resources being accessible and available, and 4) families being part of the community decision making process.
- We support the community as they advance their role in primary prevention.
- We enter neighborhoods as collaborators in building a capacity to meet family s needs.

Supervising to Meeting Family Basic Needs Through Community Partnership

Did you?

þ Ensure that the assessment has not focused solely on diagnosis and treatment but actually looked at what families need in order to make their lives work on a day to day basis? NOTE: The Strengths and Risk Assessment provides ways for workers to ask questions that will better engage the family in identifying their basic needs.

þ Check to see if the worker feels totally responsible for doing all of the work? Have they found ways to share the work with kin and informal community supports?

þ Challenge the workers to interact with the resource families respectfully and with honor as members of the professional team. The more we engage the resource family the greater help that the worker receives.

þ Check to see if the worker has found ways to improve networks and community connections and improve the family s connection to specific community supports?

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[1] Institute of Applied Research. St. Louis Missouri.. (2004)

[2] Lutz, Lorrie. Promising Practices in Adoption Competent Mental Health Services. Casey Family Services. 2002.

[3] Dubowitz, H. (1990). The physical and mental health and educational status of children placed with relatives. Baltimore MD: Department of pediatrics, School of Medicine, University of Maryland.

Exhibit 36

Unusual Incident Reporting
(DES 1-07-02 A & B)

UNUSUAL INCIDENT REPORTING (EMPLOYEE) – DES 1-07-02.A

1. AUTHORITY
Arizona Administrative Code, Title 2, Chapter 10, Department of Administration – Risk Management Services; Occupational Safety and Health Administration (OSHA) Act 29 CFR 1904.

2. PURPOSE
a. This policy establishes the minimum requirements for the Department of Economic Security (DES) henceforth referred to as the Department, Unusual Incident Reporting (UIR) Program.
b. The policy establishes procedures for notification of management and supervisory staff of unusual incidents and lists requirements for subsequent investigations.

NOTE: In case of death of an employee while in the performance of official duties, the notification of Department management and the DES Office of Risk Management (ORM) must be immediate.

3. SCOPE
This policy applies to all Department employees while in the performance of official duties. DES policy 1-07-02B applies to those incidents that occur to clients or the general public while on state property (owned or leased) and to clients that are in the care, custody, and control of the Department.

4. DEFINITIONS
a. Unusual Incident: An unusual incident is any unforeseen, unexpected, or unplanned event that involves, but is not limited to:
    1. Incidents of workplace violence
    2. Theft of state and/or personal property
    3. Occupational workplace injury or illness of an employee
    4. Hospitalization of an employee from a work related injury or illness
    5. Death of an employee while performing official duties
    6. Items considered newsworthy or would give rise to a liability claim against the Department or the state.

b. Workplace Violence: Any physical assault, threatening behavior, and written or oral abuse occurring in the workplace. The workplace may be in any location, either permanent or temporary, where an employee performs work-related duties.
c. Unusual Incident Report Form J-309: Is a confidential internal document used to record and notify Department personnel of an unusual incident. Information on the J-309 is considered confidential and as such is not releasable outside the Department without specific written approval of the Department Risk Management section.

5. UNUSUAL INCIDENT REPORTING

a. An Unusual Incident Report (UIR) should be completed for incidents involving:
    1. Death, injury or illness of an employee that is work related
    2. Hospitalization of an employee that is work related
    3. Damage to a Department or State asset
    4. Theft of state or personal property where the theft of personal property occurred on state property
    5. Vandalism to state or personal property where the vandalism to personal property occurred on state property
    6. Physical or verbal threats or acts against employees or state property
    7. Incidents considered newsworthy or incur liability to the Department or State of Arizona.

6. PROCEDURES

All unusual incidents shall be reported. In many cases minor incidents are indicators that major incidents might occur if action is not taken to eliminate the cause of the minor incident.

A.R.S. § 41-621 requires that all property losses, liability claims, or incidents that may give rise to a claim being reported.

a. Immediately after an incident has occurred, the employee most closely involved must make a verbal report of the incident to his/her supervisor. This report should include the items listed on the form J-309 (person(s) involved in incident, nature of incident, location, date, time of incident, brief description of incident).
b. Incident reports can be made via fax, regular mail, or by electronic means using the approved J-309, in time frames set forth in this policy.
c. The manager/supervisor will report injuries that involve death or significant property loss to the DES ORM, Program Administrator, and the appropriate Assistant Director or designee as soon as possible after the incident (preferably within four hours of the incident or within four hours after the manager/supervisor is made aware of the incident) using the J-309 Unusual Incident Report form. If the Program Administrator or Assistant Director or his/her designee cannot be reached, the responsible manager/supervisor will notify the Director’s Office or Deputy Director’s Office.

d. The DES ORM will contact the Office of Attorneys General, Arizona Department of Administration (ADOA) Risk Management, and the Arizona Department of Occupational Safety and Health (ADOSH) as required for incidents involving death of an employee or hospitalization of employees resulting from a single incident and those incidents that may give rise to a large liability claim.
e. In the event of an employee's death on state property or while performing job related duties, the Director's Office or Deputy Director's office will be notified immediately.

7. REPORTING TIME FRAMES

Reporting requirements to DES ORM and management, unless otherwise stipulated in division procedures/policy shall be:

a. Immediately for incidents that involve the death of an employee that is work related.
b. Within one (1) day of the incident, in writing, or by electronic means for a worked related injury or illness.
c. Within one (1) day of the incident, in writing, or by electronic means for an injury to a client or the general public on state property (owned or leased).
d. Within one (1) day of the incident, in writing, or by electronic means for property loss expected to exceed $10,000.
e. All other claims or incidents within ten (10) days of the incident in writing or by electronic means.

8. INVESTIGATIONS

a. The Assistant Director or the Program Manager or their designees, may make recommendations for investigation to the DES ORM.
b. The ORM reserves the right to investigate those incidents that present a high degree of risk, liability, or recurrence. Reports will be provided to appropriate management for implementation of corrective action(s).
c. All deaths or hospitalizations of employees occurring from any incident will be investigated and reviewed by an investigation committee to be chaired by the Assistant Director of the Division of Employee Services and Support.
d. The division is responsible for taking appropriate action to prevent a recurrence of similar incidents. When the division requires assistance from ORM or other sources, these requests will be documented and a corrective action plan developed to address the loss potential detailed in the UIR.
e. The report will be issued after the investigation committee is adjourned. The report will be forwarded to the appropriate Assistant Director or designee for action and implementation of the corrective action plan.
f. All investigations will be completed in accordance with appropriate Department policy and confidentiality rules.

9. ADDITIONAL REPORTING REQUIREMENTS

a. Employee Workers' Compensation

Employee workers' compensation claims require reporting on the IR-050, with copies sent to DES ORM at site code 842C and to ADOA Workers' Compensation at 100 N 15th Ave #301, Phoenix AZ 85007 – fax (602) 542-2021.

b. Damage to State Property or Assets

Damage to state property requires a J-939 Property Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/Property and Liability at 100 N 15th Ave #301, Phoenix, AZ 85007 – fax (602) 542-1490.

c. Damage to State Vehicle

Damage to a state vehicle or motor vehicle accident involving a state vehicle requires a J-940 Automobile Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/Property and Liability at 100 N 15th Ave #301, Phoenix AZ 85007 – fax (602) 542-1490.

UNUSUAL INCIDENT REPORTING (CLIENT) – DES 1-07-02.B

1. AUTHORITY

Arizona Administrative Code, Title 2, Chapter 10, Department of Administration – Risk Management Services; Occupational Safety and Health Administration (OSHA) Act 29 CFR 1904.

2. PURPOSE

a. This policy establishes the minimum requirements for the Department of Economic Security (DES), henceforth referred to as the Department, Unusual Incident Reporting (UIR) Program.
b. The policy establishes procedures for notification of management and supervisory staff of unusual incidents and lists requirements for subsequent investigations.

NOTE: In case of death of a client while on state property or while in the care, custody, and control of the Department, immediate notification of program management must be accomplished and the DES ORM shall be notified.

3. SCOPE

This policy shall also apply to clients that are in the care, custody, and control of the Department

and/or are participating in state operated group homes. This policy also applies to those incidents that occur to clients or the general public while on state property (owned or leased). Excluded are clients who receive services from the Department and are not in the custody and control of the Department; example – DDD contract provider group homes, DCYF Foster Care.

4. DEFINITIONS

a. Unusual Incident: An unusual incident is any unforeseen, unexpected, or unplanned event that involves, but is not limited to:
    1. Theft of client property
    2. Injury to a client or individual of the general public while on state property (owned or leased)
    3. Hospitalization of a client
    4. Death of a client receiving services from the Department, and/or while on state property or in the care, custody, and control of the Department
    5. Items considered newsworthy or would give rise to a liability claim against the Department or the state.
b. Client: Client refers to a person that is in the care, custody, and control of the Department. Client also refers to those individuals of the general public receiving services provided by the Department while they are on state property (owned or leased).
c. Unusual Incident Report Form J-309: Is a confidential internal document used to record and notify Department personnel of an unusual incident. Information on the J-309 is considered confidential and as such is not releasable outside the Department without specific written approval of the Department Risk Management section.

5. UNUSUAL INCIDENT REPORTING

a. An Unusual Incident Report (UIR) should be completed for incidents involving:
    1. Death, injury or unexplained illness of a client in the care, custody, and control of the Department
    2. Unexplained hospitalization of a client in the care, custody, and control of the Department
    3. Damage to a DES or State asset
    4. Injury to a client or individual of the general public while on state property (owned or leased)
    5. Theft of client property where the theft of client property occurred on state property (owned or leased)
    6. Vandalism to client property where the vandalism to client property occurred on state property (owned or leased)
    7. Theft or vandalism of client property where the client is in the care, custody, and control of the Department

8. Physical or verbal threats or acts against clients or by clients
9. Incidents considered newsworthy or would give rise to a liability claim against the Department or the state.

6. PROCEDURES

All unusual incidents shall be reported. In many cases minor incidents are indicators that major incidents might occur if action is not taken to eliminate the cause of the minor incident. A.R.S. § 41-621 requires that all property losses, liability claims, or incidents that may give rise to a claim being reported.

a. Each division providing services to clients, such as those clients in foster care or who are receiving services from providers and/or contractors, shall implement an incident reporting procedure/policy that ensures incidents occurring to participating clients are promptly reported to division staff.
b. If the division develops a procedure/policy, this procedure/policy shall reflect Department policy and should be approved by the appropriate Assistant Director.
c. Every two (2) years, the DES ORM shall review each division's procedure/policy; it is the division's responsibility to ensure that reviews and approval are completed.
d. Immediately after an incident has occurred, the employee most closely involved must make a verbal report of the incident to his/her supervisor. This report should include the items listed on the form J-309 (person(s) involved in incident, nature of incident, location, date, time of incident, brief description of incident).
e. Incident reports can be made via fax, regular mail, or by electronic means using the approved J-309, within the time frames set forth in this policy.
f. The manager/supervisor will report injuries that involve death or significant property loss to the DES ORM, Program Administrator, and the appropriate Assistant Director or designee as soon as possible after the incident (preferably within four hours of the incident or within four hours after the manager/supervisor is made aware of the incident) using the J-309 Unusual Incident Report form. If the Program Administrator or Assistant Director or their designees cannot be reached, the responsible manager/supervisor will notify the Director's Office or Deputy Director's Office.

7. REPORTING TIME FRAMES

Reporting requirements to DES ORM and Department management, unless otherwise stipulated in division procedures/policy shall be:

a. Immediately for incidents that involve the death of a client that is receiving services by the Department and is in the care, custody, and control of the Department
b. Within one (1) day of the incident, in writing, or by electronic means for an injury to a client or individual of the general public on state property (owned or leased)
c. Within one (1) day of the incident, in writing, or by electronic means for property damage expected to exceed $10,000

d. Within one (1) day of the incident, in writing, or by electronic means for property loss expected to exceed $10,000
e. All other claims or incidents within ten (10) days of the incident in writing or by electronic means.

8. INVESTIGATIONS

a. The Assistant Director or the Program Manager or their designees, may make recommendations for investigation to the DES ORM.
b. The ORM reserves the right to investigate those incidents that present a high degree of risk, liability, or recurrence. Reports will be provided to appropriate management for implementation of corrective action(s).
c. The division is responsible for taking appropriate action to prevent a recurrence of similar incidents. When the division requires assistance from ORM or other sources, these requests will be documented and a corrective action plan developed to address the loss potential detailed in the UIR.
d. The report will be issued after the investigation committee is adjourned. The report will be forwarded to the appropriate Assistant Director or designee for action and implementation of the corrective action plan.
e. All investigations will be completed in accordance with appropriate Department policy and confidentiality rules.

9. ADDITIONAL REPORTING REQUIREMENTS

a. Damage to State Property or Assets

Damage to state property requires a J-939 Property Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/ Property and Liability at 100 N 15th Ave #301, Phoenix AZ 85007 – fax (602) 542-1490.

b. Damage to State Vehicle

Damage to a state vehicle or motor vehicle accident involving a state vehicle requires a J-940 Automobile Loss Report in addition to the UIR J-309. Send copies to DES ORM at site code 842C and to ADOA Risk Management/Property and Liability at 100 N 15th Ave #301, Phoenix AZ 85007 – fax (602) 542-1490.

Exhibit 37

GUIDELINES FOR PREPARING A CHILD FOR ADOPTIVE PLACEMENT

A. The primary goals of preparation activities are to help the child:

1. Recognize and accept the family circumstances that led to the present plan of adoptions.
2. Understand the meaning of adoption in providing security to child, and express his feelings about the adoption plan.
3. Develop a trusting relationship with the case manager that will help sustain the child during the transition from foster to adoptive child.
4. Acquire a positive sense of identity to bring into the adoption experience.
5. Develop internal strengths to cope with the feelings of separation and loss of emotional ties with the birth family and the foster home, in order to enter adoptive placement with as much resolution of feelings as possible.
6. Enter adoptive placement with ongoing therapeutic or medical needs clearly identified.

B. To accomplish these goals it will be necessary for the case manager to:

1. Allocate ample time to see the child frequently and regularly.
2. Develop preparation activities individually for each child, appropriate to the child's age and condition.
3. Retain a flexible personal attitude toward the child, to provide trust without excessive attachment or over-protection.

C. Activities which may be used for preparation of the child include, but are not limited to:

1. Case manager and child:

a. Individual interviews with child concerning identity, as appropriate to the child's age and condition.
b. Excursions to parks, stores, restaurants, libraries, museums, and other public places help develop a comfortable and trusting relationship, while providing the case manager with valuable observations and insight as to how the child behaves in a variety of social situations.
c. Preparation of a scrapbook containing pictures, mementos, and stories of the child's history - should be done privately, in an atmosphere that will encourage the child to discuss feelings and ask questions. Visits to people or places significant in

the child's past may help the child fit together family history.

d. Visits to the department offices, and to the Juvenile Court, to familiarize the child with the people and organizations involved in planning the child's future.

e. For the very young child, holding and/or playing with the child on foster home visits may be the only one-to-one contact necessary. For the suspicious toddler or older child, a period of such contact in the security of the foster home may be necessary before the child is able to venture out with the case manager alone. Since the understanding of the young child is limited, trust in the worker takes on added significance at the time of placement.

2. Child and Others:

a. Foster parents' daily support of the child, ability to answer questions and discuss casually, as the need arises, the child's hopes and fears.

b. Group sessions with other children entering adoption.

c. Continue or initiate therapy as needed.

d. Any other services identified as necessary.

3. CPS Specialist and Others:

a. Support from the foster family is an invaluable asset to a child entering adoption. To enable the family to provide this support the case manager must take the responsibility to keep the family informed of plans for the child and progress toward adoption; help them understand the adoptive process and their importance in preparing the child; recognize their feelings of providing information to the case manager on the child's day-to-day attitudes and behavior; develop their strengths in assisting the child in transition.

b. Provide specific information and requests to therapist, medical doctor or other professionals working with the child, so that their activities and reports are consistent with and complementary to other preparation activities.

Exhibit 38

GUIDELINES FOR SELECTING AN ADOPTIVE FAMILY

A. Recognizing that both families and children fall short of perfection, home selection should determine the best available family relative to the highest priority needs of the child. Consideration of the following questions, related to the defined needs of the child, will help reduce the likelihood of an inappropriate selection.

1. Motivation of Prospective Parents:

a. What are the reasons for adopting?

b. Do both parents have a genuine liking for children and like to be involved with most any age group? What age groups do they especially enjoy or dislike?

c. Do they have adequate knowledge of and experience with children to know what they may realistically expect of the "average" child of a given age?

d. Are the children in the home genuinely excited about receiving a child and are they equally enthusiastic about adopting? Will they be able to share their parents with a sibling? What are their expectations of the child?

e. Can the prospective parents realistically list both positives and negatives about being a parent?

2. Life Style of Prospective Parents:

a. How much time do they have for children and are they willing to curtail some of their present activities in order to have time for the child. If so, what would they curtail, or give up? Will they be able to share each other with a child?

b. What is the general life style of the family, for example what activities do they enjoy; are they expressive or non-expressive of feelings? What is the general level of activity in the household? How do they handle discipline and give affection? Does the family life style fit with that of the child for whom they are under consideration?

c. Are both prospective parents family oriented: If not, which one seems more strongly motivated and involved with children: Is this person the stronger person in

the marriage?

d. Do they display a sense of humor about themselves? Are they flexible or rigid?

e. Do the adoptive parents have sufficient satisfactions in their marriage, work, interests or other children so that the relationship with the adoptive child will not have to make up for areas in which they lack satisfaction?

f. Have either or both of the adoptive parents been physically or sexually abused as children? If so, how has this been addressed.

3. Expectations of Prospective Parent:

a. How important is their preconceived idea of a child, and what are their expectations. For example, if a man likes hunting and sports, how important is it that his son likes these things?

b. How would they respond to specific behaviors this child may exhibit, such as an older child who wets the bed, a child of any age who refuses to take a bath, has bad table manners, is not neat, has poor sleeping habits or nightmares, refuses to try new foods or refuses to obey requests or instructions? Also, how would they cope with one who would say, "I don't want to live here", "I'll call my caseworker to look for a new home for me", or "I hate you, you're not my mother"? How would they cope with their other children saying similar things to the adopted child? How would they cope with lying, shoplifting or running away? What type of punishment would be used for different types of behavior? Do they believe that such behavior is abnormal? A result of heredity?

c. Do they appear to be perfectionists? How will they accommodate an imperfect child?

d. How would they work with special needs such as, poor speech, stubbornness, temper tantrums, poor personal hygiene or bonding and attachment problems?

e. Are they willing and capable of giving love to a child before receiving love or an outward demonstration of love and/or gratitude from a child?

4. Acceptance of Adoption:

a. When there are special circumstances where a specific child's assessment has revealed a need for race or ethnicity to be taken into account, are the parents under consideration able to nurture, support, and reinforce the racial, ethnic, or cultural identity of the child? Are the parents aware of and prepared to deal with the thoughtless questions and possible discrimination from relatives, neighbors, peers and the community? Can the parents help the child cope constructively with this type of treatment?

b. How does the child to be placed compare with their existing children? Are there marked differences in intellectual capacity or social behavior? How will this affect all the children involved? How will the parents cope with these differences?

c. How will the parents react to conflict between the children? To their own younger child learning "bad habits" from an older adoptive child?

d. Are they willing to accept counseling or therapy as indicated?

e. How open have they been with the agency? How honest will they be in sharing with case manager problems they are having with the child?

B. Recognizing that a wide variety of types of families are able to parent successfully, specific characteristics should be considered in view of the child's needs, rather than personal preferences including:

1 Number of children in the home

2 Employment of the parents

3 Economic status

4 Lifestyle

5 Religion

6 Geographic location and neighborhood

7 Ages of family members

8 Marital status

9 Physical condition or disabilities of family members

Exhibit 39

CULTURAL COMPETENCE: STARTING WHERE THE FAMILY IS

CULTURE is the dynamic pattern of learned behaviors, values and beliefs exhibited by a group of people who share historical and geographical proximity. (*Dodson, 1983*).

CULTURAL COMPETENCE is a set of congruent behaviors, attitudes, and policies that come together in a system or agency, or among professionals, that enable the system, agency, or those professionals to work effectively in cross-cultural situations. (*Cross, et al., 1989).*

CULTURALLY COMPETENT PRACTICE includes the practitioner's commitment to provide culturally competent services, an awareness and acceptance of cultural differences, an awareness of one's own cultural values, an understanding of what occurs in cross cultural interactions, and a basic knowledge about the culture of the people with whom one is working and an ability to adapt practice skills to fit that culture. (*Cross, et al., 1989).*

A child welfare practitioner and the organization as a whole need to know, appreciate, and be able to utilize the culture of populations served. Cultural competence calls for respecting cultural differences and recognizing behaviors, values, and beliefs of the cultures of children and families served. This is crucial to that classical social work axiom of "starting where the client is." For example:

The very definition of "family" varies from group to group. While the dominant culture has focused on the nuclear family, African Americans define family as a wide network of extended family, nonblood kin and community.
Native American Indian families traditionally include at least three generations and multiple parental functions delegated among aunts and uncles, as well as grandparents. Cousins are considered siblings. For the Chinese, the definition of family may include all their ancestors and all their descendants. (McGoldrick, et al.)

The family life-cycle phases also vary for different groups, and cultural groups differ in the emphasis they place on certain life transitions. Mexican families announce a girl's entrance into womanhood at age 15 with a quinceañera (cotillion), a transition that the dominant society hardly marks at all. Birth, marriage, and death are the most important life transitions in the Puerto Rican life cycle. (McGoldrick, et al.)

Families vary culturally in terms of what behavior they see as problematic and what behavior they expect from children. While the dominant society may be concerned about dependency or

emotionality, Puerto Ricans may be concerned about their children not showing respect. (McGoldrick, et al.) Japanese families may be concerned about their children not fulfilling their responsibilities. (Lynch and Hanson)

Families also differ in their norms around communication and their expectations for how communications in specific situations will occur. African Americans and Americans from the dominant culture differ, for example, in what information they consider public information and what they will discuss readily with persons whom they do not know well. (Kochman) Nonverbal communications styles also vary according to culture. Professionals from the dominant culture may ask many questions and view eye contact as a sign of listening and respect. In contrast, some Native American Indian people are brought up to show respect for people of knowledge and authority by not asking direct questions and not giving eye contact.

Different cultural groups also vary in their traditional practices and views of adoption. African Americans have a very strong tradition of informal adoption or "taking children in." Puerto Rican families tend to have flexible boundaries between the family and the surrounding community so that "child lending" is an accepted practice. (McGoldrick, et al.) Other groups have much clearer boundaries between family members and outsiders and may place a stronger emphasis on bloodlines or blood ties. For these and other reasons, adoption has not been a part of the culture in Korea; and, thus, many Korean children have been adopted by U.S. families.

References:

Kochman, Thomas, *Black and White Styles in Conflict*. Chicago: University of Chicago Press, 1981.

Lynch, Eleanor W. and Hanson, Marci J., *Developing Cross-Cultural Competence: A Guide for Working with Young Children and Their Families*. Baltimore: Brooks Publishing Co., 1992.

McGoldrick, Monica; Pearce, John K.; Giordano, Joseph, eds., *Ethnicity and Family Therapy.* New York: Guilford Press, 1982.

Exhibit 40

FOSTER FAMILY AND HOME REEVALUATION

APPLICANT(S)' DEMOGRAPHICS

Complete Name
Date of Birth
Social Security Number

COMPLETE MAILING ADDRESS AND LOCATION ADDRESS

City, state, complete zip code and directions, if necessary.

TELEPHONE NUMBERS: Home, office, business, emergency contact. Note if numbers are wireless or other types of two way communication lines. List pager and fax numbers if applicable. Can they be contacted at work?

OTHERS IN HOUSEHOLD DEMOGRAPHICS

For all household members included in prior evaluations.
Complete Name
Date of Birth
Social Security Number
Relationship to Applicant(s)

NEW HOUSEHOLD MEMBER DEMOGRAPHICS

*For all household members **not** included in prior evaluations.*
Complete Name
Date of Birth
Social Security Number
Ethnicity
Place of Birth
Relationship to Applicant(s)

LICENSING AND CERTIFICATION HISTORY: Current and prior certification dates and court case numbers, if applicable. Current license effective and expiration dates, if applicable. Number of years licensed and/or certified in Arizona and the county.

*This reevaluation format combines the reports to relicense a foster home or amend a foster home license; to update a report to certify a foster parent or a former adoptive parent to adopt or extend an adoptive home certification. Some topic areas will be exclusive to a specific program or purpose while other topic areas will be required by both the foster care and adoption programs.

CONTACTS: Since the last Evaluation or Reevaluation, list dates and type of contacts (i.e., home visits, phone calls, collateral contacts). For in-person contacts, list the names of the persons seen and the location of the contact.

FINGERPRINTING AND CRIMINAL HISTORY RECORD CHECKS: Document and describe any arrests reported by the applicants or adult household members since issuance of the last foster home license or certification. Include the date of arrest, name of arresting agency, charge, and the disposition.

For foster homes, annually have each applicant and adult household member complete the Foster Parent/Applicant Criminal History Declaration, FC-202. Document annual Arizona criminal records checks and results on all persons previously cleared. A new federal criminal history records check is required every fourth year. For adult members of the household added during the year and all "children", including foster children, who turned 18 during the year, give the date of fingerprinting and state and national clearances. If clearances are not available, explain the reason. Include the following statement: "Documents filed in the foster home CPS record".

For update reports to certify to adopt foster parents or former adoptive parents or for extension of certification reports, state that the Department will provide the results of the state and federal criminal history records check directly to the court.

CHILD PROTECTIVE SERVICES RECORD CHECKS: For foster homes, complete and document the annual Child Protective Services Central Registry checks, including the date and by whom the check was made, of the applicant(s) and household members. Include the following statement: "Documents filed in the foster home CPS record".

When completing an update report for certification of the applicant, do a Child Protective Services Central Registry check and summarize the results.

CPS INVESTIGATIONS: If CPS reports were received and investigations conducted during the year, list dates and summarize the results. All CPS reports, written reports of investigations, investigation findings, licensing specialist’s contact notes, etc. are filed in the foster home CPS record.

COURT ACTION: If an applicant has been involved in any court actions since the last Evaluation or Reevaluation was written, describe and explain.

LICENSING CONCERNS AND CORRECTIVE ACTIONS: *Use only for foster home relicensing, amendment and addendum reports* If complaints and concerns were received, list by date the outcome of the investigation (do not name any child involved in the investigation). If specialized training or a corrective action was recommended following a CPS investigation or licensing inquiry process, was the recommendation followed and accomplished?

TRAINING AND SKILL BUILDING DEVELOPMENT: Assess the family's development and accomplishments during the past year. Names of sessions attended, dates and hours completed by each family member. For non-ACYF sponsored training, document topics, dates, hours credited, and ACYF prior approval. What education or skills development needs were recommended during the year? Were the recommendations accomplished and how successful were they? What is the family's skills building plan for next year?

AGREEMENTS: List all Agreements signed by the applicants, such as the Agency-Foster Parent Agreement, FC-006. All points of agreement(s) discussed. Both parents signed? Any reservations?

FINANCES AND EMPLOYMENT: Does the family have the financial resources to meet their own family needs without relying on foster care reimbursement or adoption subsidy payments? Total monthly income and expenditures. Any employment or employer changes?

INSURANCE: Liability insurance on vehicles - policy information and expiration dates(s). Any changes in medical or life coverage? Are driver's licenses valid?

HOME, NEIGHBORHOOD, AND COMMUNITY: Describe significant physical changes in the home. If the foster parent moved recently, complete a new Section 7 of the FW-257. For foster homes, document inspection requests and the results of the annual visual safety inspection completed by the licensing specialist. What was the result of the every three year inspection by the Arizona Department of Health Services? Resource tool: Most recent Arizona Department of Health Services Foster Home Inspection form on the residence.

To license a certified adoptive family, send ADHS Foster Home Inspection Request, FC-135 to Arizona Department of Health. Document the correction of all deficiencies noted in the DHS Foster Home Inspection Checklist. If the home has a swimming pool, confirm the separate enclosure of the pool from the house according to Exhibit 1 of DES 5-58, Family Foster Parent Licensing Requirements *(Instructions)*.

FAMILY MEMBERS HEALTH: Discuss any physical or behavioral health problems or changes of any family or household member during the past year. Has any family member received counseling? Health report from a physician is required every third year or more frequently if health concerns arise.

CHILD CARE AND TEMPORARY CARE: What arrangement has the family had for child care and baby-sitting in the past year? Have there been any problems, issues or concerns? Does the family plan to change child care providers?

DISCIPLINE TECHNIQUES: Review the ACYF Discipline Policy with the family. Discuss concerns and issues with the family and address results. What discipline techniques have been used or will be used with children? Are the same discipline techniques used with foster and/or adoptive children as other children living in the home? Have there been any problems or issues dealt with during the year? What are the family's strengths and needs in this area.

RECORDS ON AND ABOUT FOSTER CHILDREN: *Use only for foster home relicensing, amendment and addendum reports.* List names, ages, dates of placement, reason for departure and placement destination. For each child placed, what types of issues (i.e., school, behavior) have the parents seen in the child within the past year. How did the family respond to these issues? For foster homes with children placed for receiving and respite care, address these items in general. If the family cared for a child of a different cultural heritage, how did they acknowledge the differences and how did they meet the child's needs? Include comments from children's case managers.

Discuss records required on foster children. Are records current? Do they contain necessary information? Does each foster child have a Child's Placement Packet? Is the Placement Packet current? A foster parent licensed only for respite care is not required to maintain and update Placement Packets.

OTHER EXPERIENCE WITH CHILDREN: Have applicant(s) had new experiences with children? Any expressed changes in attitudes? Any other changes?

FAMILY RELATIONSHIPS: Discuss changes in family composition, adjustment of the family to any children placed with the family. How do the parents, own children and children in placement interact with each other? Discuss significant events in family's life including growth or problem areas and new responsibilities of the family or individuals.

RELIGION/SPIRTUALITY: Have there been issues, concerns or problems with meeting the foster child's religious/spiritual needs? Has the parent's religious or spiritual practices been impacted by parenting children other than their own?

TEAM MEMBER PARTICIPATION: How has the family reacted to supervision by the various agencies involved with the child and the family? Include case managers' input and assessments. Does the family look for guidance? Does the family follow policy and procedures, etc.? What is the family's assessment of the services provided to the child and their family by the various agencies?

Have the parents received notice of court hearing and case plan staffings? Have the parents participated in case plan staffings, Foster Care Review Board hearings, and court hearings? Does the family wish to receive copies of the case manager's written reports on the foster children? Has the family received the reports?

For foster parents, have the foster parents provided transportation in accordance with the case plan and any agreements. Has the foster parent submitted Foster Parent Wrap-Up forms, FC-129, from the Child's Placement Packet when the placement ends or the case manager for a child changes.

RELATIONSHIP WITH THE CHILD'S FAMILY: Has there been contact between the family and child's family? If yes, what have been the family's attitudes toward the child's family? Has there been visitation with the child's parents, relatives, family members, and significant persons? Have barriers been set-up? If no, are they willing to have contact; open to participate during visits?

CHILD DESIRED/PREFERRED: Review Section 3 of the FW-257 to update, if needed, the family's range of acceptance to reflect changes or expansion of the types and needs of children they will accept. What is the specialist's assessment of the types of children the family can and can not accept. It is essential to give the family a legitimate opportunity for selection.

CENTRAL ADOPTION REGISTRY: *Use this section for update reports to certify to adopt foster parents or former adoptive parents or for extension of certification reports.* Has the CHILDS Provider Registry function been explained to the family? Do they wish to be listed on the Provider Registry of certified adoptive homes for consideration for the placement of children available for adoption?

FEES: *Use this section for update reports to certify to adopt foster parents or former adoptive parents for extension of certification reports.* List fees charged, whether they have been paid or how they will be paid.

MOTIVATION AND PLANS FOR CHILD: *Use this section for update reports to certify to adopt foster parents or former adoptive parents or for extension of certification reports.* Discuss the family's current feelings about adoption and waiting for a placement. Include any discussion or clarification with the family on reasons for non-selection or concerns that the specialist may have obtained from the CHILDS Adoption Registry.

If the family is intending to adopt a specific child or children, discuss the family's relationship to the child, their understanding of the child's needs, and their ability to permanently provide for those needs. Discuss future issues such as contact with siblings, grandparents and other significant persons. Under what conditions will contact be allowable? Would they be willing to contact the birth parents in the future or have the birth parents contact the child? Indicate any alternative plans for rearing the child to adulthood should the parents' health be impaired or should one or both die. What arrangements would be made if a parent died or became disabled, including legal custody plans, trust funds. Does the family have a will? Provide information on parents' retirement plans.

CHANGES IN CIRCUMSTANCES THAT AFFECT THE PROSPECTIVE ADOPTIVE PARENT'S ABILITY TO ADOPT: *Use this section for update reports to certify to adopt foster parents or former adoptive parents or for extension of certification reports.* Include information on changes in family circumstances that adversely affect the applicant's parenting ability. Address any other significant and material changes in the family not addressed in other sections of the report.

EVALUATION: Does the family and home meet the requirements of the Department of Economic Security? Identify strengths, needs, weaknesses, problems, and concerns. Summarize your professional opinion of the family's ability to successfully foster and/or adopt children. If the parents were referred for any psychological evaluation, consultation, counseling or specialized training, what is your assessment of the results.

RECOMMENDATIONS: For foster home licensing, recommend issuance of a license (as amended or per addendum) or application denial. If home is to be licensed, recommend licensing conditions: number, gender (male, female or both male and female), age range of foster children to be placed, and the foster home certification types(s). A provisional license may be issued if the training is the only licensing requirement not met.

If court certification is needed, recommend the family as acceptable or not acceptable to adopt.

NAME OF AGENCY (IF APPLICABLE)

NAME OF SPECIALIST, COMPLETE ADDRESS, TELEPHONE NUMBER, SIGNATURE AND DATE

NAME OF SUPERVISOR, COMPLETE ADDRESS, TELEPHONE NUMBER, SIGNATURE AND DATE

Exhibit 41

FOSTER CARE FAMILY AND HOME EVALUATION

Information obtained from the family during interviews, training and from references and background/records check are resources to be used in completing the Family and Home Evaluation. The Foster Home License, Adult Developmental Home License or Adoption Certification Application, LCR-1032A and Foster Care/ Adoption Assessment Guide, LCR 1031A are also resource tools that are designed to help the licensing/ certification specialist compile information needed to do a comprehensive evaluation of the applicant(s). All topic areas and/or questions are not required to be addressed as some topic areas/questions may be more applicable to one program while not to another.

APPLICANT(S)' DEMOGRAPHICS:

Complete Names,

Date of Birth,

Ethnicity,

Place of Birth, and

Social Security Number

OTHERS IN HOUSEHOLD DEMOGRAPHICS:

Names

Date of Birth

Relationship to applicant

Social Security Number

PERSONS RESIDING ON PREMISES OF HOME:

Names

Date of Birth

Relationship to applicant

Social Security Number

CITIZENSHIP: (If not US. citizen confirm status.)

TRIBAL MEMBERSHIP OF APPLICANTS: (if applicable)

MAILING AND PHYSICAL ADDRESS: (include city, state, zip code and provide directions, if necessary).

TELEPHONE NUMBERS WITH AREA CODE: (indicate home, office, business, and emergency contact). Note if numbers are cellular or other type of two way communication lines. List pager and fax numbers if applicable.

LICENSING OR CERTIFICATION AGENCY NAME AND ADDRESS

SPECIALIST'S NAME AND TELEPHONE NUMBER: (include site code and fax number if applicable).

CERTIFICATION/LICENSING HISTORY: Has the family ever applied to adopt or adopted before (when, to what agency)?

- § Have they ever been denied certification/approval (when, where, what were the circumstances)?
- § Have they ever had an unsuccessful adoptive placement (when, where, what were the circumstances)? Include foster care licensing and day care certification history.
- § Are they currently licensed as a foster home or certified as a day care home?
- § Have they ever been denied a foster care license, a day care certification or had a license or certification revoked or suspended? Review the foster care or day care file and discuss the family with the foster care licensing or day care certification specialist.

CONTACTS: For each contact provide date, location, individuals present, length of contact and type of contact, such as in person, telephone, etc.

MOTIVATION: Include reasons for wanting to adopt and/or foster. Are the applicants' motivations consistent with the realities of adoption and/or foster parenting? Explain why or why not. Has this been a total family decision?

CHILD DESIRED/PREFERRED: Discuss types of legal status of children in care. What type of legal risk are they willing to take? Does the family understand the Foster/Adoption Program? Will they participate in the Foster/Adoption Program? Address each major topic area in the Placement Preferences Section of the Assessment Guide, LCH-1031A. Focus on range of acceptance and reflect change or expansion of type of children they can accept, including children with an unknown parent, parental substance abuse, criminal record, mental illness, and mental challenges. Is the family willing to accept a sibling group? What is the specialist's assessment of the type of children the family should and/or should not parent?

EXPERIENCE WITH CHILDREN: Based on their experience with their own and other children and their expressed attitudes, identify the strengths and weaknesses of the family as they will impact their ability to adopt or foster a child. Consider the family's experience with needs and behaviors such as feeding, stealing, enuresis, running away, masturbation, etc. and any experience with children that are emotionally disturbed, delinquent, developmentally or physically impaired or have other special needs.

DISCIPLINE TECHNIQUES: What are the discipline techniques used or to be used by the applicants? Are these techniques consist with foster parent licensing requirements and Discipline Policy? How will the applicants' discipline techniques impact on their ability to parent. Review with the applicants their ideas and methods of discipline and supervision used with their children and their attitude toward the Discipline Policy.

CHILD CARE AND TEMPORARY CARE: What are the child care plans if both parents or a single parent is working out of the home? For adoptive parents, are there plans for reduced hours, maternity or paternity leave, extended leave, or one parent quitting work at the time of placement?

FUTURE PLANS FOR THE CHILD: Discuss future issues such as contact with sibling, grandparents, relatives and other significant persons. Under what conditions will contact be allowable? Indicate alternate plans for rearing the child to adulthood should the parents' health be impaired or should one or both die. Provide information on parent's health and retirement plans. What arrangement would be made if a parent died or became disabled? Discuss custody goals in the event of their incapacity or death of either or both parents (might include arrangements for trust fund). Have they made a Will? What expectations do they have for the child they will adopt in terms of academic achievement, employment and career choices, peer relationships, relationship to own children, affection, intimacy and general personality and interest.? How important is it that a child live up to these expectations? Discuss when and how will they tell the child about the adoption? What will they tell the child? What will they tell the child about the birth parents? Would they be willing for the child to contact the birth parents in the future, or have the birth parents contact the child? Would they be willing to assist the child in locating the birth parents? Do they understand the law on closed records as it is currently?

APPLICANT'S FAMILY AND GENERAL BACKGROUND: Address issues, concerns, previous experiences, and events that would impact the applicants ability to be an adoptive and/or foster parent.

Include a brief biography of each applicant in the family generally describing them according to the following items:

Family & Childhood:

- Siblings relationships
- Relationships of applicant or applicants with parents/stepparents/guardians
- Parents' descriptions and occupations

- Type of home life: history of domestic violence or sexual abuse, degree of affection and how expressed in the family; religion/spirituality and how expressed in family; mobility of family
- Discipline: methods used; feelings and memories
- Physical, emotional, or *substance* abuse history
    - § School/Educational history
    - § Work history - stability (if served in Armed Services, discharge papers)
    - § Friends and activities outside of the home
    - § General consensus description of the personality and temperament of the applicants
    - § Management of stress and anger
    - § Experiences with loss and separation

MARRIAGE/RELATIONSHIP OF APPLICANTS: Do members of this family have activities and friendships outside of the home which can provide support and an outlet for emotions, as opposed to a closed family system with no supports or outlet other than each other?

§ How do they demonstrate trust, love?

§ How do they feel about affection and intimacy, modesty in the home?

§ What would they change?

§ How have they handled difficult adjustments?

§ If previously married, how is this marriage different?

§ Describe family relationships, including extended family, family rituals, schedules and values.

§ What changes do they anticipate with placement of a child?

§ How do they handle stress individually and as a couple?

§ What crises or stresses have they had to face as individuals, as a family?

§ How rigid, or flexible is the family system of values and conduct?

§ How much tolerance do they have for different lifestyles?

§ How do they function as individuals and as a couple?

§ How do they share in the relationship?

§ If married less than 18 months, discuss the need for some evidence of marital stability prior to adopting, and the added strains the placement of a child brings to a marriage still in the early stages of adjustment.

§ Discuss any special circumstances to be considered in assessing the stability of a marriage of less than 18 months.

PREVIOUS MARRIAGES OR RELATIONSHIPS: How were previous marriages/relationships dealt with? Were there any children? What is their current relationship with these children? What is the custody arrangement? Is child support paid, amount, if current and if court ordered docket number.

FAMILY/OTHER HOUSEHOLD MEMBERS/RELATIONSHIP: Summarize information about these individuals according to the following items by name and age:

a. Their role in the home and feelings regarding adoption and/or foster care

b. What relationship will the person(s) have with the child

§ Do members of this family have activities and friendships outside of the home which can provide support and an outlet for emotions, as opposed to a closed family system with no supports or outlet other than each other?

§ How do they demonstrate trust, love?

§ How do they feel about affection and intimacy, modesty in the home?

§ What would they change?

§ How have they handled difficult adjustments?

§ Describe family relationships, including extended family, family rituals, schedules and values.

§ What changes do they anticipate with placement of a child?

§ How do they handle stress?

§ What crises or stresses have they had to face as individuals, as a family?

§ How rigid, or flexible is the family system of values and conduct?

§ How much tolerance do they have for different lifestyles?

FINANCES AND EMPLOYMENT: Do the applicants have the financial resources to meet their own family needs without relying on adoption subsidy payments or foster care reimbursement? Total monthly income and expenditures. List the applicant's current employer - can they be contacted at their job. Have the applicant's ever taken bankruptcy in the last 10 years? If yes, what was the history and what are the current circumstances?

RELIGION AND SPIRITUALITY: Applicant's affiliation and attendance, role of religion/spirituality in the home, and plan regarding adoptive and/or foster child. Are there religious beliefs or spirituality issues that might impact the care of a foster child?

HEALTH AND PSYCHOLOGICAL: Dates of medical statements and summary. Confirmation of immunization records of the child. Are there any medical, physical, emotional health, alcohol or substances abuse history or current issues or concerns with the applicants, family or household members that might impact the care of a foster or adoptive child? Are there any incidents or issues with domestic violence in the current family? General condition of health of all members of the family and household, including behavioral health. Past and present serious illnesses and /or problems.

CHILDREN OF APPLICANTS: Briefly describe the children: provide name and age, physical description,

personality, interests and academic progress Discuss peer and sibling relationships and each child's concept of foster care and adoption. How do the children feel about bringing a new member into the family? Will these children be able to share with a foster or an adopted child? Will they be able to tolerate some difficult behavior? Describe their concept of the discipline they receive. For what behaviors are they disciplined? What are the rules of the house? What happens if the rules are broken? What rules are never to be broken? If the children are old enough, ask them to describe themselves either in writing or verbally.

Provide names, addresses and ages of any children of applicants not living in the home. Describe the situation and relationship include both minors and adult children as described by the applicants and household members or through contacts with any children not living in the home.

PERSONS RESIDING ON THE PREMISES OF THE HOME: Identify persons by name and age and summarize information regarding their direct or unsupervised access to the foster or adoptive child. Specify the persons role, if any, in the care of the foster or adoptive child.

NEIGHBORHOOD AND COMMUNITY: Give the major characteristics of the neighborhood: rural or urban retirement, young families, single family housing. Do they know their neighbors? Ethnic/racial makeup, resources available, etc. Include the community resources, i.e., schools, medical facilities, recreational areas, etc. that they will avail themselves of. How can a special needs child’s medical, psychological, and social needs be met? Be specific.

HOME: Note number of rooms, bedrooms, particularly the area for adoptive and/or foster child. Describe housekeeping standards, yard area. If they have a pool, is it fenced from the rest of the yard? Notice compliance with A.R.S. § 36-1681, Pool Fence Statue and Family Foster Licensing Requirements including CPR certification. Does anyone in the home smoke? Confirm that there is a current fire evacuation plan for the home. Please explain. Note any hazardous conditions (i.e. pets). If requesting handicapped child, is the home handicap accessible? If applicable, give results of home safety inspection. Status of any noted deficiencies?

INSURANCE: Provide liability insurance information on vehicles - policy information and expiration date (s). Are driver’s licenses valid? Provide information on parent’s life and health insurance, including health insurance coverage for an adopted child.

REFERENCES: For foster home licensing, four references are required. For adoption certification, a minimum of three references are required. Were the references generally positive, non-committal or negative? Describe any concerns mentioned and the specialist’s follow-up on the concerns. Give consideration to the length of relationship and degree of contact. Obtain a reference from at least one relative. What is the attitude of the extended family toward adoption or foster care? If family has school age children, a school reference is recommended, whenever possible.

FINGERPRINTING AND CRIMINAL HISTORY RECORDS CHECKS: Whose fingerprints were taken and when? Describe the arrest record information disclosed by the applicant and all adult household members and the individual’s explanation of arrest record and disposition.

CHILD PROTECTIVE SERVICES RECORD CHECKS: Describe any self disclosed history of the applicant and all adult household members of any history of contact with any child protection agency as obtained from the application, a self disclosure form or during interviews. Confirm clearances of the applicants and all other household members on Child Protective Services Records. Document the date and by whom the check was made. If CPSCR records check result shows prior substantiated reports, include the individual's explanation of the events and their explanation of the outcome of the investigation.

COURT ACTION: Have the applicants ever had a child (natural, step, or adopted) who was the subject of one or more court actions (i.e., dependency, severance, guardianship, juvenile action, domestic relations action, or criminal action) while in their custody or control? If so, explain the circumstances, name, place of birth, and birth date of child(ren), name of case manager(s), attorney(s), and judge(s) involved and results of those action (s).

CENTRAL ADOPTION REGISTRY: Has the CHILDS Provider (Adoption) Registry function been explained? Do they want to be listed with the CHILDS Provider (Adoption) Registry for consideration for available children?

TEAM MEMBER PARTICIPATION: What is the specialist's assessment of the foster and foster/adoptive family's willingness to participate in case staffing, review board hearings, and court hearings? What are the family's attitudes toward the child's parent's, siblings and family members contact and visitation with foster child? Are they willing to have contact; open to participate during visits?

TRAINING AND SKILL BUILDING DEVELOPMENT: Did the trainer have any concerns? Were they addressed with the family? What is the specialist's assessment of the concerns? Has any family member received first aid or CPR training? Is any family member currently certified in CPR?

AGREEMENT(S): List the agreement(s) signed. Were all points of agreement(s) discussed. Did both parents sign the required agreement(s)? Any reservations?

FEES: List fees charged, whether they have been paid or how they will be paid.

EVALUATION: Summary of specialist's impressions and assessment of family's capacity for maintaining a successful adoption. Include any referral of the family for any psychological evaluation, consultation, counseling or additional education. Does the family and home meet the licensing requirements of the Department of Economic Security? Summarize your professional opinion of the family. Identify overall strengths, weaknesses, and concerns.

RECOMMENDATION: State: "It is recommended that these applicants (this applicant) be certified as acceptable to adopt children in the State of Arizona." Or state: "It is recommended that these applicants (this applicant) be certified as not acceptable to adopt children in the State of Arizona"

Recommend issuance of a foster home license or application denial. If home is to be licensed, recommend licensing conditions: number, sex, age of foster children to be placed, and the foster home certification type (s).

NAME OF SPECIALIST, SIGNATURE AND DATE

NAME OF SUPERVISOR, SIGNATURE AND DATE

Exhibit 42

CASE NOTE TYPES

- **AG CONTACT** - To identify a case note documenting staff contact with an Assistant Attorney General. This case note is confidential and should not be released to parties outside the Department.

- **CASE CONFERENCE** - To identify a case note documenting a meeting between DCYF staff and at least one other person.

- **CHILD CONTACT** - To identify a case note documenting staff, or another approved professional's contact with a child.

- **COLLATERAL CONTACT** - To identify a case note documenting staff contact with parties associated with a case such as therapists, counselors, parent aides, attorneys, CASAs, probation officer, parole officers, school personnel, physicians, etc.

- **COURT HEARING** - To identify a case note documenting events that occurred during a court or FCRB hearing or Department initiated Administrative Case Review.

- **FAMILY CONTACT** - To identify a case note documenting staff or another approved professional's contact with multiple family members at the same time such as a parent, child, and grandparent.

- **HEALTH/EDUCATION CONTACT** - To identify a case note documenting contacts with health care providers, education and school system staff, and other collateral contacts or key events regarding the child's well-being including education, mental health, physical health, or dental health.

- **IN-HOME INTENSIVE PROVIDER** - To identify a case note documenting contacts between the in-home intensive provider and the family. This case note type is only to be utilized by the provider. The provider should only select the “contact about” when creating this case note.

- **IN-HOME MODERATE PROVIDER** - To identify a case note documenting contacts between the in-home moderate provider and the family. This case note type is only to be utilized by the provider. The provider should only select the "contact about" when creating this case note.

- **INVESTIGATION** - To identify a case note documenting the investigation of a report and staff contact with persons during the investigation.

- **KEY ISSUES** - To identify a case note documenting significant case conflicts, significant needs of case participants, or high profile case.

- **OUT OF HOME CARE PROVIDER** - To identify a case note documenting staff or another approved professional's contact with a person or agency authorized by the Department to provide care for or control of a child in out-of-home care such as unlicensed relatives/non-relatives, licensed relative/non-relatives, and group care staff

- **PARENT AIDE** - To identify a case note documenting contacts between the Parent Aide provider and the family. This case note type is only to be utilized by the provider. The provider should only select the "contact about" when creating this case note.

- **PARENT/CARETAKER CONTACT** - To identify a case note documenting staff or another approved professional's contact with a parent/caretaker.

- **REPORT COMMENT** - To identify a case note documenting observations and comments about a report to CPS.

- **STAFFING** - To identify a case note documenting a case plan staffing.

- **SUPERVISORY/MANAGEMENT CONTACT** - To identify a case note documenting staff contact with or by a supervisor or with or by management staff such as Assistant Program Manager, Deputy Program Manager, Program Manager, Field Operations Manager, ACYF Program Administrator, DCYF Assistant Directory, and other management staff.

- **TRANSFER SUMMARY** - To identify a case note used by staff to document reason for transfer, future hearing dates and appointments, to summarize progress, events and concerns related to the transfer of a case.

ADDITIONAL QUALIFIERS TO CASE NOTES

- **IN PLACEMENT CONTACT** - Checkbox only used to indicate that a case manager, or another approved professional, visited with a child, parent, or out-of-home care provider in the child's placement including a parent's home if the child is placed in the physical custody of the parent.

- **IN PERSON** - A Radio Button choice to designate face-to-face contact with participants or associates in the case.

- **BY PHONE** - A Radio Button choice to designate telephone contact with participants or associates in the case.

- **OTHER** - A Radio Button choice to designate that information recorded in the Case Note was obtained by means other than in person or by phone contact.

- **CONTACT WITH** - To identify which participant or associate the contact is with.

- **CONTACT ABOUT** - To identify which participant or associate the contact is about.

Exhibit 43

ARMSS Activity Codes

Activity Code	Descriptive Title
A	Child Protective Services Investigation
B	Case Management for in-home case with no case plan indicating clear risk of out-of-home placement
C	Case Management for in-home case with a case plan indicating clear risk of out-of home placement
D	Case Management for out-of-home foster care case whether removal is voluntary or court-ordered
E	Case management for adoption case
F	Non-case related general administration

ACTIVITY CODE A - CHILD PROTECTIVE SERVICES INVESTIGATION

Examples of tasks in Activity Code A are:

1. Receiving and screening reports of child maltreatment, including:

   § Asking and obtaining information via cue questions;

   § Entering report related information in CHILDS windows;

   § Searching other databases for information related to the family involved in the report; and

   § Consulting with a supervisor to determine if the information received meets the criteria of a report for investigation.

2. Assessing the validity of reports of emergency situations including:

   § Gathering third party documentation to support or dispute the allegations of maltreatment (i.e. police reports, medical records, or mental health records);

   § Obtaining or arranging for medical, psychological, or other examinations and evaluations;

§ Conducting or arranging interviews, via telephone or face-to-face contact, of persons potentially having information regarding the report; and

§ Consulting with other professionals to assess the validity of a report.

3. Assessing the risk of maltreatment if the children in the reported emergency situation were to remain in their current living arrangement.

4. Coordinating, cooperating, or consulting with a supervisor, Attorney General's Office, psychologist, medical professional, or law enforcement agency in order to protect children prior to a determination the case will be opened for ongoing case management services.

5. Arranging for and participating in the removal Review Team to consider alternatives to out of home placement.

6. Providing CPS counseling (counseling provided directly by a CPS case manager).

7. Documenting any of the above activities, for example:

- Entering Case Notes in CHILDS;
- Completing the Uniform Case Practice Record Investigation and Assessment Module;
- Filing documents in the hard copy case record; and
- Entering data into CHILDS investigation windows.

8. Completing Investigation forms; for example, PSRT forms.

9. Travel associated with any of the above activities.

10. Consultation or meetings with an ACYF supervisor or manager regarding a CPS investigation.

11.Reading or replying to e-mail related to any of the above activities.

ACTIVITY CODE B - CASE MANAGEMENT FOR IN-HOME CASE WITH NO CASE PLAN INDICATING CLEAR RISK OF OUT-OF-HOME PLACEMENT

Examples of tasks in Activity Code B are:

1. Obtaining and providing preventative services for a child remaining in home, who is not at clear risk of out of home placement, or the child's family. Examples include obtaining and providing:

- § Referral information on community agencies;
- § Family preservation services;
- § In-home support services;
- § Parent aides;
- § Food, clothing, or household items;
- § Case management.

2. Obtaining medical and psychological evaluations and services needed for reasons other than a CPS investigation.

3. Assessing the treatment needs of a child remaining in home, who is not at clear risk of out of home placement, or the child's family, including:

- § Gathering third party documentation of a child or family member's functioning (i.e. mental health or educational records);
- § Obtaining or arranging for medical, psychological, or other evaluations;
- § Conducting or arranging interviews, via telephone or face-to-face contact, of persons having information on the child or family member's functioning; and
- § Consulting with other professionals to identify treatment needs (including MDT's)

4. Providing case management services for a child remaining in-home, who is not at clear risk of out of home placement, or the child's family, including:

- § Conducting home visits;
- § Making or answering case related telephone calls;
- § Developing a case plan document;
- § Arranging, facilitating, and documenting case plan staffings or case conferences;
- § Obtaining service authorizations;
- § Referring for treatment services through form completion or telephone contact; and
- § Consulting with other professionals.

5. Documentation associated with any of the above activities including:

- § Entering case notes in CHILDS;
- § Entering data in CHILDS case management windows;
- § Completion of hard copy forms; and
- § Filing documents in the hard copy case record.

6. Travel associated with any of the above activities.

7. Participation in consultations or meetings with an ACYF supervisor or manager, related to a child remaining in home and not at risk of out of home placement.

8. Reading or replying to e-mail related to any of the above activities.

ACTIVITY CODE C - CASE MANAGEMENT FOR IN-HOME CASE WITH A CASE PLAN INDICATING CLEAR RISK OF OUT-OF-HOME PLACEMENT

Examples of tasks in Activity Code C are:

1. Obtaining and providing preventative services for a child remaining at home, or the child's family, where the child is at clear risk of out of home placement. Examples include obtaining and providing:

- § Referral information on community agencies;
- § Family preservation services;
- § In-home support services;
- § Parent aides;
- § Food, clothing, or household items;
- § Case management.

2. Obtaining medical and psychological evaluations and services needed for reasons other than a CPS investigation.

3. Assessing the treatment needs of a child remaining at home, or the child's family, where the child is at clear risk of out of home placement, including:

§ Gathering third party documentation of a child or family member's functioning (i.e. mental health or educational records);

§ Obtaining or arranging for medical, psychological, or other evaluations;

§ Conducting or arranging interviews, via telephone or face-to-face contact, of persons having information on the child or family member's functioning; and

§ Consulting with other professionals to identify treatment needs (including MDT's)

4.Providing case management services for a child remaining at home, or the child's family, where the child is at clear risk of out of home placement, including:

§ Conducting home visits;

§ Making or answering case related telephone calls;

§ Developing a case plan document;

§ Arranging, facilitating, and documenting case plan staffings or case conferences;

§ Obtaining service authorizations;

§ Referring for treatment services through form completion or telephone contact; and

§ Consulting with other professionals.

5.Serving a Temporary Custody Notice (TCN) in person or through other means.

6.Documentation associated with any of the above activities including:

§ Entering case notes in CHILDS;
§ Entering data in CHILDS case management windows;
§ Completion of hard copy forms; and
§ Filing documents in the hard copy case record.
§ Travel associated with any of the above activities.

8.Participation in consultations or meetings with an ACYF supervisor or manager, related to a child remaining at home, or the child's family, where the child is at clear risk of out of home placement.

9.Reading or replying to e-mail related to any of the above activities.

ACTIVITY CODE D - CASE MANAGEMENT FOR OUT-OF-HOME FOSTER CARE CASE WHETHER REMOVAL VOLUNTARY OR COURT ORDERED

Examples of tasks in Activity Code D are:

1.Assisting parents, or a youth age 12 or older, with the completion of the voluntary placement agreement;

2.Preparing for, or participating in any judicial hearing or conference, or Foster Care Review Board (FCRB) regarding a child in out of home care, including:

- § Preparing a list of witnesses,
- § Writing and disseminating a court report,
- § Obtaining or preparing attachments to a court report,
- § Waiting for a court hearing or FCRB to begin, when no other activity is conducted while waiting,
- § Participating in a court hearing or Foster Care Review Board (FCRB);

3. Communicating or coordinating for non-investigative purposes with the Attorney General's Office, attorneys, probation officers, CASAs, guardians ad litem, or judicial personnel;

4. Arranging, preparing for, and participating in a department-initiated administrative review;

5.Writing, compiling attachments to, and filing a dependency petition.

6.Assessing the treatment needs of a family who has a child in out of home care (such as those activities listed in Activity B, number 4);

7Providing case management services to a family who has a child placed in out-of-home care (such as those listed under Activity B, number 5);

8.Developing and documenting case plans, including:

- § Reassessing and documenting family strengths and risks in CHILDS,
- § Completing the Uniform Case Practice Record (UCPR),
- § Collaborating with family and team members to develop a case plan for a child,
- § Arranging and facilitating case plan staffings,
- § Disseminating the UCPR to team members;

9. Initiating or facilitating counseling, parent aide, child care, therapeutic, or placement services;

10. Assessing client progress toward case plan outcomes through review of written reports or direct contact with service providers;

11. Searching for missing parents and potential relative placements, including:

- § Obtaining and recording information on relatives,
- § Completing parent locator and relative search forms,
- § Writing letters to or initiating phone contact with such persons;

12.Performing all duties relating to facilitation of guardianship for a dependent child;

13.Communicating with out of home placement providers to prepare them to receive a child, or support them to provide ongoing care for a child;

14.Contacting or communicating with biological parents, out of home care providers, or others regarding the status of a child, the case plan, goals for the child and family, and/or administrative procedures of the agency;

15.Arranging, facilitating, or supervising visitation of the child with family members or potential out of home providers;

16.Arranging educational services, including:

- § Enrollment,
- § Obtaining surrogate parents,
- § Documenting special needs,
- § Transferring records,
- § Attending Individual Educational Plan (IEP) conferences, or
- § Obtaining special education vouchers;

17. Performing activities relating to the Interstate Compact on Placement on Children (ICPC) for a child in out of home care;

18. Performing case management functions to assist a child in achieving independent living;

19. Completing paperwork which contributes to the above activities;

20. Documentation associated with any of the above activities, including examples listed in Activity B, number 8;

21. Travel associated with the above activities;

22. Participation in meetings or consultations with an ACYF supervisor or manager, related to a child in out of home care; and

23. Reading or replying to e-mail related to any of the above activities.

ACTIVITY CODE E - CASE MANAGEMENT FOR ADOPTION CASE

"Post adoption subsidy case management" means case management performed for a child who is placed in an adoptive placement and has a signed adoption subsidy agreement in place, regardless of whether the adoption has been finalized.

Examples of tasks in Activity Code E include:

1. Discussing, explaining, preparing, and processing agency consents to adopt;

2. Supporting the adoptive placement, including:

- § Conducting home visits,
- § Obtaining collateral information regarding the success of the placement,
- § Arranging services for the adoptive family and child;

3. Maintaining Adoption Subsidy Program support, including maintenance payments;

4. Preparing and submitting to the court reports and documents to request adoption finalization;

5. Documentation associated with any of the above activities;

6. Participation in meetings or consultations with an ACYF supervisor or manager, related to a child in this category;

7. Travel associated with any of the above activities; or

8. Reading or replying to e-mail related to any of the above activities.

ACTIVITY CODE F - NON-CASE RELATED GENERAL ADMINISTRATION

Examples of tasks in Activity Code F include:

1. Taking a break or having lunch,

2. Using any type of leave of absence from work, such as annual or sick leave,

3. Preparing bi-weekly time sheets,

4.Preparing mileage reimbursement forms,

5. Meeting with a supervisor to review job performance (ESTEEM meetings),
6. Attending administrative meetings or non-program related training, such as:

- § unit meetings, section meetings, or district meetings,
- § training on safety in the workplace, ESTEEM or ethics.

7. Reading or replying to non-case related e-mail.

Exhibit 44

ARIZONA ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILES DISCIPLINE POLICY

A. SCOPE OF POLICY

Most children in the foster care program have experienced patterns of inappropriate punishment, abuse and/or violence in their families. Therefore, issues related to punishment often are confusing for the child. For foster children punishment is often connected to a wide variety of issues such as attention, power, revenge, control, loss of self-esteem, and pain-love.

This policy is clarification of the Agency's position on Discipline and point 9, of the Agency-Foster Home Agreement (FC-006). It should be read before signing the Agency-Foster home Agreement prior to becoming licensed and when relicensed.

B. PUNISHMENT vs. DISCIPLINE

Punishment implies the threat or use of power and/or fear to change inappropriate behavior. Punishment relies on external forces.

Discipline is a teaching process through which the child learns to develop and maintain the self-control, self-reliance, self-esteem, and orderly conduct necessary to assume responsibilities, make daily living decisions, and live according to accepted levels of social behavior.

C. POLICY

Children in foster care are to be disciplined, not punished. Discipline techniques help a child develop and maintain self-control, self-reliance, self-esteem and orderly conduct.

The purpose of discipline is to educate. Children are able to learn from their mistakes in a safe environment. Therefore, foster parents shall:

1. Develop rules that set the limits of acceptable behavior in the family. These rules will be clearly explained and applied based on the child's past experiences, personality and age as appropriate to each child in the family.

2. Develop fair, reasonable, age- or developmentally appropriate and consistent consequences, related to the offense, for implementing these rules. These consequences will also be communicated to each child.

3. Share with the team members any concerns or difficulties about disciplining a foster child, so constructive ideas and/or plans can be agreed upon.

D. ACCEPTABLE DISCIPLINE METHODS

Discipline should be communicated in such a way as to help the child develop self-control and assume responsibility for his or her own behavior. Individual children will respond to different methods based on age, personality and life experiences. Suggested methods which might be used are:

1. **Natural Consequences:** allowing the child to experience the results of his or her behavior by not intervening. If Susie forgets her softball glove, she will be unable to try out for the team.

2. **Logical Consequences:** imposing consequences which are as directly related as possible to the inappropriate behavior. If Johnnie broke the window, he can do extra chores to earn the money to pay for the new window.

3. **Encouragement/Praise:** identifying specific behaviors and strengths that encourage the child to develop and increase self-esteem. "That model car looks great! I like the color you chose. You did a job you can be proud of!"

4. **Positive Communication**: using language in positive terms to describe what you want, rather than what you don't want. "Walk around the pool" rather than "Stop that running!"

5. **Active Listening**: listening with understanding and then clarifying the statement and responding to the feelings. "It sounds like your teacher really scolded you in class and you must have felt really embarrassed by that."

6. **"I" Message:** communicating by phrasing in the first person. "I feel worried and upset when I don't know where my children are."

7. **Incentives/Rewards/Motivation**: providing short term incentives that help the child focus on desired behavior. If the child completes all the chores on his "job list" this week, he can go out for an ice cream cone on Saturday. (The younger the child, the shorter the period of time before an incentive or reward should be given.)

8. **Contracting:** negotiating with the child to create a written mutual agreement that provides incentives to help the child focus on a desired behavior. This is particularly appropriate with older children. If Tom passes all his subjects with at least a "C" grade, then he will have more time for recreation next semester.

9. **Redirecting**: substituting an acceptable behavior for an unacceptable one. "Carol, you can't play with Bob's stereo, but let's go find your crayons and some paper, so that you can make a picture."

10. **Role Modeling**: showing by example the behavior the parent wants from the child. If one shows respect for the child's property and privacy, the child will learn to respect the property and privacy of others.

11. **Time-out:** removing the child from the situation (usually 1 or 2 minutes for each year of the child's age). A specific chair or place in the room should be identified for the child as the "time-out" place.

12. **Removing Privileges**: losing a privilege which is related to the unacceptable behavior. The loss should be of short-term duration. Losing the use of the phone, time with friends, TV time, etc. could be used depending on what is important to the particular child.

Exhibit 45

SUPERVISING AN ADOPTIVE PLACEMENT

A. From initial placement of a child with adoptive parents to finalization of a Petition to Adopt, the Department shall provide all appropriate support services to achieve successful integration of the child into the adoptive family.

B. Recognizing that the post-placement period is a crucial time in solidifying the adoption, the supervising case manager shall:

1. Interview all members of the adoptive family's household and be readily accessible to the family and child to discuss and address events, behaviors and feelings of all family members.

2. Meet on a one-to-one basis with the parents, and discuss:

   a. How the presence of the child has changed family relationships;

   b. How the child and extended family view each other;

   c. The role each family member has assumed regarding child care and discipline;

   d. How the parent is coping with the needs and demands of the placed child;

   e. How the child challenges or tests the placement and how the family reacts to these episodes;

   f. How the family perceives the child's sense of identity and the need to fill in the gaps in the child's history; and,

   g. How the child has adjusted to the school and the environment.

3. If developmentally appropriate, privately interview the child during each supervisory visit about the child's feelings about the adoption and other issues discussed in 2 above.

4. Provide non-judgmental emotional assistance and support to family in dealing with child's problems. Provide perspective for interpretation of child's behavior based on adjustment to adoption and feelings of separation and loss.

5. Assist the adoptive family in building a support system to deal with the child's and family's needs.

6. Encourage and facilitate open communication within the adoptive family regarding the adoption experience.

7. Work to develop resources within the agency for education or casework oriented groups for parents and children.

8. As the adoptive parents are increasingly able to provide for the child's emotional needs, gradually phase out the one-to-one nature of the case manager/child relationship.

9. Assist the adoptive parents in their efforts to obtain the most appropriate ongoing services to meet the child's previously defined medical, dental, educational and social needs.

10. Consult with the supervisor to evaluate adjustment progress and problems.

11. Consult with the (family's or child's) case manager who is not directly supervising the adoptive placement in order to:

    a. Report progress, problems and adjustment;

    b. Gain added insight through that case manager knowledge of the person(s) involved.

12. As the adjustment proceeds satisfactorily, encourage the family to file the Petition to Adopt.

13. Continue home visits as needed to the date of the final Adoption Court Hearing, to enhance stabilization of placement and capacity for independent functioning after the adoption if finalized.

14. If major adjustment problems are preventing movement toward independent family functioning:

    a. Define and assess contributing factors, possible causes and solutions with family and child.

    b. Consult with supervisor regarding family strengths and weaknesses.

    c. Consult with (family's or child's) case manager who is not supervising the placement to further assess the family situation

    d. Jointly formulate a plan toward resolution of placement problems including, but not limited to one or more of the following:

        i. Provision of additional supportive services, such as, counseling, therapy, group meetings, intensified remedial services, adoption subsidy, referral to additional community resources.

        ii. If the adoptive petition has been filed, counsel with the family regarding possible time extension or withdrawal of the petition.

        iii. Discuss the feasibility of alternative solutions with family and child:

            1. Changes in family's expectations of the child and themselves.

2. Changes in contributing external factors (i.e., neighbors/extended family's reactions to placement.

3. Possible adjustments to unanticipated personal reactions to placement (e.g. jealousy of one parent or siblings, feelings of loss of privacy). Possible adjustments to unanticipated personal reactions to placement (e.g., jealousy of one parent or siblings, feelings of loss of privacy).

4. If the family continues to have serious questions about ultimate success of placement, the supervising case manager shall assists them in reaching a decision, based on consultation with case manager and other involved professionals.

C. Supervisor:

1. Regularly reviews case with case manager to ascertain how adoption is progressing.

2. Provides consultation to case manager in dealing with casework problems engendered in the adoptive placement.

3. Assists case manager in assessing whether community resources are indicated or whether group programs might be developed for adoptive families.

4. Reviews case with worker prior to filing of the Petition to Adopt.

Exhibit 46

INPATIENT ASSESSMENT REPORT

CHILD'S NAME **DOB** **COURT CASE NUMBER** **DATE/TIME ADMITTED**

A. ASSESSMENT

I am the licensed ___ psychiatrist, ___ psychologist or ___ physician (check one) who conducted an inpatient assessment of the above-named child on _____ (date) which included the following as required by A.R.S. § 8-273:

___ 1. Observation of the child's behavior while the child is in an inpatient facility.

__ 2. Psychological or psychiatric testing, if indicated.

___ 3. A determination as to whether the child needs inpatient psychiatric acute care services and whether inpatient psychiatric acute care services ar ethe least restrictive available alternative.

___ 4. The administration of psychotropic medication and medication monitoring, if necessary to complete the assessment or to prevent the child from being a danger to self or others.

___ 5. A psychiatric or psychological assessment, including a clinical interview with the child.

___ 6. A written report that summarizes the results of the inpatient assessment, including specific recommendations for follow-up care.

___ 7. An explanation to the child of the least restrictive alternatives available to meet the child's mental health needs.

___ 8. A determination as to whether the child may be suffering from a mental disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled, as defined in A.R.S § 36-501.

___ 9. A review of the child's medical, social and psychological records, if available.

B. INPATIENT ASSESSMENT RECOMMENDATIONS

Based on the foregoing assessment, I recommend that the child be either (Circle one):

___ 1. Admitted to a psychiatric acute care facility for inpatient psychiatric care services. (If this alternative is checked, proceed to Part C below)

___ 2. Provided with residential treatment services.

(If this alternative is checked, proceed to Part D below)

___ 3. Discharged to an entity and provided with outpatient treatment services.

___ 4. Discharged to the entity without further psychological or psychiatric services because the child does not suffer from a mental disorder, is not a danger to self or others or is not persistently or acutely disabled or gravely disabled.

C. RECOMMENDATION FOR INPATIENT PSYCHIATRIC ACUTE CARE SERVICES

My recommendation that the child be admitted for inpatient psychiatric acute care services is based on the following:

___ 1. Inpatient psychiatric acute care services are in the child's best interest for the following reasons:

___ 2. Inpatient psychiatric acute services are the least restrictive alternative for the following reasons:

___ 3. The diagnosis of the child's condition requiring inpatient psychiatric acute care services is:

___ 4. The estimated length of time the child will require inpatient psychiatric acute care services is:

D. RECOMMENDATION FOR RESIDENTIAL TREATMENT SERVICES

My recommendation that the child receive residential treatment services is based on the following:

___ 1. Residential treatment services are in the child's best interests for the following reasons;

___ 2. Residential treatment services are the least restrictive treatment available for the following reasons:

___ 3. The child's behavioral, psychological, social, or mental health needs require residential treatment services for the following reasons:

___ 4. The estimated length of time the child will require residential treatment services:

_____ _____

Psychiatrist, psychologist, or physician performing assessment Date of Report

Exhibit 47

OUTPATIENT ASSESSMENT REPORT

CHILDS NAME **DATE OF BIRTH** **DATE OF REPORT**

A. ASSESSMENT

I am the licensed ___ psychiatrist, ___ psychologist or ___ physician (check one) who conducted an outpatient assessment of the above-named child on _____ (date) which included the following as required by A.R.S. § 8-271(7) and A.R.S. § 8-272(B):

___ 1. A psychiatric or psychological assessment, including a clinical interview with the child.

___ 2. An explanation to the child of the least restrictive alternatives available to meet the child's mental health needs.

___ 3. A determination as to whether the child may be suffering from a mental health disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled.

___ 4. A review of the child's medical, social and psychological records, if available.

___ 5. A determination as to whether the child needs an inpatient assessment or inpatient psychiatric acute care services and whether inpatient psychiatric acute care services are the least restrictive available alternative.

B. OUTPATIENT ASSESSMENT RECOMMENDATIONS

Based on the foregoing assessment, I recommend that the child be either (check one):

___ 1. Admitted to a psychiatric acute care facility for an inpatient assessment.

___ 2. Admitted to a psychiatric acute care facility for inpatient psychiatric care services.
(If this alternative is checked, proceed to Part C below)

___ 3. Provided with residential treatment services.
(If this alternative is checked, proceed to Part D below)

___ 4. Discharged to an entity and provided with outpatient treatment services.

___ 5. Discharged to the entity without further psychological or psychiatric service because the child does not suffer from a mental disorder, is not a danger to self or others or is not persistently or acutely disabled or gravely disabled.

C. RECOMMENDATION FOR INPATIENT PSYCHIATRIC ACUTE CARE SERVICES

My recommendation that the child be admitted for inpatient psychiatric acute care services is based on the following:

___ 1. Inpatient psychiatric acute care services are the child's best interest for the following reasons:

___ 2. Inpatient psychiatric acute care services are the least restrictive alternative for the following reasons:

___ 3. The diagnosis of the child's condition requiring inpatient psychiatric acute care services is:

___ 4. The estimated length of time the child will require inpatient psychiatric acute care services is:

D. RECOMMENDATION FOR RESIDENTIAL TREATMENT SERVICES

My recommendation that the child receive residential treatment services is based on the following:

___ 1. Residential treatment services are in the child's best interests for the following reasons:

___ 2. Residential treatment services are the least restrictive treatment available for the following reasons:

___ 3. The child's behavioral, psychological, social, or mental health needs require residential treatment services for the following reasons:

___ 4. The estimated length of time the child will require residential treatment services:

_____ _____

Psychiatrist, psychologist, or physician performing assessment

Date of Report

Exhibit 48

STATEMENT FROM MEDICAL DIRECTOR/DESIGNEE OF INPATIENT OF INPATIENT RESIDENTIAL TREATMENT FACILITY OR ACUTE INPATIENT FACILITY

CHILD'S NAME **DOB** **COURT CASE NO.**

I am the Medical /Clinical Director or designee of _____ (name of residential treatment facility). Pursuant to A.R.S. § 8-273 (C), I have determined that this facility's services are appropriate to meet the child's needs.

_____ _____

Medical/Clinical Director/Designee Date

A.R.S. § 8-201(19) defines a "medical director of a mental health agency" as a psychiatrist, or licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the agency as the person in charge of the medical services of the agency, or a psychiatrist designated by such governing body to act for the director. The term includes the superintendent of the state hospital.

Exhibit 49

60 DAY REVIEW OF RESIDENTIAL/PSYCHIATRIC TREATMENT SERVICES

CHILD'S NAME **DOB** **COURT CASE NUMBER** **DATE OF REPORT**

FACILITY NAME **DATE OF PLACEMENT**

Summary of Referring Problems:

Psychiatric Treatment Plan Status:

Medications:

Current Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis IV:

Axis V:

Psychological/Therapy Update:

Individual therapy:

Group:

Family:

Medical/Dental Update:

Educational/Vocational Update:

Family Contact:

Clinical Treatment Plan Status:

(Include recommendation for continued residential treatment services and estimated length of services)

Projected discharge date:

Recommendation for level of care and potential placement options upon discharge:

60 DAY REVIEW OF

RESIDENTIAL TREATMENT SERVICES

CHILD'S NAME **DOB** **COURT CASE NUMBER**

STATEMENT FROM MEDICAL DIRECTOR/DESIGNEE

I am the Medical/Clinical Director or designee of _____ (name of residential treatment facility) and have reviewed the records, staff reports and recommendations of the clinical staff. I have determined that residential treatment services in this facility continue to be necessary to meet the child's mental health needs and that it is the least restrictive available alternative.

_____ _____

Medical/Clinical Director/Designee Date

A.R.S.§ 8-201 (19) defines a "medical director of a mental health agency" as "a psychiatrist, or licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the agency as the person in charge of the medical services of the agency, or a psychiatrist designated by such governing body to act for the director" The term includes the superintendent of the state hospital.

Exhibit 50

NOTICE TO RESIDENTIAL TREATMENT AND ACUTE PSYCHIATRIC FACILITY PROVIDERS: REPORTING REQUIREMENTS

Janet Napolitano
Governor

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
3443 N.Central Ave., P.O. Box 6123, Phoenix, AZ 85005

David E. Berns
Director

A.R.S. § 8-272 and 8-273 require psychiatric acute care facilities and residential treatment facilities to assume increased reporting requirements. These reporting requirements are specific to children who are subject to the delinquency and dependency proceedings.

The psychiatrist, psychologist or physician completing an inpatient or outpatient assessment that recommends inpatient psychiatric acute care services will complete a report that addresses:

- The reason inpatient psychiatric acute care services are in the child's best interests;
- The reason inpatient psychiatric acute care services are the least restrictive treatment available;
- A diagnosis of the child's condition that requires inpatient psychiatric acute care services; and
- The estimated length of time the child will require inpatient psychiatric acute care services.

In addition to the above, a written statement from the medical director or designee of the inpatient psychiatric acute care facility stating that facility's services are appropriate to meet the child's mental health needs, is required.

If a child is admitted to an inpatient psychiatric acute care facility for treatment, the court will review the child's continuing need for inpatient psychiatric acute care services at least every 60 days after the date of the treatment order, unless a hearing is requested. The facility will be required to submit a written progress report to the court and all parties, including the child's attorney and guardian ad litem, at least **five days** before the review. The report must make recommendations and shall include the following:

- The nature of the treatment provided, including any medications and the child's

current diagnosis;

- The child's need for continued inpatient psychiatric acute care services, including the estimated length of the services;
- A projected discharge date;
- The level of care required by the child and the potential placement options available to the child on discharge;
- A statement from the medical director of the inpatient acute care facility or designee as to whether;

    a. inpatient psychiatric acute care services are necessary to meet the child's mental health needs, and

    b. whether the facility that is providing the inpatient psychiatric acute care services to the child is the least restrictive available alternative.

If the psychiatrist, psychologist or physician recommends residential treatment services, the written assessment must include:

- The reason why residential treatment services are in the child's best interest;
- The reason why residential treatment services are the least restrictive treatment available;
- The reason why the child's behavioral, psychological, social or mental health needs require residential treatment services; and
- The estimated length of time the child will require residential treatment services.

The court will review the child's continuing need for residential treatment services at least every **60 days** from the date of the treatment order. The residential treatment facility is required to submit a written progress report to the court and all parties, including the child's attorney and guardian ad litem, at least **five days** before the review. The report must include:

- The nature of the treatment provided, including any medication and child's current diagnosis;
- The child's need for continued residential treatment services, including estimated length of services;
- The level of care required by the child and potential placement options available to the child on discharge;
- A projected discharge date;
- A statement from the medical or clinical director of the facility or designee, as to whether:

a. residential treatment services are necessary to meet the child's needs, and
b. the facility is the least restrictive available alternative.

Within **twenty days** after the child is discharged from inpatient psychiatric acute care services, a Notice of Discharge must be filed with the court. The mental health professional at the facility will be required to provide a copy of the discharge summary. The discharge summary must include a description of mental health services provided to the child and the child's family.

When the child is discharged from residential treatment services, the mental health professional is required to provide a copy of the discharge summary. The discharge summary must include a description of services provided to the child and the child's family.

The Department of Economic Security Administration for Children, Youth and Families has prepared the attached document detailing the mandatory responses required by this law. All providers are expected to use these formats or their own, if comparable.

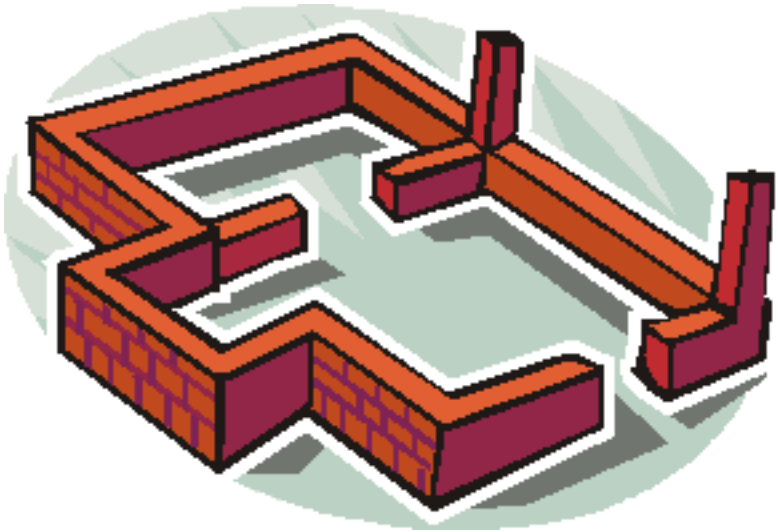
If you have any questions, please contact Randy Grover, Children's Behavioral Health Policy Specialist, at (602) 542-3981.

Sincerely,

Mary Lou Hanley
Assistant Director
Division of Children, Youth and Families

Exhibit 51

The Foundation of Safety Assessment



Information is the foundation of safety assessment.

What information do you gather and analyze in order to determine if a child is unsafe? Do you have a clear sense about what information you need in order to draw conclusions about a child's safety?

There are 10 standardized safety threats common to all safety models. Within safety assessment, standardized safety threats represent your conclusion about child safety. That conclusion is based on your understanding of a family gained from **the information you've collected.**

The effectiveness of your safety assessments is totally dependent on:

- Whether information you've collected is **pertinent** to understanding threats to child safety.

- Whether you have **enough** information to have confidence about child safety.

Isn't It Obvious?

Occasionally when conducting training about child safety intervention, participants comment to us that recognizing threats to safety is not difficult. They say, "We do it all the time." This is not an uncommon point of view. A while back when we were debriefing a statewide evaluation of child safety intervention by CPS, a newspaper reporter challenged us with, "Being able to detect a problem with a child's safety is no big deal. If a child is not safe, it's obvious. You child

welfare people make this more difficult than it is."

In our March article about threats to safety we emphasized the difference between present danger and foreseeable danger. People who believe that threats to child safety are obvious may be thinking about present danger.

> *Present danger is an immediate, significant and clearly observable threat to a child occurring in the present.*

You don't need much information at all to identify present danger. It's transparent and usually immediately understood. It's like a toddler standing in the middle of a busy intersection. So, present danger certainly fits with what the newspaper reporter thought and even with what some in child welfare think.

But…much of what constitutes danger to a child is not obvious. We've referred to that as foreseeable danger.

> *Foreseeable danger refers to threatening family conditions that are not obvious or active or occurring in your presence but are out of control and likely to have a severe effect on a child in the near future.*

Foreseeable danger can be elusive. To uncover and understand foreseeable danger you must develop a deeper familiarity with a family. To effectively assess foreseeable danger you must inquire into pertinent areas of family life and do so in an abundant fashion with due respect for the constraints and realities of CPS work.

Six Questions

There are six areas of family life that can provide pertinent and sufficient information to complete an effective assessment of threats to child safety. Based on 15 years of field experience related to safety decision making, we know that these six areas can effectively provide sufficient information for completing safety assessments. We've chosen to consider these six areas in the form of questions. The six questions are:

1. What is the extent of the maltreatment?

2. What surrounding circumstances accompany the maltreatment?

3. How does the child function on a daily basis?

4. What are the disciplinary approaches and typical context used by the caregiver?

5. What are the overall, pervasive parenting practices used by the caregiver?

6. How does the caregiver function with respect to daily life management and general adaptation including substance use and mental health functioning?

These six questions are not for the family to answer but are for you. These six questions provide the boundaries for what you seek to understand about a family. The answers to these six questions provide the data foundation from which you identify the presence of threats to child safety.

What is the extent of the maltreatment?

This question is concerned with the maltreating behavior and the immediate physical effects on a child. It considers what is occurring or has occurred and what the results are (e.g. hitting, injuries.) The answer to this question also results in a finding of maltreatment (as in a substantiation of the alleged maltreatment.) This question is typically the focus of most investigations. So, it is very important. However, relying only on information from this question is inadequate for assessing safety.

Information that answers this question includes:

- Type of maltreatment
- Severity of the maltreatment
- History of the maltreatment
- Description of specific events
- Description of emotional and physical symptoms
- Identification of the child and maltreating caregiver

What surrounding circumstances accompany the maltreatment?

This question is concerned with the nature of what accompanies or surrounds the maltreatment. It addresses what is going on at the time that the maltreatment occurs or occurred. It serves to

qualify the nature of the maltreatment.

Information that answers this question includes:

- The duration of the maltreatment
- Caregiver intent concerning the maltreatment
- Caregiver explanation for the maltreatment and family conditions
- Caregiver acknowledgement and attitude about the maltreatment
- Other problems occurring in association with the maltreatment (like substance use or mental disturbance)

How does the child function on a daily basis?

This question is concerned with a child's general behavior, emotions, temperament and physical capacity. It addresses how a child is from day to day rather than focusing on points in time (i.e., CPS contact, time of the maltreatment event.) A developmentally appropriate standard is applied in this area of inquiry.

Information that answers this question includes:

- Capacity for attachment
- General mood and temperament
- Intellectual functioning
- Communication and social skills
- Expressions of emotions/feelings
- Behavior
- Peer relations
- School performance
- Independence
- Motor skills
- Physical and mental health
- Functioning within cultural norms

What are the disciplinary approaches and typical context used by the caregiver?

This question is concerned with the manner in which caregivers approach discipline and child guidance. Discipline is considered in the broader context of socialization – teaching and guiding the child. This question is broken out from parenting generally because we found that this aspect of family life is highly related to both risk of maltreatment and threats to child safety.

Information that answers this question includes:

- Disciplinary methods
- Concept and purpose of discipline
- Context in which discipline occurs
- Cultural practices

What are the overall, pervasive parenting practices used by the caregiver?

This question explores the general nature and approach to parenting which forms a basis for understanding caregiver-child interaction in more substantive ways.

Information that answers this question includes:

- Reasons for being a caregiver
- Satisfaction in being a caregiver
- Caregiver knowledge and skill in parenting and child development
- Caregiver expectations and empathy for a child
- Decision making in parenting practices
- Parenting style
- History of parenting behavior
- Protectiveness

How does the caregiver function with respect to daily life management and general adaptation including substance use and mental health functioning?

This question is concerned with how the adults/caregivers in the family feel, think and act on a daily basis. The question here focuses on adult functioning separate from parenting. For instance, here we are concerned with how these adults in the family behave regardless of whether they are parents or not.

Information that answers this question includes:

- Communication and social skills
- Coping and stress management
- Self control
- Problem solving

- Judgment and decision making
- Independence
- Home and financial management
- Employment
- Citizenship and community involvement
- Rationality
- Self care and self preservation
- Substance use
- Mental health
- Physical health and capacity
- Functioning within cultural norms

Experience has confirmed repeatedly that the information related to these six questions can be effectively gathered by CPS staff using acceptable interviewing approaches during initial assessment/investigation. While we acknowledge variation in the ease of getting information from families, we've know that usually you can gather pertinent and sufficient information related to these six questions from one to a few family contacts.

Relationship of the Six Assessment Questions to Threats to Safety

The following table shows the relationship of the six questions to informing about specific threats to child safety. The table uses the 10 safety threats that are contained (in some language) within every safety intervention model. The table shows matches questions to the different safety threats.

As you look at the table you notice that different assessment questions can relate to a single safety threat. For instance, notice that you can learn about a caregiver's lack of control by considering how the person functions as an adult generally and how the person functions specifically with respect to disciplinary practices.

Table 1

Information – Assessment Questions	Related Safety Threat
1. What is the extent of maltreatment?	❍ Caregiver threatened/caused serious physical harm to a child.

2. What circumstances surround the maltreatment?	❍ Caregiver cannot/will not explain a child's injuries. ❍ Child provokes maltreatment.
3. How does the child function on a daily basis?	❍ Child is fearful. ❍ Child provokes maltreatment
4. What are the disciplinary practices?	❍ Violent caregivers or others in the household. ❍ Caregiver lack of self control.
5. What are the general parenting practices?	❍ Caregiver makes child inaccessible. ❍ Caregiver has distorted perception of a child. ❍ Caregiver fails to protect/supervise. ❍ Caregiver is unwilling/unable to meet immediate needs of child.
6. How does the adults/caregiver function with respect to daily life management and general adaptation?	❍ Violent caregivers or others in the household. ❍ Caregiver lack of self control. ❍ Caregiver is unwilling/**unable** to meet immediate needs of child.

Exhibit 52

CASE CLOSURE REASONS

- **ADOPT FINALIZED (ADOP) ---**This reason is to be selected due to the finalization of an adoption.
- **ADOPT SUB TERMI (ADTE) ---** This reason is to be selected when adoption subsidy cases are closed.
- **AGE OF MAJORITY (AGEO)** --- This reason is to be selected when a child reaches the age of majority and is no longer receiving CPS services.
- **ALLEGTN UNSUB (ALUN)** --- This reason is selected when there is no longer a need for CPS involvement as the family's safety and risk factors have been addressed and the allegation is unsubstantiated.
- **CASE PLAN ACHIE (CASE)** --- This reason is selected when the case plan has been successfully completed. The family's safety and risk factors have been addressed and no further CPS intervention is warranted.
- **CHILD MARRIED (MARR)** --- This reason is selected when the child has married.
- **CHILD NO LONGER H (CHNO)** --- This reason is selected when a child victim is no longer in the home. There are no outstanding safety and risk factors which would warrant CPS intervention for any other child remaining in the home. This could be due to runaway status, child moving to a different parent, relative, or parent approved non-relative.
- **CLIENT DEATH (CLIE)** --- This reason is selected due to the death of the child and there are no other children in the home.
- **COURT DISMISS (COUR)** --- This reason is selected when the court dismisses the petition (or relieves CPS of involvement in the case).
- **NO JURISDICTION (NJUR)** --- This reason is selected when CPS does not have jurisdiction in the case. Examples would include sheltering a child who is the ward of a court of another state, or a tribal ward.
- **OPENED IN ERROR (OPEN)** --- This reason is selected when a case is opened in error.
- **OPN/CLSE-REVIEW (OCRV)** --- This reason is selected when a case is opened for review purposes only.
- **RETURNED HOME (RTHM)** --- This reason is selected when a child is returned home.
- **TRANSFER CASE (TRAG) ---** This reason is selected when a case is transferred to another Arizona program. Examples would include Independent Living and Adoption case transfers, as well as DDD.
- **TRANS TO TRIBE (TRIB)** --- This reason is selected when jurisdiction and custody of a child is transferred to a tribe from CPS.
- **UNABLE TO LOCATE (UNBL)** --- This reason is selected when CPS is unable to locate the child victim and the child's family.
- **SVC DECLINED (VOFA)** --- This reason is selected when a family declines to participate in services and there are no outstanding safety or risk factors which require CPS intervention.

Exhibit 53

Glossary

Abandonment or Abandoned: The failure of a parent to provide reasonable support and to maintain regular contact with the child, including providing normal supervision. Abandoned/ Abandonment includes a judicial finding that a parent has made only minimal efforts to support and communicate with the child. Failure to maintain a normal parental relationship with the child without just cause for a period of six months constitutes prima facie evidence of abandonment [ARS §8-201(1)].

Abuse: Infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to ARS §8-821, and is caused by the acts or omission of an individual having care, custody and control of a child

Abuse includes:

(a) inflicting or allowing sexual abuse (ARS §13-1404)
sexual conduct with a minor (ARS §13-1405)
sexual assault (ARS §13-1406)
molestation of a child (ARS §13-1410)
commercial sexual exploitation of a minor (ARS §13-3552)
sexual exploitation of a minor (ARS §13-3553)
incest (ARS §13-3608)
child prostitution (ARS §13-3212)

b) physical injury to a child that results from abuse as described in section 13-3623, subsection C, and includes but is not limited to circumstances in which a child is permitted to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person for the purpose of manufacturing a dangerous drug in violation of section 13-3407, subsection A, paragraph 4.
[ARS §8-201(2)]

A child, who in good faith, is being furnished Christian Science treatment by a duly accredited practitioner shall not, for that reason alone, be considered to be an abused child. [ARS §8-201.01 (1)]

A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered an abused child for that reason alone. [ARS §8-201.01(2)]

ACYF: The Administration for Children, Youth and Families, within the Division of Children, Youth and Family Services (DCYF), Department of Economic Security.

Acquired Immune Deficiency Syndrome (AIDS): is a disorder in which a person's immune system is severely suppressed. It is caused by the HIV virus. AIDS is only one of the severe manifestations of HIV infection. It is not a disease, but a syndrome consisting of a specific complex of symptoms defined by the Centers for Disease Control.

Administration: The Administration for Children, Youth and Families within the Division of Children Youth and Family Services (DCYF), Department of Economic Security (DES).

Administrative Case Review: The formal consideration of the status of a child in out-of-home placement. This occurs every six months and is generated and presided over by either the Foster Care Review Board (FCRB) or department personnel. The latter occurs only when the FCRB cannot schedule its review in conformance with federal guidelines.

Adoption Certification: A judicial determination that a prospective adoptive parent is a fit and proper person to adopt.

Adoption Subsidy: A grant provided to a child with special needs which has been applied for through the department. [ARS §8-41 (A)(1)]

Adoption Subsidy Agreement: A written agreement between adoptive parents and the department that identifies special needs of the child for which maintenance payments and/or medical services will be provided by the department.

Adoption Subsidy Review Committee: A group of three or more members appointed by the Program Administrator to review all adoption subsidy cases for appropriateness of documentation and compliance with regulations.

Adoptive Parents: Any adult or adults who are residents of Arizona, whether married, unmarried or legally separated, who qualify to adopt children or have adopted children.

Adoptive Parents of Another State: Any adult or adults who are residents of a state other than Arizona who qualify to adopt children, or have adopted children according to the laws of that state.

Adult: A person 18 years of age or older.

Adult Court: The appropriate justice court, municipal court or criminal division of the superior court that has jurisdiction to hear proceedings concerning offenses committed by juveniles as provided in sections 8-327 and 13-501. [ARS §8-201(4)]

Advocate: To represent the interests of the family with community agencies to participate removing barriers and obtaining services to meet identified needs.

Age: For the purpose of Special Needs Adoption, means age 6 or older at the time of application for Adoption Subsidy.

Agency: Any organization which provides services; this includes but is not limited to state, private nonprofit, and private for-profit organizations.

Aggravate: Specific circumstances that may necessitate a decrease in a standard response time for any risk level.

AHCCCS: The Arizona Health Care Cost Containment System which administers Title XIX medical services for the State of Arizona.

AHCCCS Hospital Reimbursement System: The payment structure used by the Arizona Health Care Cost Containment System to pay for inpatient hospital admissions and outpatient hospital services.

AHCCCS Mental Health Policy Manual: The document published by AHCCCS which defines the policies and procedures applicable to Title XIX mental health and substance abuse services that the AHCCCS health plans, including the Department of Economic Security's Comprehensive Medical and Dental Program, and the Arizona Department of Health Services' Regional Behavioral Health Authorities must comply with and that are not in conflict with.

Alleged Abusive Parent, Guardian, or Custodian (or Alleged Abuser): The individual about whom the allegation of abuse, neglect, abandonment or exploitation of a child was made.

Alternative Investigation: A disposition assigned to a report by a CPS Supervisor, when all children living in the home have been observed by a professional mandated reporting source and determined not to be a victim of child maltreatment.

Alternative Method of Compliance: The department, in consultation with the Attorney General's Office, may forgo compliance with a licensing standard required by department rules, and not otherwise required by law, if it is found to be in the best interests of a particular foster child to be placed in a particular home. The purpose of the standard must be otherwise fulfilled.

Any Combination of Special Needs: Children for whom the combination of circumstances rather than the severity of any one problem is the barrier to permanent placement.

Approved Adoptive Family: A family who has been certified by the court or approved by an authorized entity as acceptable to adopt a child.

Approved Relative Adoptive Family: An individual(s) who is related to the child to be adopted by the whole or half-blood or by marriage or adoption and is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle or grandparent; is assessed by the department as acceptable to adopt a child; and capable of meeting the childs placement needs.

Arizona Department of Education Exceptional Student Services (ADE/ESS): The state agency which oversees special education programs and issues educational vouchers.

Arizona Department of Health Services (ADHS or DHS): The state department mandated to serve the public health needs of all Arizona residents. Within this department, the Office of Children's Behavioral Health (OCBH), a subdivision of the Division of Behavioral Health Services (DBHS), oversees the ADHS contracts with regard to children's services with the Regional Behavioral Health Authorities (RBHAs). Staff of the Office of Child Care Licensure, a subdivision of the Health and Child Care Review Services, conduct safety and sanitation inspections of potential and licensed foster homes.

Arizona Health Care Cost Containment System (AHCCCS): The state department that administers the Arizona Medicaid Program, a managed care system for low income adults and children. AHCCCS distributes federal Title XIX funds for mental health and substance abuse, through Arizona Department of Human Services, to the Regional Behavioral Health Authorities; it distributes federal dollars for other medical services through the health plans, including Comprehensive Medical and Dental Program.

Approved Relative Adoptive Family: An individual who is related to the child to be adopted by the whole or half-blood or by marriage or adoption and is the spouse of the natural or legal

parent of the child to be adopted or is the adult sibling, aunt, uncle or grandparent; and is assessed by the department as acceptable to adopt the child and capable of meeting the childs placement needs.

Assessment: The evaluation of family strengths and capacities and risk to children living in the home on the basis of history, observations, professional opinions and other information.

Authorized Representative: A person designated by the department or an agency to perform specific, identifiable work activities and functions.

Behavior Management: Services that primarily involve supervision and direction of the individual, but may also include services related to activities of daily living and household services incidental to, and consistent with, the behavioral health needs of the individual.

Behavioral Health Coordinator/ CMDP: The designated person in CMDP who is responsible for the coordination of referrals to the RBHAs, prior authorization for non-Title XIX authorized inpatient hospital and inpatient psychiatric facility services, authorization of non-Title XIX covered psychiatric services and authorization of out of state behavioral health services for CMDP enrolled children.

Behavioral Health Group Home (HGH): A group care facility which is licensed as a Level III behavioral health facility by ADHS. The HGH provides a supportive, protective environment, with 24 hour supervision. Services are provided to improve or stabilize the child's behavioral health and prevent placement in a more restrictive environment. The HGH will arrange for and support off-site educational services.

Case: A report regarding a child or family that is assigned for investigation or a child or family unit receiving services from ACYF.

Case Conference: A documented meeting between a DES employee and at least one other person. Case conferences may be more frequent and informal than case plan staffings.

Case Management: The planning and coordination of all services to a client by an individual who, working with members of a service team, provides assessment, identifies and obtains services, monitors, evaluates, records progress and terminates services in accordance with established time frames.

Case Manager: A professional employed or contracted by the department to provide social services to eligible children and families. A case manager's responsibilities include the establishment of a case plan, determination and arrangement of appropriate services, evaluation of progress, recommendations to the juvenile court and other agencies and the termination of

services.

Case Notes: A CHILDS window used to document case activity, primarily contact between department staff and other persons associated with a case.

Case Opening: The date upon which a case is assigned for initial investigation.

Case Plan: A written document which is a separate and distinct part of the case record. It identifies the permanency goal and target date, desired outcomes, tasks, time frames, and responsible parties. The case manager is responsible for the development and implementation of the case plan in consultation with the family and service team.

Case Plan Staffing: A documented meeting arranged for the purpose of sharing information, the development and/or review of the case plan, and the evaluation of services and case progress. The staffing includes the case manager, the family and members of the service team.

Case Planning: The process through which a permanent plan for the child is established, reviewed and revised as necessary. Case planning is continuous throughout the duration of a case, is implemented through the use of staffings, and is documented in the case record.

Case Record: The department's official collection of information regarding a client or family and the services provided. This may include, but is not limited to, case notes, social histories, staffing minutes, medical, psychological and educational information, legal documents, correspondence and DES forms. The case record includes an electronic and hard copy record.

Centers for Medicare and Medicaid Services (CMS): An agency of the U.S. Department of Health and Human Services, which provides technical assistance, disburses Title XIX funds, and monitors AHCCCS for compliance with federal regulations.

Central Registry: A confidential registry of substantiated reports of child abuse and neglect (ARS §8-804).

Certified: See **Adoption Certification**.

Child: An individual who is under 18 years of age.

Child Abuse Prevention (CAP) Fund: The CAP Fund was established by the legislature in 1982 to promote child abuse and neglect prevention. Utilizing a Request for Proposal process, CAP Fund dollars are used to contract with community agencies to provide child abuse and neglect services to children and families.

Child Care: The provision of substitute care for a child during a portion of a day, on an ongoing basis.

CPS Information: Includes all information the Department gathers during the course of a Child Protective Services investigation from the time a file is opened and until it is closed. CPS information does not include information that is contained in child welfare agency licensing records. [ARS §8-807(T)(1)]

Child Protective Service Worker: A person who has been selected by and trained under the requirements prescribed by the department and who assists in carrying out the provisions of child protective services. [ARS §8-801(1)]

Child Protective Services: See Protective Services

Child Welfare Agency: Any agency or institution maintained by a person, firm, corporation, association or organization to receive children for care and maintenance; any institution that provides care for unmarried mothers and their children; any agency maintained by the state, or a political subdivision thereof, person, firm, corporation, association, or organization to place children or unmarried mothers in a foster home. This does not include state operated institutions or facilities, detention facilities for children established by law, health care institutions that are licensed by the Department of Health Services pursuant to title 36, chapter 4 or private agencies that exclusively provide children with social enrichment or recreational opportunities and that do not use restrictive behavior management techniques.

CHILDS: The Children's Information Library and Data Source is the Division of Children, Youth and Families' automated child welfare record keeping system.

CHILDS Adoption Registry: Preplacement information on children legally free for adoption, children partially free for adoption, children who have a plan of adoption and are to be placed out-of-state and children who are to be placed in a foster-adoptive home.

CHILDS Case Management Information System: (Children's Information Library and Data Source) is the Division of Children, Youth and Families' automated child welfare record keeping system. The CHILDS Case Management Information System is a repository of all reports of child abuse and neglect and related records and identifies statistical data relating directly to child protective services. (ARS § 8-804.01)

CHILDS Provider (Adoption) Registry: A registration maintained by the department consisting of currently certified adoptive home studies.

Client: A person who receives services from the department. May also be referred to as a Participant in CHILDS.

Clinical Case Management Team: The interdisciplinary team of professionals who are responsible for providing continuous treatment and support to children/clients with serious mental illnesses and for locating, accessing, and monitoring the provision of mental health services. The clinical case management team shall consist of a psychiatrist, case manager, and other mental health professionals as needed, based on the eligible person's need for medically necessary services.

Communication: A telephone, fax or letter contact with the Child Abuse Hotline/Central Intake Unit which may be a report of child abuse and neglect, a request for services or information sharing.

Communication Agreement: A written agreement, approved by the court, regarding communication with a child adoptee, the adoptive parents and a birth parent.

Community Advisor: An individual who serves as a role-model, mentor and part of the young adult's support system. The community advisor assigned to each young adult provides encouragement, social and emotional support and offers the young adult a link with the community.

Compact: The Interstate Compact on the Placement of Children.

Compact Administrator: The department employee who shall be general coordinator of activities under the Compact in the State jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of the Compact.

Compact State: All states, the U.S. Virgin Islands, the Commonwealth of Puerto Rico and the District of Columbia.

Comprehensive Medical And Dental Program (CMDP): The AHCCCS health plan under DES which provides medical and dental services for children in out-of-home care, including foster children enrolled in ALTCS, in the custody of DES, the Administrative Office of the Courts (juvenile probation), and the Department of Juvenile Corrections.

Concurrent Case Planning: Actively implementing the case plan goal while also actively pursuing an alternative plan including adoption or legal guardianship for children in out-of-home care through a Voluntary Foster Placement Agreement or dependency action.

Concurrent Permanency Planning: Actively implementing the family reunification permanency goal while simultaneously planning for the possibility of other permanent options. Concurrent planning means that early in the process of serving the family the worker identifies possible caregivers who would be willing to care for the child on a permanent basis if the child is unable to be reunified with his/her birth family.

Conditions: For the purpose of a Special Needs Adoption, means a physical, mental or developmental disability that existed prior to the finalization of the adoption.

Conflict Resolution: A method or technique for settling disagreements or disputes among individuals of agencies.

Consent to Place a Child for Adoption: A document that, once signed by the parent, gives the Arizona Department of Economic Security permission to place a specific child for adoption and is irrevocable unless obtained by fraud, duress or undue influence. See also, relinquishment.

Contact: Face-to-face meetings, telephone calls, correspondence and any other means of communication between case participants and associates, providers, department staff, service team members, and any other person regarding the case.

Contact and Visitation Plan: The arrangement for providing contact between a child in out-of-home placement and his parent/caregiver, siblings, family members, other relatives, and other significant persons such as friends and former foster parents. This is accomplished as a cooperative effort among these persons, the case manager, the out-of-home care provider and the child, if age appropriate.

Continuity of Care: The provision of services with minimal or no interruption of time, provider, location, or modality, as appropriate for the welfare of the DES eligible child/client, including transitioning that person between service categories or mental health systems.

Contract Personnel: Individuals employed by contract providers to deliver services under the terms of the contract.

Contract Provider: Any private agency, institution, public agency or vendor which has executed an agreement with the department to furnish services for monetary reimbursement.

Counseling: Professional guidance of a nonmedical nature which assists individuals and families in dealing with a wide range of personal, situational and functional problems.

Court: The Juvenile Division of the Superior Court.

Courtesy Supervision: Supervision by a receiving district for a child who is placed outside of his or her home district.

CPS Mental Health Specialist: A district level mental health coordinator who serves as a liaison to the DHS Regional Behavioral Health Authorities (RBHAs) for behavioral health services.

Custodian: A person, other than a parent or legal guardian, who stands in loco parentis to the child or a person to whom legal custody of the child has been given by order of a court of competent jurisdiction [ARS §8-201(8)].

DDD: The Division of Developmental Disabilities, Department of Economic Security

Delay of Placement: Placement of a child in an adoptive home more than 90 days after the Home Study Case Conference resulting in the identification of the placement.

Delinquent Act: An act by a juvenile that if committed by an adult would be a criminal offense or a petty offense, a violation of any law of this state, or of another state if the act occurred in that state, or a law of the United States, or a violation of any law that can only be violated by a minor and that has been designated as a delinquent offense, or any ordinance of a city, county or political subdivision of this state defining crime. Delinquent act does not include an offense under section 13-501, subsequent A or B if the offense is filed in adult court. Any juvenile who is prosecuted as an adult or who is remanded for prosecution as an adult shall not be adjudicated as a delinquent juvenile for the same offense. [ARS §8-201(10)]

Delinquency Hearing: A proceeding in the juvenile court to determine whether a juvenile has committed a specific delinquent act as set forth in a petition. [ARS §8-201(9)]

Denial of License: The act of refusing to issue a license to an applicant.

Department: The Arizona Department of Economic Security (DES).

Department of Law: The Office of the Arizona Attorney General, and/or designated Assistant Attorney General staff.

Dependency Petition: The formal legal petition requesting the Court to adjudicate a child dependent.

Dependent Child: A child who is adjudicated one or more of the following:

- in need of proper and effective parental care and control and has no parent or guardian, or one who has no parent or guardian willing to exercise or capable of exercising such care and control.

- destitute or who is not provided with the necessities of life, including adequate food, clothing, shelter or medical care, or whose home is unfit for him by reason of abuse, neglect, cruelty or depravity by either of his parents, his guardian or other person having his custody or care.

- under the age of 8 years who is found to have committed an act that would result in adjudication as a delinquent or incorrigible child if the act was committed by an older child.

- Incompetent or not restorable to competency and who is alleged to have committed a serious offense as defined in Section 13-604. [Applies to delinquent children under ARS § 8-201(11)]

A dependent child does not include a child who in good faith is being furnished Christian Science treatment by a duly accredited practitioner if none of the circumstances described above exists. [ARS §8-201(13), ARS §8-201.01(1)]

A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered a dependent child for that reason alone[ARS §8-201.01(2)]

DES: The Arizona Department of Economic Security.

DES Fee Schedule: Allowable amounts established by the department to pay for the provision of medical, dental, psychological and psychiatric care for client children.

Detention: The temporary confinement of a juvenile who requires secure care in a physically restricting facility that is completely surrounded by a locked and physically secure barrier with restricted ingress and egress for the protection of the juvenile or the community pending court disposition or as a condition of probation. [ARS §8-201(14)]

Detoxification Services: treatment services that are provided to reduce physical dependence on alcohol, drugs or other substances through the use of therapeutic procedures, including medications, rest, diet, counseling or medical supervision.

Developmental Disability: Either a strongly demonstrated potential that a child under the age of six years is developmentally disabled or will become developmentally disabled, as determined by a test performed pursuant to ARS §36-694 or by other appropriate tests, or a severe, chronic disability which is:

- attributable to mental retardation, cerebral palsy, epilepsy, or autism;
- manifested before age 18;
- likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services which are lifelong or extended in duration. [ARS §36-551(15)]

Disposition: The point at which the decision is made to process a CPS report as "Case Assigned for Investigation," "Alternative Investigation," "State or Federal Statute, or Court Order Prevents CPS Investigation," "Referred to Family Builders," or "Not Investigated."

Dually Adjudicated Child: a child who is found to be dependent or temporarily subject to court jurisdiction pending an adjudication of a dependency petition and who is alleged or found to have

committed a delinquent or incorrigible act.

Educational Voucher: The mechanism for transferring funds for a child's education from the state's public school system to an approved private school in a residential facility (RTC). Vouchers cover funding for both special and nonspecial education.

Electronic Record: Maintained in CHILDS and includes window data and electronically created documents.

Eligibility: The requirements an individual or family must meet to receive services funded by the department.

Eligible Person(s): An individual or family who meets all the requirements for receiving a service.

Emergency Intervention: Services provided in coordination by the department to protect a child who is at imminent risk of maltreatment.

Emotional Disturbance: A condition which impedes the ordinary developmental progress of the child as defined by accepted psychiatric or psychological standards and as diagnosed by one or more psychiatrists or psychologists approved by the department. [ARS §8-141(A)(7)]

Entity: The Department of Economic Security, Department of Juvenile Corrections or a Child Welfare Agency that has been granted legal care, custody and control of a child by order of the juvenile court and that is responsible for securing inpatient psychiatric acute care services or residential treatment services for a child. Entity includes a probation department or juvenile detention center that either recommends or is ordered by the court to provide inpatient psychiatric acute care services or residential treatment services for a child.

EPSDT: A 1972 amendment to Title XIX (Medicaid) requiring screening, diagnostic, and treatment services at periodic intervals and as medically necessary to be offered, upon request, to all eligible children. A 1989 amendment to Title XIX expanded EPSDT to include additional medical services, mental health and substance abuse services.

Evaluation: A study of a home for an identified purpose which describes family members, the home and community, and relates its findings and recommendations to the needs of the child or children for who the study is requested.

Explain: A CHILDS window function that allows for narrative entry for further details.

Exploitation: Use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities.

Extreme Serious Conduct Allegation: An allegation of conduct by a parent, guardian or custodian of a child that, if true, would constitute any of the following:

a) A violation of section 13-3623 involving child abuse.

b) A felony offense that constitutes domestic violence as defined in section 13-3601.

c) A violation of section 13-1404 or 13-1406 involving a minor.

d) A violation of section 1405, 13-1410 or 13-1417.

e) Any other act of abuse that is classified as a felony. [ARS §8-801(2)]

Family: Persons, including at least one child, related by blood or law, or who are legal guardians of a child, or who reside in the same household. Where persons related by blood or law do not reside in the same household and where adults other than spouses reside together, each may be considered a separate family when it is to the benefit of the child. Family includes both parents regardless of whether they are living together for case planning purposes.

Family Care Provider: Any person providing out-of-home care in a family home. Includes relatives, significant persons and licensed foster homes.

Family Care Settings: Includes relative, significant person/other, family foster home, and treatment foster homes.

Family Foster Home: A home maintained by any individual or individuals having the care or control of minor children, other than those related to each other by blood or marriage, or related to such individuals, or who are legal wards of such individuals [ARS §8-501(A)(4)].

Family Group Foster Home: A family foster care facility licensed for placement of more than five minor children but not more than ten minor children. Licensed under A.A.C. R65-59, Group Foster Home Licensing Standards. [ARS §8-501(A)(6)]

Family Preservation Services (Federal funds): Family Preservation services are directed to reduce risk factors and stabilize a family unit in response to a crisis event when there is significant risk to the family. These services include an intensive level of intervention to successfully meet the crisis needs of the family or to reunify children who are in non-permanent placement. The services are provided through contracts with private providers.

Family Support Services (Federal funds): Family Support Services are preventative services provided on a proactive basis to improve the well being of families, enhance family functioning, and foster a sense of self reliance. The services are provided through contracts with private providers.

Findings: Result of an investigation stated as propose substantiated, substantiated or unsubstantiated.

Fiscal Year: The period of time from July 1st through June 30th.

Foster/Adoptive Applicant: A person who requests consideration as a prospective foster or adoptive parent by completing the required application forms. Foster Care licensing includes both spouses of the adult household, if caregivers are married.

Foster-Adoptive Placement: The placement of a child whose case plan goal is adoption and who is not legally free for adoption, in a home of a family that is certified as acceptable to adopt and licensed as a foster home by the department.

Foster Care: Alternative care for children in non-parent relative placements, family foster homes, group homes or child welfare agencies. See also Out-Of-Home Care.

Foster Care Facility: A setting licensed to provide out-of-home care to children, including licensed relative placements, foster homes, group homes and child welfare agencies.

Foster Care Provider: Any person or agency licensed to provide out-of-home care for children.

Foster Child: A child placed in a foster home or child welfare agency. [ARS §501(A)(3)]

Foster Parent: Any adult individual or individuals maintaining a licensed foster home. [ARS §8-501(A)(5)]

Foster Parent Adoption: The adoption of a child by his or her current foster parents who became certified to adopt after the child was placed in the home for foster care purposes.

Group Care Setting: A licensed, agency-administered group home, therapeutic group home, residential treatment center (RTC) or mobile program.

Group Home: A group care facility that provides 24 Hour supervision within a group setting. Therapeutic services are generally provided off site.

Guardian: A person who has qualified as a guardian of a minor pursuant to testamentary or court appointment, but excludes one who is merely a guardian ad litem. [ARS §14-5201 et seq. and ARS §8-531(9)]

Guardian Ad Litem: A person appointed by the court to protect the interest of a minor or an incompetent person in a particular case before the court. [ARS 8-531(7)]

Guardianship of the Person: With respect to a minor, means the duty and authority to make important decisions in matters affecting the minor including but not necessarily limited either in number or kind to:

a) The authority to consent to marriage, to enlistment in the armed forces of the United States and to major medical, psychiatric and surgical treatment, to represent the minor in legal actions, and to make other decisions concerning the child of substantial legal significance.

b) The authority and duty of reasonable visitation, except to the extent that such right of visitation has been limited by court order.

c) The rights and responsibilities of legal custody, except where legal custody has been vested in another individual or in an authorized agency.

d) When the parent-child relationship has been terminated by judicial decree with respect to the parents, or only living parent, or when there is no living parent, the authority to consent to the adoption of the child and to make any other decision concerning the child which the childs parents could make. [ARS §8-531(8)]

HLCI: The High Level Client Index Number. A unique identification number assigned to each participant in CHILDS who is the recipient of a service.

Hard Copy Record: A paper file that is maintained at the local office and includes: Documents generated outside the Division of Children, Youth and Families (DCYF); Documents that require signatures from individuals outside DCYF; and Hard Copy forms not maintained electronically.

Health service provider: A practitioner licensed by the State of Arizona or other state to provide physical or mental health services, or others approved by the department as having the appropriate credentials to carry out the service, practicing within the scope of such credentials.

Healthy Families Arizona: Healthy Families Arizona (HFAz) is a community-based, multi-disciplinary program serving families of newborns, and is designed to reduce stress, enhance

family functioning, promote child development, and minimize the incidence of abuse and neglect within a multi-cultural environment. Family Support Specialists visit new parents in their home anywhere from weekly to quarterly according to their level of need. Participation may continue until the child reaches five years of age.

High Risk of Physical or Mental Disease: A potentially debilitating condition, as defined by accepted standards of the health service profession, as certified by one or more health service providers approved by the department. [ARS §8-141(A)(9)]

High Risk of Severe Emotional Disturbance if Removed from the Care of Foster Parents or Relatives: The development of significant emotional ties to the foster family as documented by the child's case manager and as diagnosed by a psychiatrist or psychologist approved by the department [ARS §8-141(A)(10)]. These ties include:

- Identification of the child as a member of the foster family or relative family
- Identification by the foster family or relative family of the child as belonging to that family
- The likelihood that the child will not establish significant emotional ties to another family if denied permanent placement with the foster family, or relative family. [ARS § 8-141(A)(8)]

HIV: Is the acronym for human immunodeficiency virus. This is the name for the virus which causes AIDS. The virus causes a deficiency in the human immune system, the body's natural defense against disease. HIV progressively damages the immune system and leaves its victims unable to fight off even small infections.

HIV/AIDS Field Representative: the person in each district designated to be a resource person regarding HIV/AIDS issues. This person is to be included in all decisions regarding HIV/AIDS testing, should be made aware of test results, and should be consulted regarding placement of children who are HIV positive or diagnosed with AIDS.

HIV/AIDS Risk Factors: Are those behaviors and/or reasons that put an individual at risk for contracting the AIDS virus:

a. Voluntary risk behaviors

i. The sharing of needles and syringes ("works") for the purpose of intravenous drug use since 1978.

ii. Unprotected sexual activities with single or multiple partners who are infected or whose HIV status is unknown.

b. Non-behaviorial reasons that put an individual at risk

i. Children of mothers who are infected and/or whose mothers engaged in high risk behaviors

ii. Children and youth who have been involuntary sex partners (victims of sexual assault, rape, sexual abuse, etc.) of individuals who are infected.

iii. Hemophiliacs, because of their need for transfusions or blood products; the risk to this population, however, has been greatly reduced since the testing of all blood and blood products was instituted in March, 1985.

HIV Positive: Means that a blood test has indicated the presence of antibodies to the HIV virus. This means that at some point the person has been infected with the virus and the immune system has responded by producing antibodies. People who have the antibody but are otherwise asymptomatic for AIDS are referred to as "HIV positive only". This condition does not inevitably begin a progression to AIDS, although it may. These people are capable of transmitting the virus through high risk behaviors.

Home Management Tasks: Training and/or instruction in activities related to routine household maintenance and family functioning.

In-Home Placement: The placement of a child in the home of the child's parent or legal guardian.

In-Home Respite care: Respite care provided by a licensed foster parent in a home that is not that individual's own home.

In-home Voluntary Child Protective Services Case: A case in which all children remain within the family home while the department provides services and in which a dependency petition has not been filed.

Incoming Communication: Verbal, written, or in-person contact to Child Protective Services.

Incorrigible Child: A child who is:

a) Is adjudicated as a child who refuses to obey the reasonable and proper order or directions of a parent, guardian or custodian and who is beyond the control of that person.

b) Is habitually truant from school as defined in section 15-803, subsection C.

c) Is a runaway from the childs home or parent, guardian or custodian.

d) Habitually behaves in such a manner as to injure or endanger the morals or health of self or others.

e) Commits any act constituting an offense that can only be committed by a minor and that is not designated as a delinquent act.

f) Fails to obey any lawful order of a court of competent jurisdiction given in a non-criminal action. [ARS §8-201(15)]

Independent Living Services Program: An array of services that prepare young adults for attaining independence and self-sufficiency in the community.

Independent Living Subsidy: A program for young adults in foster care which offers them the opportunity to experience community living while still receiving services from the department. This placement option, authorized by ARS §§8-845(A)(8) and 8-521, serves dependent youth 17 years of age and older and young adults who remain in care voluntarily after age 18.

Individual Service Plan: A specific plan developed by the RBHA case manager and the clinical case management team, with the participation of the DES case manager, to identify and facilitate appropriate mental health services for a DES eligible child. It must include treatment goals, specific services and units of delivery, service cost, anticipated time frames, and identified providers. The ISP will be incorporated as the mental health portion of the child welfare case plan and is subject to authorization and approval as required.

Individuals with Disabilities Education Act (IDEA): A federal law which mandates a free appropriate public education in the least restrictive environment for children with disabilities. It outlines services and procedural safeguards for children needing special education.

Infant: A child under the age of one year.

Information and Referral: An incoming communication without sufficient identifying information or content to constitute a report. Information is given, and/or an individual is directed to an appropriate resource.

In-Home Intervention: A program of services provided while the child is still in the custody of the parent, guardian or custodian. (ARS §8-891)

Initial Report: Information as entered on the CHILDS Case Management Information System pertaining to a particular report, up to the point of disposition.

Initial Response: An action by CPS, law enforcement or other emergency personnel to determine that the child victim is currently safe. The initial response is determined by the highest risk level.

Inpatient Assessment: includes all of the following:

a. the observation of a childs behavior while the child is in an inpatient assessment facility.
b. psychological or psychiatric testing, if indicated.
c. a determination as to whether a child needs inpatient psychiatric acute care services and whether inpatient psychiatric acute care services are the least restrictive available alternative.
d. the administration of psychotropic medication and medication monitoring, if necessary to complete the assessment or to prevent the child from being a danger to self or others.
e. a written report that summarizes the results of an inpatient assessment, including specific

recommendations for follow-up care.

f. a psychiatric or psychological assessment, including a clinical interview with a child.

g. an explanation to a child of the least restrictive alternatives available to meet the childs mental health needs.

h. a determination as to whether the child may be suffering from a mental disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled as defined in section 36-501.

i. a review of a childs medical, social and psychological records, if available.

Inpatient Assessment Facility: Refer to Psychiatric acute care facility.

Intensive Treatment Program: Treatment services that are outlined in a childs individual treatment plan and that provide planned, structured and coordinated therapeutic goals

Inquiry Form: A pre-application form given to prospective applicants that compiles information used to evaluate the prospective applicants interest, commitment and desire to make application to adopt or foster children through DES.

Intake: The initial process of screening, receiving, investigating and recording information for the purpose of determining risk to children and the need for protection and services.

Intensive Family Services (Arizona Family Preservation Services): Intensive Family Services (also known as AFPS) is a program that provides services to families whose children are at immediate risk of foster care placement due to abuse or neglect. The program uses a crisis intervention approach providing a range of intensive, behaviorally-oriented services such as counseling, family therapy, communication skills, and parent education services in the family's own home. The services are provided through contracts with private providers.

Interested Parties: A person granted the right to notice of and participation in any review or hearing concerning the child, the right to review all pleadings, and the right to receive reports submitted to the court by the case manager.

Intergovernmental Agreement/Interagency Service Agreement: A written contract between two separate agencies or departments, obligating designated employees of the agencies/ departments to follow specified procedures, standards, roles, and duties for a specified time. These collaborative documents are reviewed and refined by legal representatives of both departments/agencies and are signed by the administrators of those departments/agencies.

Interstate Placement: Any movement of a child from one state to another state for the purpose of establishing a suitable living environment and providing necessary care.

Investigation: The process by which allegations of abuse or neglect, abandonment or exploitation are either found propose substantiated, substantiated or unsubstantiated. The process includes determining:

- the nature, extent and cause of any condition which would tend to support or refute the allegation that the child should be adjudicated dependent;
- the name, age and condition of other children in the home; and
- whether any child is in need of protective services

Investigation/Safety Assessment Process: Gathering information to assess current risk to a child which includes, but is not limited to:

- Review of prior CPS reports/other records
- Worker's observation(s) and/or assessment
- Face-to-face and/or phone interviews
- Collateral sources which may be persons or documents
- Documentation of the process, review and approval by the CPS Unit Supervisor

Juvenile: See child

Juvenile Court: The juvenile division of the superior court when exercising its jurisdiction over children in any proceedings relating to delinquency, dependency or incorrigibility. [ARS §8-201

(17); ARS 8-531(9)]

Kinship Care: means the full time care of a child, who is in the care, custody and control of the department, who is placed with a kinship foster caregiver.

Kinship Foster Caregiver: means an adult relative or person who has a significant relationship with a child, who is caring for a child, who is under the care custody and control of the department. A relative means grandparent; great grandparent; brother or sister, whole or half blood; aunt or uncle; or cousin.

Law Enforcement Officer: A peace officer, sheriff, deputy sheriff, municipal police officer or constable. [ARS § 8-201(18)]

Least Restrictive Environment (LRE): That setting which offers the most family-like atmosphere which is compatible with the needs of the child.

Legal Custody: A status embodying all the following rights and responsibilities:

a) The right to have physical possession of the child.

b) The right and the duty to protect, train and discipline the child.

c) The responsibility to provide the child with adequate food, clothing, shelter, education and medical care, provided that such rights and responsibilities shall be exercised subject to the powers, rights, duties and responsibilities of the guardian of the person and subject to the residual parental rights and responsibilities if they have not been terminated by judicial decree. [ARS §531(5)]

Legal Father: A man who was married to the mother of a child at the time of the child's birth or who was married to the child's mother any time in the ten months immediately preceding such birth.

Legally Free: A child who is eligible for adoption because all legal parents or guardians have either consented to adoption, had their parental rights terminated by the court, or died.

Level One Behavioral Health Facility: A behavioral health service agency that is licensed by the Department of Health Services and that provides a structured treatment setting with twenty-four hour a day supervision and an intensive treatment program

Level of Supervision: The degree of monitoring and directing required based upon the age, level of maturity, and the special needs of the child as agreed upon by the child's case manager and the care provider. The "level of supervision" required can range from being left alone for short periods of time to a need for the child to have constant monitoring and direction.

License: A document issued by the department confirming that the applicant(s) have met the standards for the provision of foster care or group care and are authorized to conduct specified services.

Licensed Family Foster Parent: means a person or persons licensed under A.A.C. R5-6-5801 et. seq., Family Foster Parent Licensing Requirements, to provide care for up to five children who are in the care, custody and control of the department.

Licensed Family Group Foster Parent: means a person or persons licensed under A.A.C. R5-6-5901 et. seq., Group Foster Home Licensing Standards, to provide care for more than five children but not more than ten children who are in the care, custody and control of the department.

Licensing Specialist: A person designated by the department or an agency to perform specific work activities and functions related to licensing, supervision, support, and monitoring of foster or group care homes.

Locked (Secured) Residential Treatment Center: A residential treatment center, Level I facility, licensed to care for children and provide behavioral health services, on a 24 hour basis, which utilizes secure settings or mechanical restraints. A court order for inpatient treatment is required for placement of a dependent child within such a facility.

Maintenance Payments: Monthly money payments for the cost of care and supervision of the foster child, or monthly money payments for the extra time and expense of caring for a special needs child on Adoption Subsidy.

Mandated Reporter: An individual who is required to report child abuse or neglect under ARS §13-3620.

Maltreatment: Abuse, neglect, exploitation, or abandonment of a child.

Medical Identification Card: The card issued by the Contract Provider for use in the purchase of all covered services.

Medical Need or Chronic Illness Means: An inherent, long-lasting severe physical or mental condition which often interferes with daily functioning and/or requires special attention and on-going medical, surgical or psychiatric care.

Medically Necessary: Under the statutory limitation of the Adoption Subsidy Program, medically necessary services are provided to prevent the progression of disease, disability and other adverse health conditions identified on the subsidy agreement, which are provided by a qualified service provider within the scope of his/her practice under state law or certification, whichever is applicable.

Medication Adjustment and Monitoring: Medication review for adjustment and/or continuing treatment for an individual, as performed by a qualified professional, including Physician, Nurse Practitioner, Physician's Assistant, or Registered Nurse who is licensed in accordance with A.A. C. Title 20.

Mental Disability: A lifelong condition which is characterized by impaired intellectual development and impedes the ability to function independently. [ARS §8-141(A)(11)]

Mental Health Standards: Standards established by AHCCCS, Department of Human Services, federal law, state statutes and rules and any subsequent amendments, defining the policies and procedures applicable to Title XIX mental health and substance abuse services.

Mitigate: Specific circumstances that may allow an increase in a standard response time for Risk Level 1, 2, and 3 reports.

Mobile Program: A group care facility that provides 24 hour care, and which is situated in and utilizes the outdoors to provide a recreational and educational opportunity in group living.

Monitor: The process of reviewing service providers for compliance with requirements.

Multidisciplinary Case Consultation Teams (MDT): A team of professionals which may include, but is not limited to, a physician, psychologist, law enforcement representative, assistant attorney general and district program manager or designee. This group meets regarding selected cases with the assigned case manager, supervisor, other service team members and the family, as appropriate. The purpose is to share information and to assess and diagnose particularly complex and difficult case situations in order to make recommendations regarding the development or review of a case plan.

Native American Child: A child who is a member of, or eligible for membership in a tribe, as defined by the tribe.

Near Fatality: Means an act that, as certified by a physician, places a child in serious or critical condition. [ARS 8-807(T)(2)]

Need to Know: Refers to the need for a person to know the HIV status of a child and is based on direct responsibility or accountability for care of the child, or involvement in an activity directly related to the child.

Neglect or Neglected: The inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, except if the inability of a parent or guardian to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services.[ARS §§8-201 (21)]. A child, who in good faith, is being furnished Christian Science treatment by a duly accredited practitioner shall not, for that reason alone, be considered to be a neglected child. [ARS §8-8201.01(1)] A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered a neglected child for that reason alone. [ARS §8-201.01(2)]

Newborn: An infant from birth to 60 days of age.

Nonrecurring Adoption Expenses: Those reasonable and necessary adoption fees, court costs, attorney fees and expenses which are directly related to the legal process of adoption of a child with special needs, meet federal requirements, and are not reimbursed by other sources, including costs relating to the adoption study, health and psychological examinations, supervision of the placement before the adoption, transportation and reasonable costs of lodging, and food for the child or adoptive parents which are incurred to complete the adoption process.

Not Investigated: A disposition assigned to a report by a CPS Supervisor only when there is inadequate staff to complete a field investigation.

Opportunistic Illnesses: Are infections that are not a threat to a healthy immune system but that could be fatal to a person who has AIDS. The opportunistic infections most commonly associated with AIDS are: Pneumocystis carinii pneumonia (PCP); Kaposi's sarcoma (KS); candidiasis (yeast infections); disseminated cytomegolovirus (CMV); unusually extensive herpes of prolonged duration; toxoplasmosis; and mycobacterial disease due to illness, both tuberculosis (TB) and atypical mycobateria.

Orientation: Instructions and information provided to employees, volunteers, and contract personnel at the time they assume service responsibilities.

Out-of-Home Placement: The placement of a child with an individual or agency other than the child's parent or legal guardian. This includes the following:

- placement in temporary custody [ARS §8-221(A) or (B)]
- voluntary placement (ARS §8-806)
- placement due to dependency action. [ARS §8-501(A)(7)]

Out-of-Home Care Provider: A person or agency authorized by the department to provide care or control of a child in out-of-home care.

Out-of-Home Care: See Out-of-home placement.

Out-of-Home Respite Care: Respite care that is provided out of the child's home and in the home of the respite provider. This may include a shelter care facility.

Outpatient Assessment: Includes all of the following:

a. a psychiatric or psychological assessment, including a clinical interview with a child

b. an explanation to a child of the least restrictive alternatives available to meet the childs mental health needs.

c. a determination as to whether the child may be suffering from a mental disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled.

d. a review of a childs medical, social and psychological records, if available

e. a determination as to whether the child needs an inpatient assessment or inpatient psychiatric acute care services and whether an inpatient assessment or inpatient psychiatric acute care services are the least restrictive available alternative.

Parent: The natural or adoptive mother or father of a child. [ARS §8-531(A)(10)]

Parent Aide: A paraprofessional who functions as a member of a team to provide parent aide services in support of a case plan. Parent aides may be department employees, volunteers, or employees of a parent aide services contract provider.

Parent Aide Services: A range of support services which may include teaching and modeling of parenting and home management skills, teaching the use of informal and formal community resources, and transportation tasks.

Parent-Child Relationship: Includes all the rights, privileges, duties and obligations existing between parent and child, including inheritance rights. [ARS §8-531(11)]

Parental Involvement: Emphasis of parental participation throughout all phases of case planning.

Parenting Skills Training: The provision of instruction and/or modeling to enhance parental functioning.

Participant: A person who is a recipient of service and member of a case (see client).

Partial Care, Basic: Therapeutic activities including those which promote coping, problem-solving and socialization skills, and offer regular activities for individuals requiring supportive counseling, skills, training and rehabilitation. This service is provided as a half day (minimum 3 hours) or full day (minimum 5 hours).

Partial Care, Intensive: Regularly scheduled program of intensive therapeutic activities, including a variety of treatment modalities such as individual, group, and/or family therapy, cognitive and psychodynamic strategies addressing the individual's issues, and treatment related activities intended to reduce the need for more intensive services. This service is provided as a half day (minimum 3 hours) or full day (minimum 5 hours).

Parties: Includes the child, the petitioners and any parent of the child required to consent to the adoption pursuant to section 8-106. [ARS §8-531(12)]

Permanent Guardian: For the purpose of adoption petitioning and guardianship subsidy, a legal guardian appointed by the court pursuant to ARS §8-871.

Person About Whom a Report is Made: An alleged abusive caregiver or other person, a child victim or a child victim's parent or legal guardian.

Personally Identifiable Information: Includes the name, address, date of birth, social security number, tribal enrollment number, telephone or fax number, driver license number, places of employment, school identification or military identification number or any other distinguishing characteristic that tends to identify a particular person.

Petition: A written statement of the essential facts that allege delinquency, incorrigibility or dependency. [ARS §8-201(22)]

Physical Disability: Chronically debilitating, progressive or fatal disease which requires assistance for the child in daily living, or requires the assistance of another person or mechanical device for movement from place to place, and is diagnosed by one or more health service providers [ARS § 8-141(A)(12)].

Physician: An individual licensed to practice medicine or medicine and surgery (including an osteopathic practitioner), a podiatrist or an optometrist. The term shall include such individuals who have been granted a license to practice by the appropriate regulatory board of the State of Arizona and shall include them only when they are practicing within the scope of such license.

"Physician" means a person who is licensed pursuant to Title 32, Chapter 13 or 17.

Physician's Assistant: A person licensed with this title by a state.

Protective Services: A specialized child welfare program that is administered by the Department and that investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family. [ARS§8-801(4)]

Psychiatrist: A person who is licensed pursuant to Title 32, chapter 13 or 17.

Psychiatric Acute Care Facility: A facility that is licensed by the Department of Health Services as a level one behavioral health facility and that provides psychiatric acute care services.

Psychiatric Acute Care Services: Any of the following:

(a) emergency or crisis behavioral health services

(b) psychiatric and psychological assessments and short-term intensive behavioral health counseling and treatment for acute episodes or mental disorders

(c) medication stabilization and twenty-four hour a day nursing care for a child who suffers from acute psychiatric or mental disorders or who needs to have a chronic mental illness stabilized

Psychologist: A person who is licensed pursuant to Title 32, chapter 19.1.

Placement: The current residence or location of a child. This includes the parent's home, a foster home, significant person's home, adoptive home, child care agency, institution, hospital or medical facility.

Pre-Existing Conditions: One or more special needs which existed before the finalization of adoption.

Primary Care Unit: The place where the child resides on a 24 hour basis.

Prior Authorization: Authorization required by the contract provider before certain covered services are rendered.

Probable Cause: Facts which provide a reasonable ground to believe that abuse or neglect occurred.

Proposed Substantiated Perpetrator Unknown: The department shall consider a report proposed substantiated perpetrator unknown after an investigation when there is insufficient evidence that abuse and neglect occurred; and the alleged perpetrator is unknown. (In**S**ufficient evidence is equivalent to the legal standard of probable cause).

Provisional: A foster home license established on a conditional basis, not to exceed six months, when the foster parent applicant(s) have completed all licensing requirements other than initial or ongoing training. [ARS §8-509(D)]

Psychiatric Evaluation: A specific assessment performed by a psychiatrist (M.D. or D.O.) meeting state licensure requirements in accordance with ARS, Title 32. The assessment shall determine and address behavioral health problems and may recommend intervention and/or treatment. The evaluation shall include a review of referral materials, a clinical interview with the client and other key informants, recommendations and orders for any necessary laboratory or other diagnostic tests, and a written report. Medications may be prescribed, modified or terminated as indicated.

Psychological Evaluation: A specific assessment conducted by a licensed psychologist to determine and address behavioral health problems and may include treatment recommendations

or advise certain interventions. Psychological assessments shall include a review of referral materials, assessment of the individuals's readiness for testing, a clinical interview, and may include intellectual testing, personality testing, educational testing, projective testing, and specialized testing for specific disabilities. Neuropsychological assessments will also delineate between the neurologically based causes for behavior versus an emotional dysfunction.

Psychosocial Rehabilitation: A comprehensive program of remedial treatment to rehabilitate skill deficits in all activities of community and daily living, training in interpersonal communication, and use of and self administration of medication.

Race/Origin: See Racial or Ethnic Factors

Racial or Ethnic Factors: Black, Hispanic, Native American, Asian, or other heritage which may prevent a child from being adopted [ARS §8-141(A)(13)].

RBHA Case Coordination: A lower intensity of case management provided to children who do not have a serious mental illness, but who are in need of mental health services. Case coordination activities include: coordination of services, development of the ISP, identification of service providers, implementation of services, and provision of follow-up as necessary.

RBHA Case Manager/Treatment Coordinator: A RBHA employee or contracted provider who meets the qualifications in the AHCCCS Mental Health Policy Manual and is responsible for collaboration with the DES case manager and the RBHAs clinical case management team in the developing, arranging, and monitoring of the most cost-effective and clinically appropriate Individual Service Plan for delivering mental health services to an eligible child/client.

Reasonable Efforts: A term used in the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) that emphasizes the need to support and preserve families through the provision of services which address remediating the risk to the child in the family. These services are to be directed towards preventing the removal of a child from a family or, if removal is unavoidable, to expedite return of the child to the family. When service provision has not accomplished return of the child to the family, services are then to be directed towards providing another permanent plan for the child.

Receiving Agency: Related to an interstate placement, the local agency in the receiving state which receives the referral, does the evaluation and if placement is made provides supervision and other services as necessary and appropriate.

Receiving Home: A licensed foster home available for a child in need of immediate placement, when taken into custody or pending medical examination and court disposition. [ARS §8-501(A)(9)]

Receiving State: Related to an interstate placement, the state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private persons or agencies, and whether for placement with state or local public authorities or for placement with private agencies or persons.

Redacting: Editing of case records to remove confidential material prior to release of the records to an individual.

Referral: A written request for the provision of services which includes all required information.

Regional Behavioral Health Authority (RBHA): An organization under contract with Department of Human Services to implement, coordinate, maintain, and monitor the delivery of a unified system of behavioral health services for a geographic area.

Relative: means grandparent; great grandparent; brother or sister, whole or half blood; aunt or uncle; or cousin [ARS 8-501(A)(12)].

Relative: for purposes of placement, a great grandparent, grandparent, brother or sister, whole or half blood, aunt or cousin. [ARS 8-501(A)(11)]

Relative: For the purpose of adoption, means the spouse of the natural or legal parent of the child, aunt, uncle, adult sibling or grandparent of the child by the whole or half-blood or by marriage or adoption.

Relinquishment: See Consent to place a child for adoption.

Removal Review Team: At a minimum, the Removal Review Team shall consist of:

- The CPS Specialist, the CPS supervisor, and two members of the local Foster Care Review Board;
- The district ICWA liaison if the child is or may be Indian;
- The childs physician if the child has a medical need or chronic illness.
- Staff from the directors Family Advocacy Office; and other professionally qualified persons who confer regarding alternatives to continued out-of-home placement and other case planning issues may be included in the Removal Review.

Report: An incoming communication containing an allegation that a person under the age of 18 is the subject of abuse or neglect, which a parent, guardian or custodian has inflicted, may inflict, permitted another person to inflict, or had reason to know another person may inflict, and containing sufficient information to locate the child.

Resident: A person who is residing in the state of Arizona with the intent of establishing a home here.

Residential Treatment Center: A group care facility that is licensed as a Level I behavioral health facility through the Arizona Department of Health Services (ADHS). The residential treatment center (RTC) provides a structured treatment setting with daily 24 hour supervision and an intensive treatment program. Onsite schooling is typically provided within this setting.

Residential Treatment Services: Services that are provided by a level one behavioral health facility, a program that provides detoxification services or an intensive treatment program.

Resource: Any service within the department or the community which is available and potentially of benefit to the client.

Respite: Short term care and supervision of a child to relieve caregivers.

Response: Initiation of investigation of a report, which includes direct or indirect contact with the child and/or alleged abusive caretaker or person which may be by telephone, or be in person onsite.

Response Time: The length of time from when the report information is received by the local office to when the local office initiates an investigation and determines the safety of the child victim.

Restricted: A licensed foster home for a specific, identified child(ren).

Revocation: The act of terminating an existing foster care or group care license.

Screening: The initial process of determining if an allegation of abuse, neglect, abandonment, or exploitation exists.

Sending Agency (Referring Agency): Related to an interstate compact, a person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought any child to another state.

Serious Emotional Injury: An injury that is diagnosed by a medical doctor or a psychologist and that does any one or a combination of the following:

a) Seriously impairs mental faculties.

b) Causes serious anxiety, depression, withdrawal or social dysfunction behavior to the extent that the child suffers dysfunction that requires treatment.

c) The result of sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, child prostitution pursuant to section 13-3212, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553 or incest pursuant to section 13-3608. [ARS §8-201(27)]

Serious Physical Injury: An injury that is diagnosed by a medical doctor and that does any one or a combination of the following:

a) Creates a reasonable risk of death.

b) Causes serious or permanent disfigurement.

c) Causes significant physical pain.

d) Causes serious impairment of health.

e) Causes the loss or protracted impairment of an organ or limb.

f) The result of sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, child prostitution pursuant to section 13-3212, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553 or incest pursuant to section 13-3608. [ARS §8-201(28)]

Service Delivery: The functions, activities, and tasks directed at controlling and removing barriers so that the identified goals may be achieved.

Service Provider: Any person, institution or entity which provides covered services to an eligible child recipient under the program.

Service Team: Individuals directly involved in the provision of services to a child or parent. The service team includes the case manager, out-of-home care provider, licensing worker, Court Appointed Special Advocates (CASA), Regional Behavioral Health Authority (RBHA), persons providing services (i.e., physicians, psychologists, therapists, and parent aides). This may also

include the entity case manager, physicians, school personnel, law enforcement and probation personnel, and attorneys.

Severance: See Termination of Parent-al Rights

Severance Specialist: A person employed by DES or under contract with the department to review the appropriateness of a plan for termination of the parent/child relationship, to assess readiness for such a plan and to write the social study as required by ARS §8-536.

Shelter: A licensed agency administered group care setting which is available for a child in need of immediate placement.

Shelter Care: A type of care provided to a child in need of immediate placement.

Sibling Group: See Sibling Relationship

Sibling Relationship: Two or more children related by blood or in law.

Significant Person: An individual who has a substantial relationship with the child.

Special Needs: One or more of the following factors which may impede the adoption of a child:

- Physical, mental or developmental disability
- Emotional disturbance
- High risk of physical or mental disease
- High risk of developmental disability
- Age of six or more years at the time of application for adoption subsidy
- Sibling relationship
- Racial or ethnic factors
- High risk of severe emotional disturbance if removed from the care of foster parents or relatives [ARS §8-141(A)(14)].

Special Services Subsidy: Payments to the adoptive parents or the providers of services for expenses incurred in the provision of medical, dental, psychiatric, psychological, or other services, as approved by the Adoption Subsidy Review Committee, to meet the preexisting health related conditions or risks of the child. This does not include routine medical, routine dental,

social or recreational services.

State or Federal Statute or Court Order Disposition (SFC): A disposition assigned to a report in which a state or federal statute or a court order prevents CPS from investigating. This disposition is usually assigned to a report concerning a child or family that resides on an Indian reservation or military base.

State Placing Agency: A state agency responsible for the care and placement of children and responsible for the submission of the special education voucher application when residential placement is necessary. DES/DCYF/DES/DDD, AOC (JPO), AZ Department of Juvenile Corrections (ADJC), and DHS are the state placing agencies.

Substantial Care Payments: Monthly special services payments for professional nursing provided by an adoptive parent to their medically fragile child, above and beyond the level of care that is reasonable or usual for a parent to provide to a child with special needs.

Substantiated: The department shall consider a report substantiated, after an investigation, when there is sufficient evidence to a support finding of abuse or neglect. (Sufficient evidence is equivalent to the legal standard of probable cause.)

Substance Exposed Newborn (SEN): A newborn infant whose positive toxicology screens gives the professional reasonable grounds to believe that the newborn infant may be affected by the presence of alcohol or a substance.

Supervised Visit: A visit between a child in out-of-home placement and his parent/caretaker, sibling, or other relative that is monitored and supported through the physical presence of a third party (e.g. case manager, visitation facilitator, parent aide, etc.).

Supervision: The act of monitoring and directing the activities of the foster child. This includes situations where the foster parent(s) provide indirect monitoring of the foster youth such as when the youth goes to the movie or shopping mall with friends, is employed or spends an overnight with a friend. The provision of indirect supervision must be approved by the child's case manager as appropriate to the needs and ability of the foster youth. Indirect monitoring also includes the foster parent(s) being available to the youth in the case of an emergency.

Surrogate Parent: An individual appointed by the juvenile court to represent the interests of a

child requiring special education services when the child's parents are unwilling or unable to do so. [ARS §15-761(35)]

Suspension of License: The act of temporarily canceling an existing foster care or group care license.

Symptoms: Of disease due to HIV infection may include: unexplained weight loss; severe night sweats; swollen lymph nodes not attributed to another illness; profound, unexplained persistent cough; blurred vision and severe headaches; easy bruising; and rashes.

Temporary Custody Notice: A written notice by the department, or law enforcement to parents, guardians, or custodians outlining reasons why the child has been taken into temporary custody and advising the parent or guardian of the preliminary protective hearing to be held within 5 to 7 days. (ARS §8-823)

Temporary Investigative Custody: The removal of a child by a Child Protective Service Specialist when the family is uncooperative and it is necessary to protect the child away from the home while the report is adequately investigated.

Temporary Protective Custody: The removal of a child by a Child Protective Service Specialist or a peace officer for a period of time not to exceed 72 hours (excluding weekends and holidays) for the purpose of protection of the child.([ARS §8-823)

Termination of Parental Rights: An order of the superior court that divests the parent and the child of all legal rights, privileges, duties and obligations with respect to each other except the right of the child to inherit and receive support from the parent. This right of inheritance and support shall only be terminated by a final order of adoption. See also Severance.

Therapeutic Group Home: A group care facility which is licensed as a Level II behavioral health facility by Arizona Department of Health Services. The therapeutic group home (TGH) provides a structured residential treatment setting with 24 hour a day supervision and counseling or other therapeutic activities for clients who do not require onsite medical services.

Therapeutic Help to Reach Infants Very Early (T.H.R.I.V.E.): T.H.R.I.V.E. (also known as High Risk Infants) provides intensive in-home services address the problems of children at risk through prenatal substance abuse. These services allow children to be safely cared for in their own home or in homes of relatives; to ensure in these children's early stages of life that they meet developmental milestones. The services are provided through contracts with private providers. (This service is only available in District I.)

Therapeutic Visit: A visit between a child in out-of-home placement and his parent/caretaker or sibling that is monitored through the physical presence of a psychologist, therapist or counselor

for the purpose of assessing interactions, response to visits, teaching parenting skills and increasing the participants understanding of the family dynamics with the goal of solving family problems.

Title XIX: The Medicaid provision of the federal Social Security Act.

Title XIX Eligible Child: Children up to age 18, who are eligible under Title XIX eligibility categories, which include COBRA, SOBRA, SSI, and Ribicoff criteria.

Title XIX Provider/Facility: A person, clinic, or residential facility licensed by the Department of Health Services that meets the Arizona Health Care Cost Containment System (AHCCCS) requirements for receiving federal Title XIX reimbursement.

Tracking Characteristics: Specific situations identified as "TB" through "TSX" in Exhibit 9 which tracks the frequency of occurrence.

Treatment Plan: That portion of the authorization process which requires that the attending physician and other professional allied health personnel involved in the care of a recipient establish and review periodically a plan of treatment and care for each recipient.

Treatment-Oriented Foster Care: Foster family-based model that provides an intensive system of supportive and clinical services to special needs children.

Unable to Locate: The department shall consider the report finding unable to locate after an investigation when reasonable efforts were made to locate the child victim; the location of the child victim remains unknown and there is insufficient evidence to conclude that the child was abused or neglected without interviewing or observing the child. (Insufficient evidence is equivalent to the legal standard of probable cause).

Unsubstantiated: The department shall consider a report unsubstantiated, after an investigation, when there is insufficient evidence to support a finding of abuse or neglect. (Insufficient evidence is equivalent to the legal standard of probable cause.)

Unsupervised Visit: A visit between a child in out-of-home placement and his parent/caretaker, sibling or other relative that is not directly visually monitored.

Unusual Incident: An occurrence that involves death, severe personal injury, an "Infant Doe" report, or property damage involving clients, their relatives or DES staff; high profile cases; any situation that may incur potential liability to the State of Arizona.

Visitation: Face-to-face contact between a child in out-of-home care and his parent/caregiver,

siblings, family members, other relatives, and other significant persons such as friends and former foster parents.

Visitation Facilitator: Any person who is designated by the case manager to monitor a visit between a child in out-of-home placement and the parent/ caretaker, sibling or other relative. This may include a parent aide, transportation worker, volunteer, psychologist, therapist, out-of-home care provider, extended family member or other party.

Visitation Guidelines for Parents: Information provided to parents which outlines agency expectations of the parent/caretaker regarding visitation.

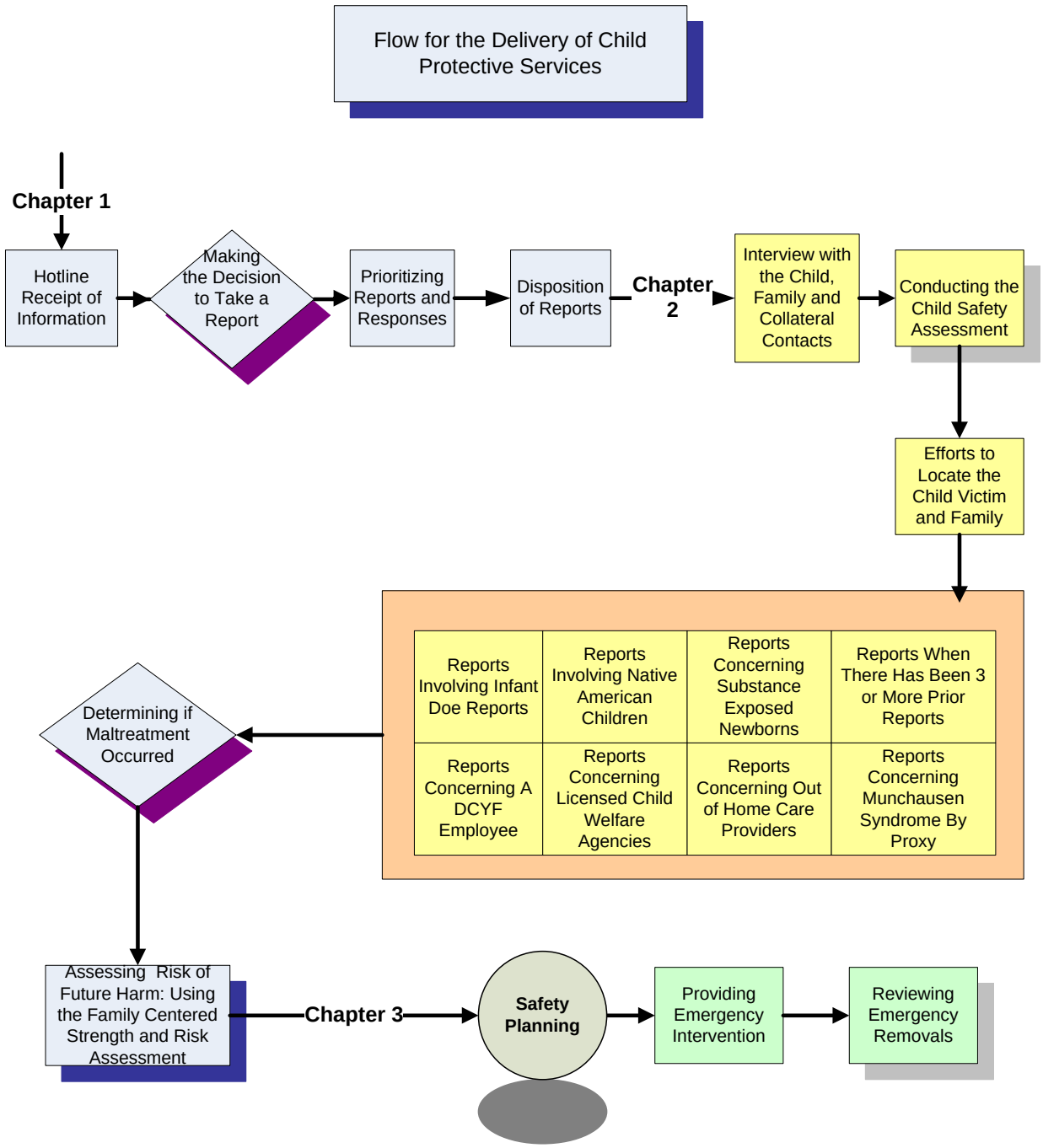
Voluntary Agreement: A written agreement, for a period not to exceed 90 days, between the parent, guardian or caretaker and the DES. If the child is over 12 years of age and not developmentally disabled, the child must also agree to and sign the voluntary agreement, unless the department determines that voluntary placement of the child is clearly necessary to prevent abuse (ARS §8-806).

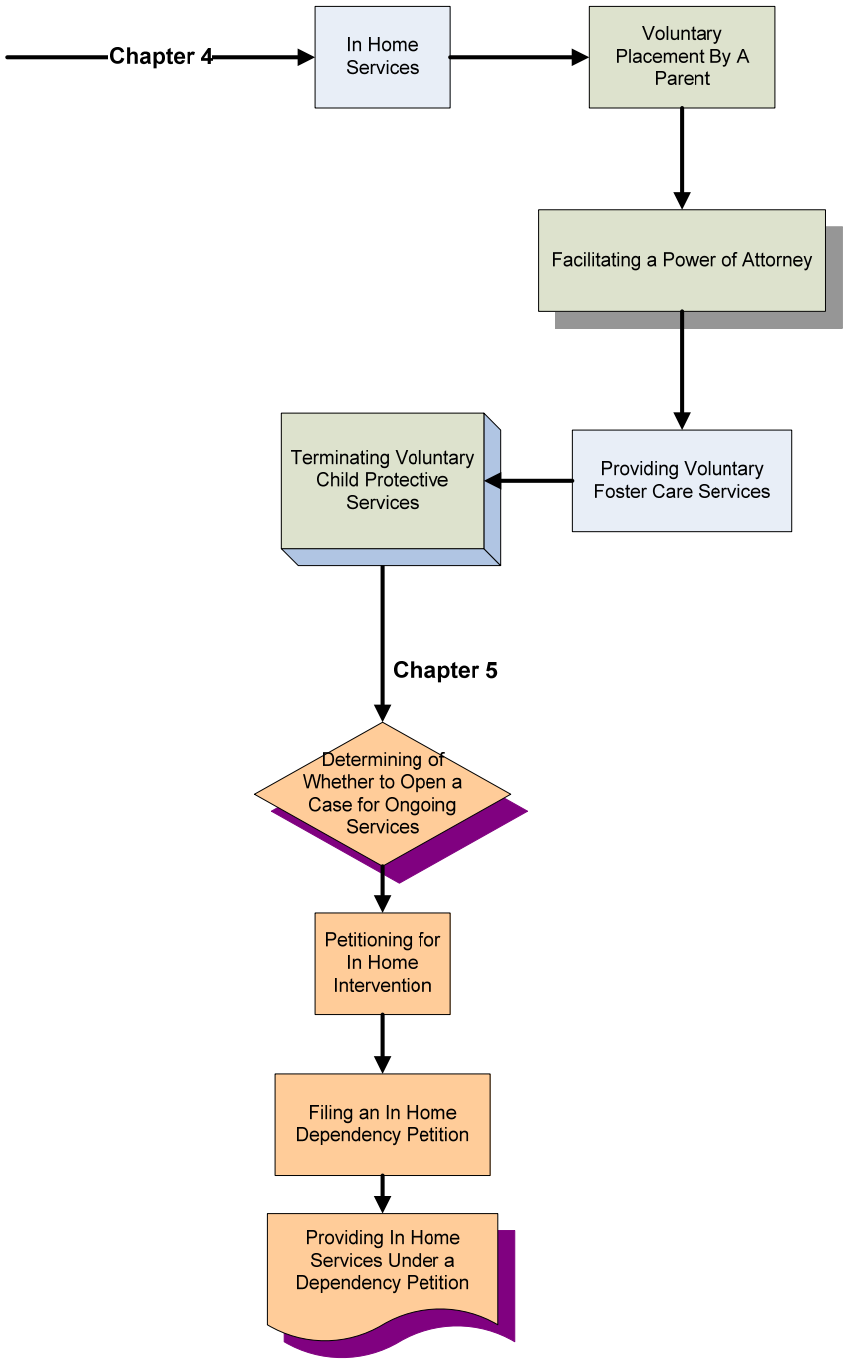
Volunteer: An individual who contributes time and services to the department without monetary compensation.

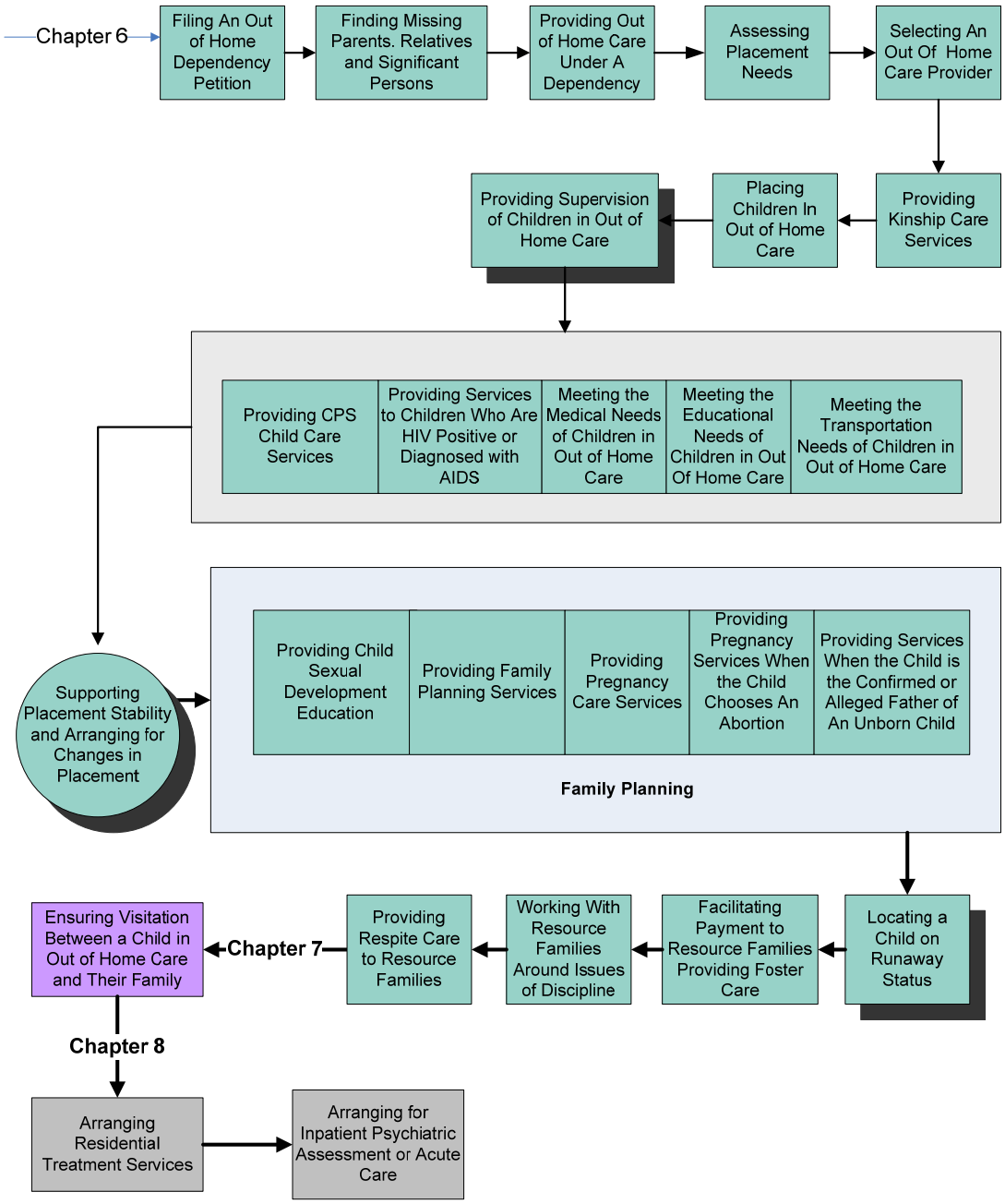
Window: A screen display used to view an application or document.

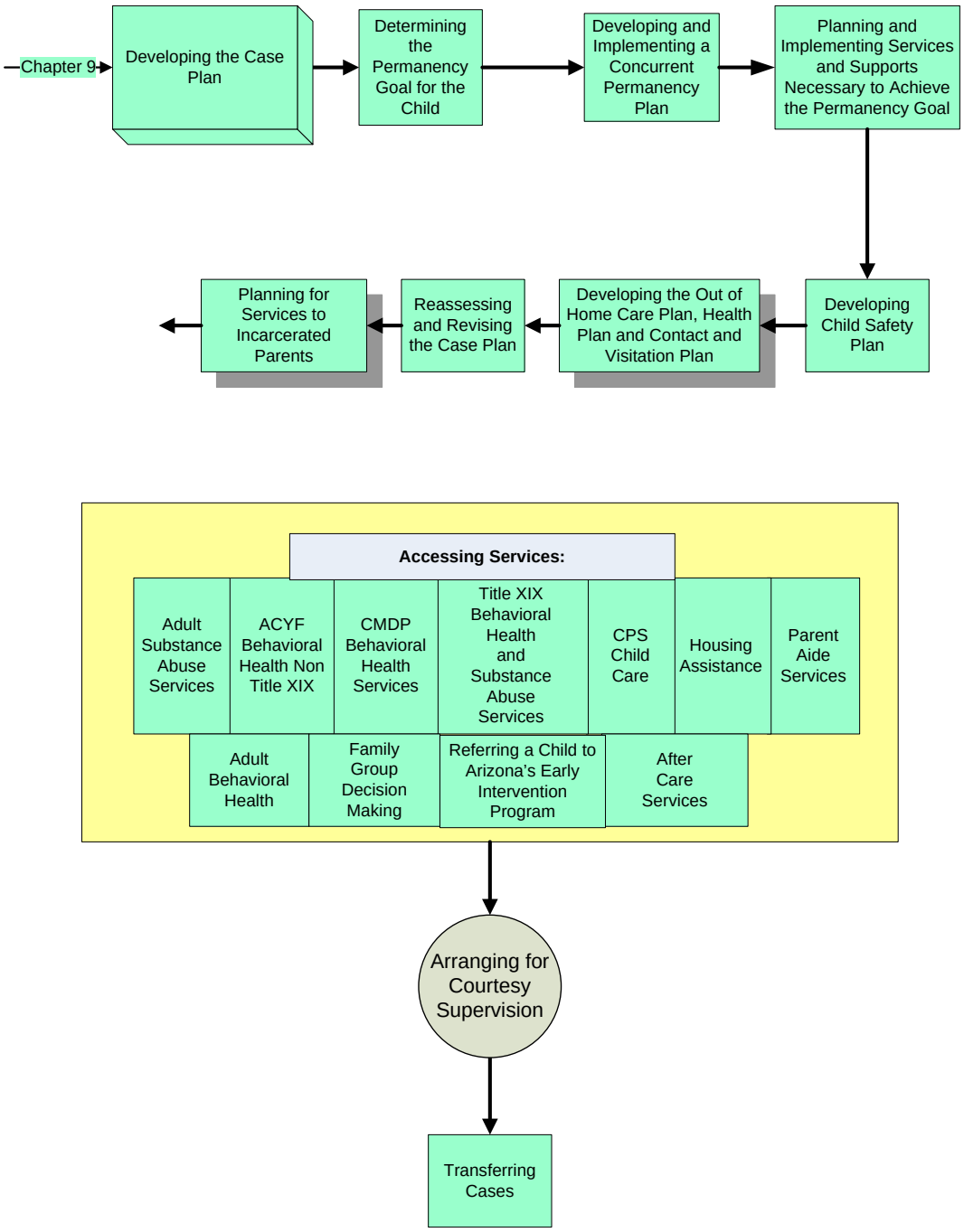
Written agreement: A written agreement between the department and the family is composed of a completed Case Plan, recorded in the Case Plan Directory.

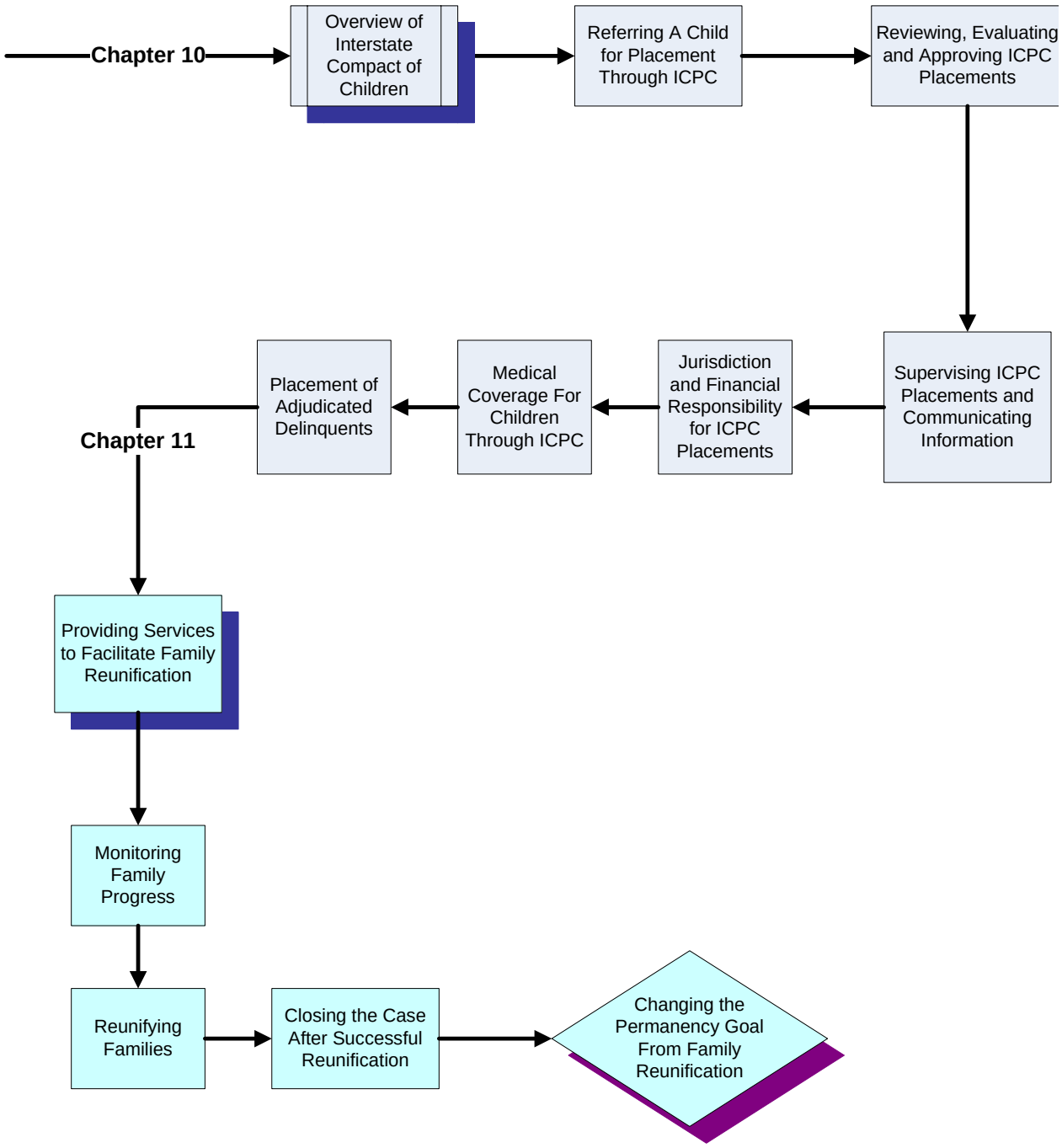
Youth: See Child

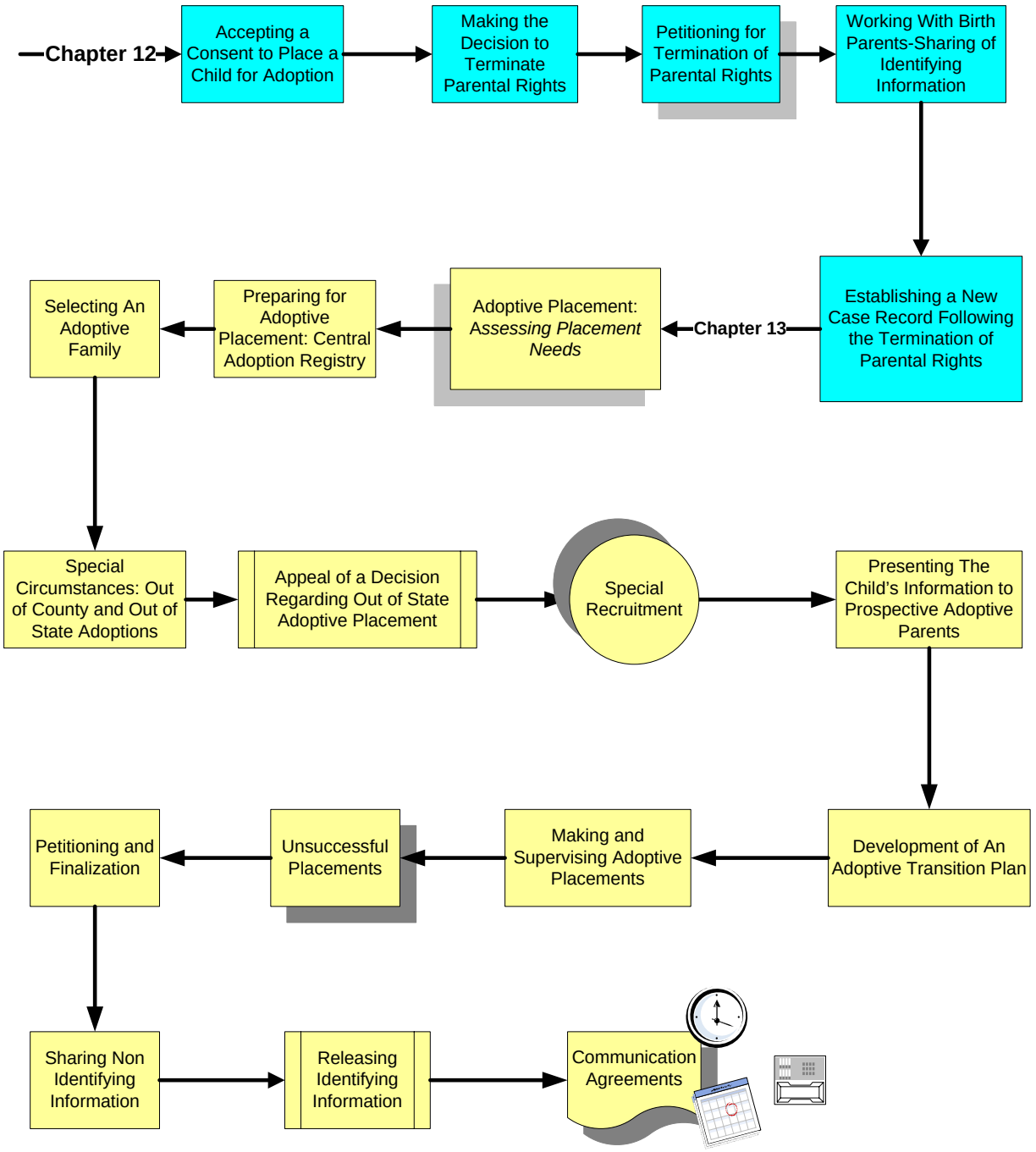

Flow for the Delivery of Child Protective Services
Chapter 1
Hotline Receipt of Information
Making the Decision to Take a Report
Prioritizing Reports and Responses
Disposition of Reports
Chapter 2
Interview with the Child, Family and Collateral Contacts
Conducting the Child Safety Assessment
Efforts to Locate the Child Victim and Family
Reports Involving Infant Doe Reports
Reports Involving Native American Children
Reports Concerning Substance Exposed Newborns
Reports When There Has Been 3 or More Prior Reports
Reports Concerning A DCYF Employee
Reports Concerning Licensed Child Welfare Agencies
Reports Concerning Out of Home Care Providers
Reports Concerning Munchausen Syndrome By Proxy
Determining if Maltreatment Occurred
Assessing Risk of Future Harm: Using the Family Centered Strength and Risk Assessment
Chapter 3
Safety Planning
Providing Emergency Intervention
Reviewing Emergency Removals

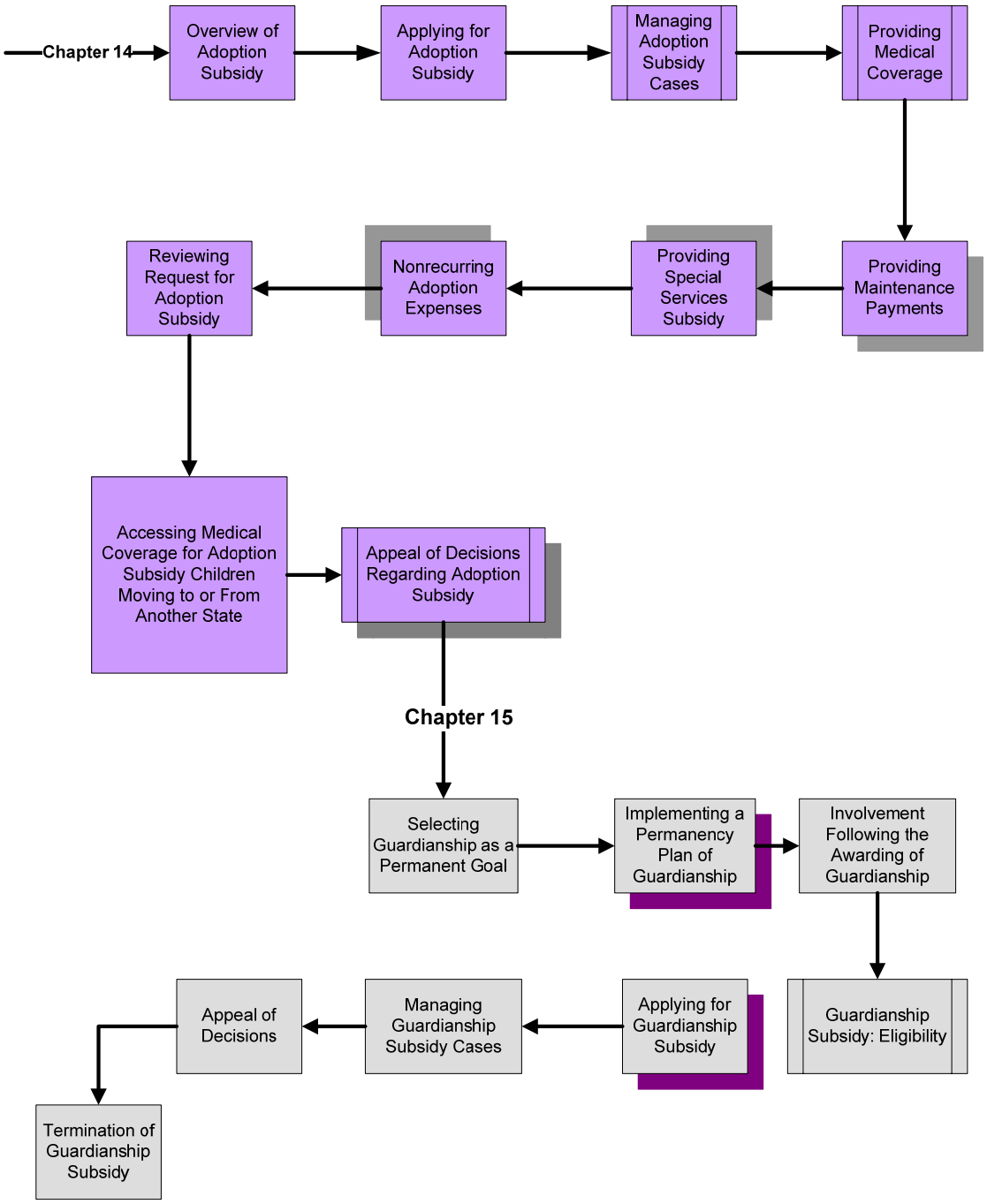

Chapter 4
In Home Services
Voluntary Placement By A Parent
Facilitating a Power of Attorney
Providing Voluntary Foster Care Services
Terminating Voluntary Child Protective Services
Chapter 5
Determining of Whether to Open a Case for Ongoing Services
Petitioning for In Home Intervention
Filing an In Home Dependency Petition
Providing In Home Services Under a Dependency Petition

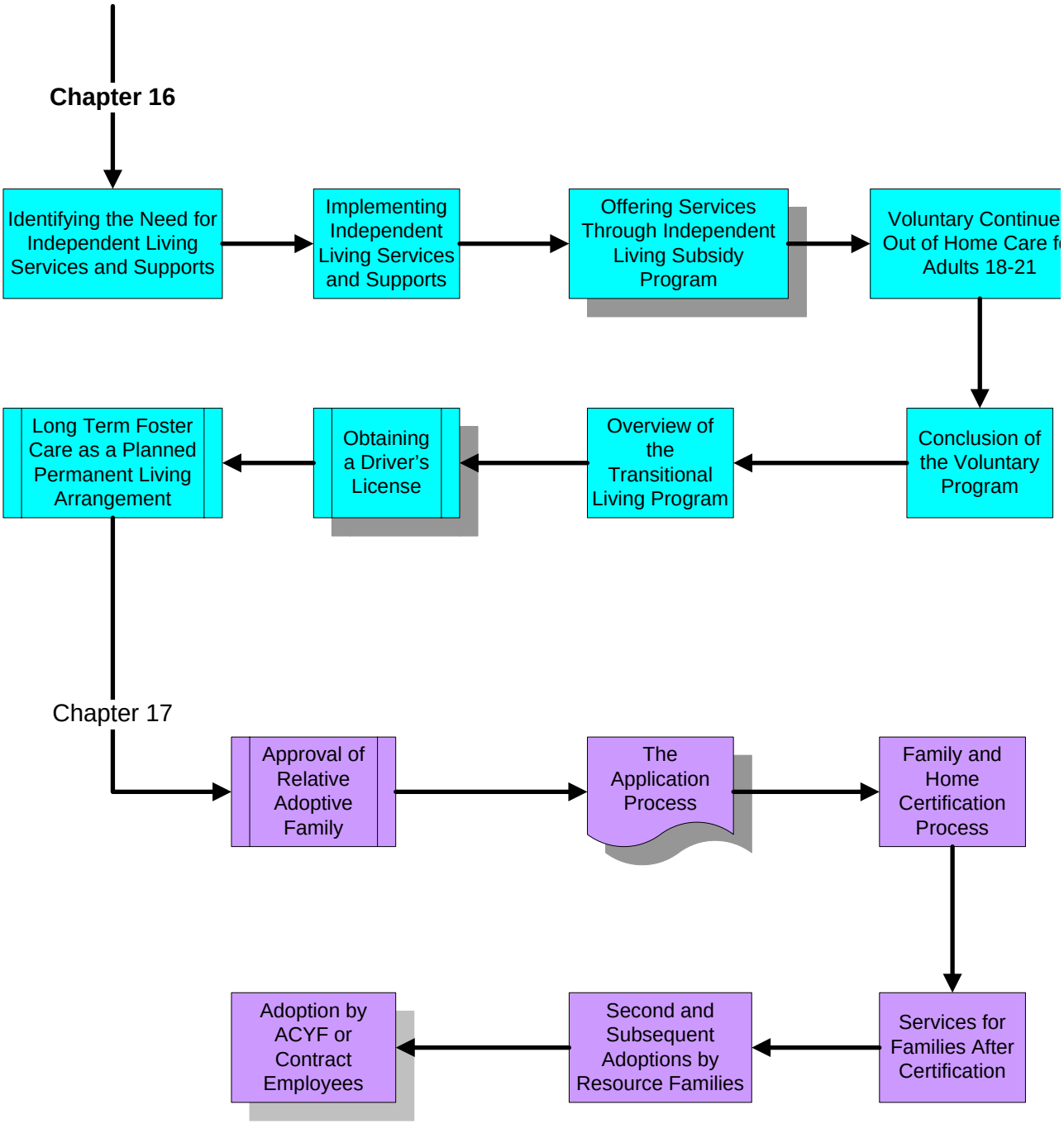

Chapter 6
Filing An Out of Home Dependency Petition
Finding Missing Parents. Relatives and Significant Persons
Providing Out of Home Care Under A Dependency
Assessing Placement Needs
Selecting An Out Of Home Care Provider
Providing Kinship Care Services
Placing Children In Out of Home Care
Providing Supervision of Children in Out of Home Care
Providing CPS Child Care Services
Providing Services to Children Who Are HIV Positive or Diagnosed with AIDS
Meeting the Medical Needs of Children in Out of Home Care
Meeting the Educational Needs of Children in Out Of Home Care
Meeting the Transportation Needs of Children in Out of Home Care
Supporting Placement Stability and Arranging for Changes in Placement
Providing Child Sexual Development Education
Providing Family Planning Services
Providing Pregnancy Care Services
Providing Pregnancy Services When the Child Chooses An Abortion
Providing Services When the Child is the Confirmed or Alleged Father of An Unborn Child
Family Planning
Locating a Child on Runaway Status
Facilitating Payment to Resource Families Providing Foster Care
Working With Resource Families Around Issues of Discipline
Providing Respite Care to Resource Families
Chapter 7
Ensuring Visitation Between a Child in Out of Home Care and Their Family
Chapter 8
Arranging Residential Treatment Services
Arranging for Inpatient Psychiatric Assessment or Acute Care

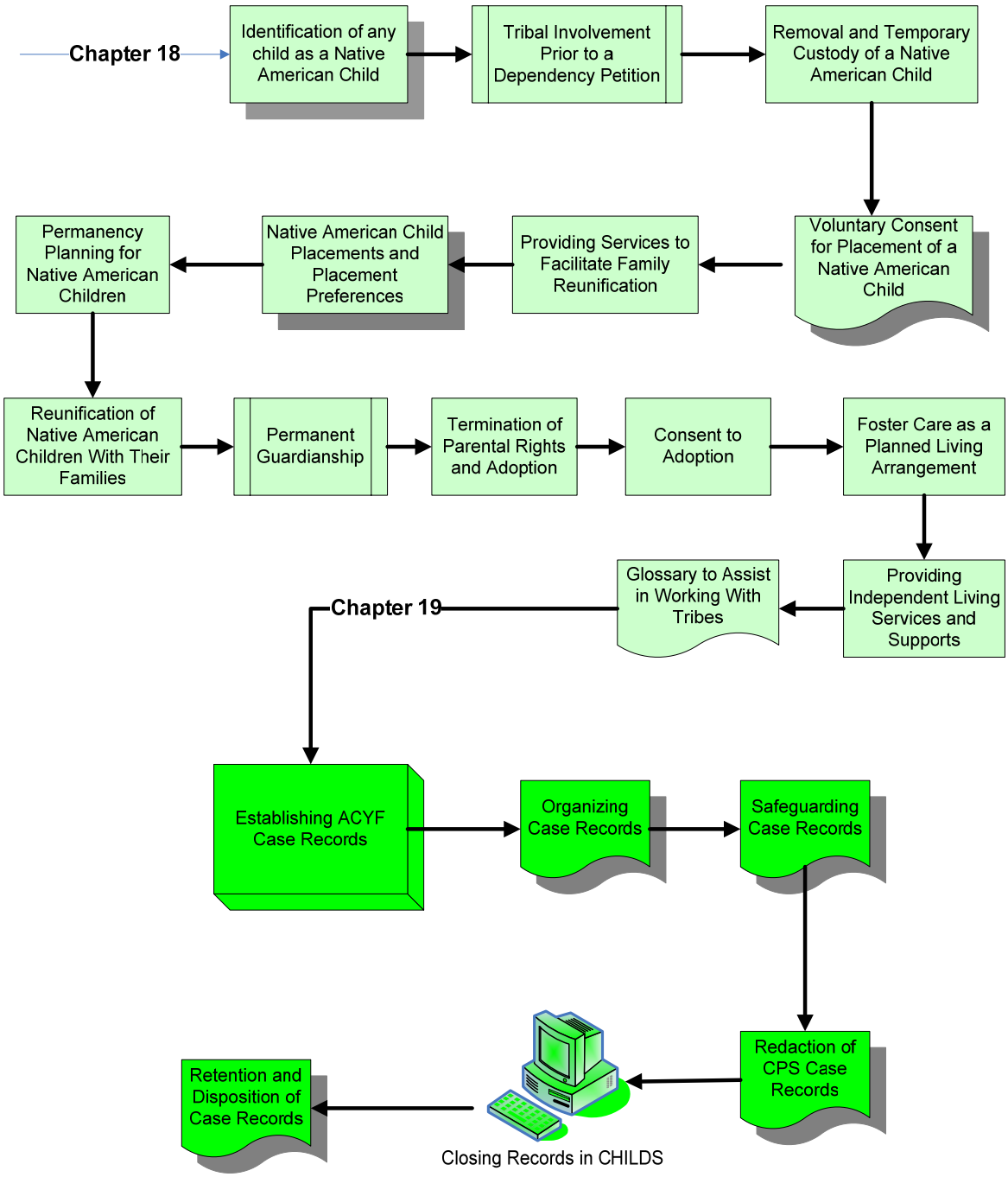

Chapter 9
Developing the Case Plan
Determining the Permanency Goal for the Child
Developing and Implementing a Concurrent Permanency Plan
Planning and Implementing Services and Supports Necessary to Achieve the Permanency Goal
Developing Child Safety Plan
Developing the Out of Home Care Plan, Health Plan and Contact and Visitation Plan
Reassessing and Revising the Case Plan
Planning for Services to Incarcerated Parents
Accessing Services:
Adult Substance Abuse Services
ACYF Behavioral Health Non Title XIX
CMDP Behavioral Health Services
Title XIX Behavioral Health and Substance Abuse Services
CPS Child Care
Housing Assistance
Parent Aide Services
Adult Behavioral Health
Family Group Decision Making
Referring a Child to Arizona's Early Intervention Program
After Care Services
Arranging for Courtesy Supervision
Transferring Cases


Chapter 10
Overview of Interstate Compact of Children
Referring A Child for Placement Through ICPC
Reviewing, Evaluating and Approving ICPC Placements
Supervising ICPC Placements and Communicating Information
Jurisdiction and Financial Responsibility for ICPC Placements
Medical Coverage For Children Through ICPC
Placement of Adjudicated Delinquents
Chapter 11
Providing Services to Facilitate Family Reunification
Monitoring Family Progress
Reunifying Families
Closing the Case After Successful Reunification
Changing the Permanency Goal From Family Reunification


Chapter 12
Accepting a Consent to Place a Child for Adoption
Making the Decision to Terminate Parental Rights
Petitioning for Termination of Parental Rights
Working With Birth Parents-Sharing of Identifying Information
Establishing a New Case Record Following the Termination of Parental Rights
Chapter 13
Adoptive Placement: *Assessing Placement Needs*
Preparing for Adoptive Placement: Central Adoption Registry
Selecting An Adoptive Family
Special Circumstances: Out of County and Out of State Adoptions
Appeal of a Decision Regarding Out of State Adoptive Placement
Special Recruitment
Presenting The Child's Information to Prospective Adoptive Parents
Development of An Adoptive Transition Plan
Making and Supervising Adoptive Placements
Unsuccessful Placements
Petitioning and Finalization
Sharing Non Identifying Information
Releasing Identifying Information
Communication Agreements


Chapter 14
Overview of Adoption Subsidy
Applying for Adoption Subsidy
Managing Adoption Subsidy Cases
Providing Medical Coverage
Providing Maintenance Payments
Providing Special Services Subsidy
Nonrecurring Adoption Expenses
Reviewing Request for Adoption Subsidy
Accessing Medical Coverage for Adoption Subsidy Children Moving to or From Another State
Appeal of Decisions Regarding Adoption Subsidy
Chapter 15
Selecting Guardianship as a Permanent Goal
Implementing a Permanency Plan of Guardianship
Involvement Following the Awarding of Guardianship
Guardianship Subsidy: Eligibility
Applying for Guardianship Subsidy
Managing Guardianship Subsidy Cases
Appeal of Decisions
Termination of Guardianship Subsidy


Chapter 16
Identifying the Need for Independent Living Services and Supports
Implementing Independent Living Services and Supports
Offering Services Through Independent Living Subsidy Program
Voluntary Continue Out of Home Care f Adults 18-21
Conclusion of the Voluntary Program
Overview of the Transitional Living Program
Obtaining a Driver's License
Long Term Foster Care as a Planned Permanent Living Arrangement
Chapter 17
Approval of Relative Adoptive Family
The Application Process
Family and Home Certification Process
Services for Families After Certification
Second and Subsequent Adoptions by Resource Families
Adoption by ACYF or Contract Employees


Chapter 18
Identification of any child as a Native American Child
Tribal Involvement Prior to a Dependency Petition
Removal and Temporary Custody of a Native American Child
Voluntary Consent for Placement of a Native American Child
Providing Services to Facilitate Family Reunification
Native American Child Placements and Placement Preferences
Permanency Planning for Native American Children
Reunification of Native American Children With Their Families
Permanent Guardianship
Termination of Parental Rights and Adoption
Consent to Adoption
Foster Care as a Planned Living Arrangement
Providing Independent Living Services and Supports
Glossary to Assist in Working With Tribes
Chapter 19
Establishing ACYF Case Records
Organizing Case Records
Safeguarding Case Records
Redaction of CPS Case Records
Closing Records in CHILDS
Retention and Disposition of Case Records

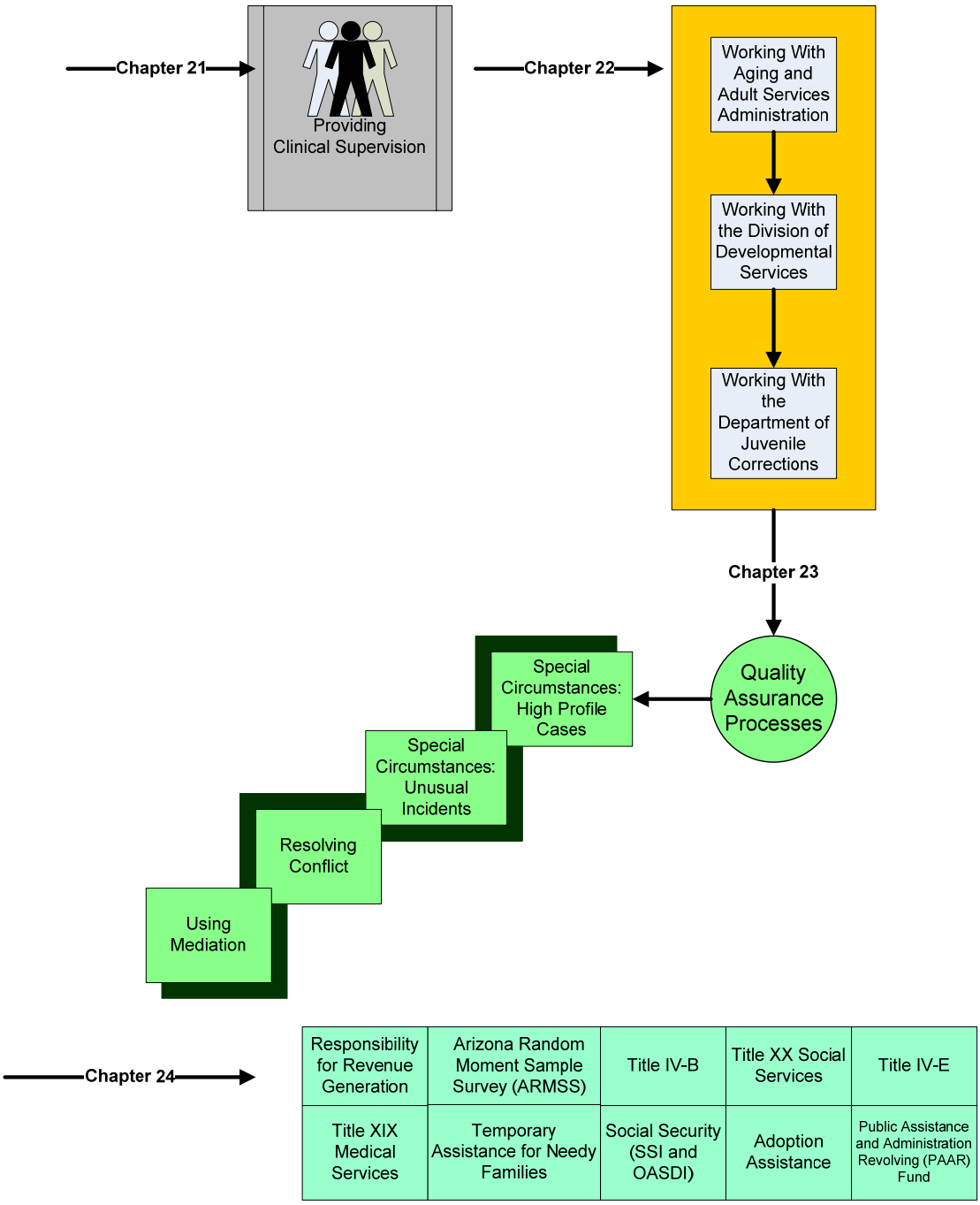

Chapter 21
Providing Clinical Supervision
Chapter 22
Working With Aging and Adult Services Administration
Working With the Division of Developmental Services
Working With the Department of Juvenile Corrections
Chapter 23
Quality Assurance Processes
Special Circumstances: High Profile Cases
Special Circumstances: Unusual Incidents
Resolving Conflict
Using Mediation
Chapter 24
Responsibility for Revenue Generation
Arizona Random Moment Sample Survey (ARMSS)
Title IV-B
Title XX Social Services
Title IV-E
Title XIX Medical Services
Temporary Assistance for Needy Families
Social Security (SSI and OASDI)
Adoption Assistance
Public Assistance and Administration Revolving (PAAR) Fund

Exhibit 53

Glossary

Abandonment or Abandoned: The failure of a parent to provide reasonable support and to maintain regular contact with the child, including providing normal supervision. Abandoned/ Abandonment includes a judicial finding that a parent has made only minimal efforts to support and communicate with the child. Failure to maintain a normal parental relationship with the child without just cause for a period of six months constitutes prima facie evidence of abandonment [ARS §8-201(1)].

Abuse: Infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to ARS §8-821, and is caused by the acts or omission of an individual having care, custody and control of a child

Abuse includes:

(a) inflicting or allowing sexual abuse (ARS §13-1404)
sexual conduct with a minor (ARS §13-1405)
sexual assault (ARS §13-1406)
molestation of a child (ARS §13-1410)
commercial sexual exploitation of a minor (ARS §13-3552)
sexual exploitation of a minor (ARS §13-3553)
incest (ARS §13-3608)
child prostitution (ARS §13-3212)

b) physical injury to a child that results from abuse as described in section 13-3623, subsection C, and includes but is not limited to circumstances in which a child is permitted to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person for the purpose of manufacturing a dangerous drug in violation of section 13-3407, subsection A, paragraph 4.
[ARS §8-201(2)]

A child, who in good faith, is being furnished Christian Science treatment by a duly accredited practitioner shall not, for that reason alone, be considered to be an abused child. [ARS §8-201.01 (1)]

A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered an abused child for that reason alone. [ARS §8-201.01(2)]

ACYF: The Administration for Children, Youth and Families, within the Division of Children, Youth and Family Services (DCYF), Department of Economic Security.

Acquired Immune Deficiency Syndrome (AIDS): is a disorder in which a person's immune system is severely suppressed. It is caused by the HIV virus. AIDS is only one of the severe manifestations of HIV infection. It is not a disease, but a syndrome consisting of a specific complex of symptoms defined by the Centers for Disease Control.

Administration: The Administration for Children, Youth and Families within the Division of Children Youth and Family Services (DCYF), Department of Economic Security (DES).

Administrative Case Review: The formal consideration of the status of a child in out-of-home placement. This occurs every six months and is generated and presided over by either the Foster Care Review Board (FCRB) or department personnel. The latter occurs only when the FCRB cannot schedule its review in conformance with federal guidelines.

Adoption Certification: A judicial determination that a prospective adoptive parent is a fit and proper person to adopt.

Adoption Subsidy: A grant provided to a child with special needs which has been applied for through the department. [ARS §8-41 (A)(1)]

Adoption Subsidy Agreement: A written agreement between adoptive parents and the department that identifies special needs of the child for which maintenance payments and/or medical services will be provided by the department.

Adoption Subsidy Review Committee: A group of three or more members appointed by the Program Administrator to review all adoption subsidy cases for appropriateness of documentation and compliance with regulations.

Adoptive Parents: Any adult or adults who are residents of Arizona, whether married, unmarried or legally separated, who qualify to adopt children or have adopted children.

Adoptive Parents of Another State: Any adult or adults who are residents of a state other than Arizona who qualify to adopt children, or have adopted children according to the laws of that state.

Adult: A person 18 years of age or older.

Adult Court: The appropriate justice court, municipal court or criminal division of the superior court that has jurisdiction to hear proceedings concerning offenses committed by juveniles as provided in sections 8-327 and 13-501. [ARS §8-201(4)]

Advocate: To represent the interests of the family with community agencies to participate removing barriers and obtaining services to meet identified needs.

Age: For the purpose of Special Needs Adoption, means age 6 or older at the time of application for Adoption Subsidy.

Agency: Any organization which provides services; this includes but is not limited to state, private nonprofit, and private for-profit organizations.

Aggravate: Specific circumstances that may necessitate a decrease in a standard response time for any risk level.

AHCCCS: The Arizona Health Care Cost Containment System which administers Title XIX medical services for the State of Arizona.

AHCCCS Hospital Reimbursement System: The payment structure used by the Arizona Health Care Cost Containment System to pay for inpatient hospital admissions and outpatient hospital services.

AHCCCS Mental Health Policy Manual: The document published by AHCCCS which defines the policies and procedures applicable to Title XIX mental health and substance abuse services that the AHCCCS health plans, including the Department of Economic Security's Comprehensive Medical and Dental Program, and the Arizona Department of Health Services' Regional Behavioral Health Authorities must comply with and that are not in conflict with.

Alleged Abusive Parent, Guardian, or Custodian (or Alleged Abuser): The individual about whom the allegation of abuse, neglect, abandonment or exploitation of a child was made.

Alternative Investigation: A disposition assigned to a report by a CPS Supervisor, when all children living in the home have been observed by a professional mandated reporting source and determined not to be a victim of child maltreatment.

Alternative Method of Compliance: The department, in consultation with the Attorney General's Office, may forgo compliance with a licensing standard required by department rules, and not otherwise required by law, if it is found to be in the best interests of a particular foster child to be placed in a particular home. The purpose of the standard must be otherwise fulfilled.

Any Combination of Special Needs: Children for whom the combination of circumstances rather than the severity of any one problem is the barrier to permanent placement.

Approved Adoptive Family: A family who has been certified by the court or approved by an authorized entity as acceptable to adopt a child.

Approved Relative Adoptive Family: An individual(s) who is related to the child to be adopted by the whole or half-blood or by marriage or adoption and is the spouse of the natural or legal parent of the child to be adopted or is the adult sibling, aunt, uncle or grandparent; is assessed by the department as acceptable to adopt a child; and capable of meeting the childs placement needs.

Arizona Department of Education Exceptional Student Services (ADE/ESS): The state agency which oversees special education programs and issues educational vouchers.

Arizona Department of Health Services (ADHS or DHS): The state department mandated to serve the public health needs of all Arizona residents. Within this department, the Office of Children's Behavioral Health (OCBH), a subdivision of the Division of Behavioral Health Services (DBHS), oversees the ADHS contracts with regard to children's services with the Regional Behavioral Health Authorities (RBHAs). Staff of the Office of Child Care Licensure, a subdivision of the Health and Child Care Review Services, conduct safety and sanitation inspections of potential and licensed foster homes.

Arizona Health Care Cost Containment System (AHCCCS): The state department that administers the Arizona Medicaid Program, a managed care system for low income adults and children. AHCCCS distributes federal Title XIX funds for mental health and substance abuse, through Arizona Department of Human Services, to the Regional Behavioral Health Authorities; it distributes federal dollars for other medical services through the health plans, including Comprehensive Medical and Dental Program.

Approved Relative Adoptive Family: An individual who is related to the child to be adopted by the whole or half-blood or by marriage or adoption and is the spouse of the natural or legal

parent of the child to be adopted or is the adult sibling, aunt, uncle or grandparent; and is assessed by the department as acceptable to adopt the child and capable of meeting the childs placement needs.

Assessment: The evaluation of family strengths and capacities and risk to children living in the home on the basis of history, observations, professional opinions and other information.

Authorized Representative: A person designated by the department or an agency to perform specific, identifiable work activities and functions.

Behavior Management: Services that primarily involve supervision and direction of the individual, but may also include services related to activities of daily living and household services incidental to, and consistent with, the behavioral health needs of the individual.

Behavioral Health Coordinator/ CMDP: The designated person in CMDP who is responsible for the coordination of referrals to the RBHAs, prior authorization for non-Title XIX authorized inpatient hospital and inpatient psychiatric facility services, authorization of non-Title XIX covered psychiatric services and authorization of out of state behavioral health services for CMDP enrolled children.

Behavioral Health Group Home (HGH): A group care facility which is licensed as a Level III behavioral health facility by ADHS. The HGH provides a supportive, protective environment, with 24 hour supervision. Services are provided to improve or stabilize the child's behavioral health and prevent placement in a more restrictive environment. The HGH will arrange for and support off-site educational services.

Case: A report regarding a child or family that is assigned for investigation or a child or family unit receiving services from ACYF.

Case Conference: A documented meeting between a DES employee and at least one other person. Case conferences may be more frequent and informal than case plan staffings.

Case Management: The planning and coordination of all services to a client by an individual who, working with members of a service team, provides assessment, identifies and obtains services, monitors, evaluates, records progress and terminates services in accordance with established time frames.

Case Manager: A professional employed or contracted by the department to provide social services to eligible children and families. A case manager's responsibilities include the establishment of a case plan, determination and arrangement of appropriate services, evaluation of progress, recommendations to the juvenile court and other agencies and the termination of

services.

Case Notes: A CHILDS window used to document case activity, primarily contact between department staff and other persons associated with a case.

Case Opening: The date upon which a case is assigned for initial investigation.

Case Plan: A written document which is a separate and distinct part of the case record. It identifies the permanency goal and target date, desired outcomes, tasks, time frames, and responsible parties. The case manager is responsible for the development and implementation of the case plan in consultation with the family and service team.

Case Plan Staffing: A documented meeting arranged for the purpose of sharing information, the development and/or review of the case plan, and the evaluation of services and case progress. The staffing includes the case manager, the family and members of the service team.

Case Planning: The process through which a permanent plan for the child is established, reviewed and revised as necessary. Case planning is continuous throughout the duration of a case, is implemented through the use of staffings, and is documented in the case record.

Case Record: The department's official collection of information regarding a client or family and the services provided. This may include, but is not limited to, case notes, social histories, staffing minutes, medical, psychological and educational information, legal documents, correspondence and DES forms. The case record includes an electronic and hard copy record.

Centers for Medicare and Medicaid Services (CMS): An agency of the U.S. Department of Health and Human Services, which provides technical assistance, disburses Title XIX funds, and monitors AHCCCS for compliance with federal regulations.

Central Registry: A confidential registry of substantiated reports of child abuse and neglect (ARS §8-804).

Certified: See **Adoption Certification**.

Child: An individual who is under 18 years of age.

Child Abuse Prevention (CAP) Fund: The CAP Fund was established by the legislature in 1982 to promote child abuse and neglect prevention. Utilizing a Request for Proposal process, CAP Fund dollars are used to contract with community agencies to provide child abuse and neglect services to children and families.

Child Care: The provision of substitute care for a child during a portion of a day, on an ongoing basis.

CPS Information: Includes all information the Department gathers during the course of a Child Protective Services investigation from the time a file is opened and until it is closed. CPS information does not include information that is contained in child welfare agency licensing records. [ARS §8-807(T)(1)]

Child Protective Service Worker: A person who has been selected by and trained under the requirements prescribed by the department and who assists in carrying out the provisions of child protective services. [ARS §8-801(1)]

Child Protective Services: See Protective Services

Child Welfare Agency: Any agency or institution maintained by a person, firm, corporation, association or organization to receive children for care and maintenance; any institution that provides care for unmarried mothers and their children; any agency maintained by the state, or a political subdivision thereof, person, firm, corporation, association, or organization to place children or unmarried mothers in a foster home. This does not include state operated institutions or facilities, detention facilities for children established by law, health care institutions that are licensed by the Department of Health Services pursuant to title 36, chapter 4 or private agencies that exclusively provide children with social enrichment or recreational opportunities and that do not use restrictive behavior management techniques.

CHILDS: The Children's Information Library and Data Source is the Division of Children, Youth and Families' automated child welfare record keeping system.

CHILDS Adoption Registry: Preplacement information on children legally free for adoption, children partially free for adoption, children who have a plan of adoption and are to be placed out-of-state and children who are to be placed in a foster-adoptive home.

CHILDS Case Management Information System: (Children's Information Library and Data Source) is the Division of Children, Youth and Families' automated child welfare record keeping system. The CHILDS Case Management Information System is a repository of all reports of child abuse and neglect and related records and identifies statistical data relating directly to child protective services. (ARS § 8-804.01)

CHILDS Provider (Adoption) Registry: A registration maintained by the department consisting of currently certified adoptive home studies.

Client: A person who receives services from the department. May also be referred to as a Participant in CHILDS.

Clinical Case Management Team: The interdisciplinary team of professionals who are responsible for providing continuous treatment and support to children/clients with serious mental illnesses and for locating, accessing, and monitoring the provision of mental health services. The clinical case management team shall consist of a psychiatrist, case manager, and other mental health professionals as needed, based on the eligible person's need for medically necessary services.

Communication: A telephone, fax or letter contact with the Child Abuse Hotline/Central Intake Unit which may be a report of child abuse and neglect, a request for services or information sharing.

Communication Agreement: A written agreement, approved by the court, regarding communication with a child adoptee, the adoptive parents and a birth parent.

Community Advisor: An individual who serves as a role-model, mentor and part of the young adult's support system. The community advisor assigned to each young adult provides encouragement, social and emotional support and offers the young adult a link with the community.

Compact: The Interstate Compact on the Placement of Children.

Compact Administrator: The department employee who shall be general coordinator of activities under the Compact in the State jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of the Compact.

Compact State: All states, the U.S. Virgin Islands, the Commonwealth of Puerto Rico and the District of Columbia.

Comprehensive Medical And Dental Program (CMDP): The AHCCCS health plan under DES which provides medical and dental services for children in out-of-home care, including foster children enrolled in ALTCS, in the custody of DES, the Administrative Office of the Courts (juvenile probation), and the Department of Juvenile Corrections.

Concurrent Case Planning: Actively implementing the case plan goal while also actively pursuing an alternative plan including adoption or legal guardianship for children in out-of-home care through a Voluntary Foster Placement Agreement or dependency action.

Concurrent Permanency Planning: Actively implementing the family reunification permanency goal while simultaneously planning for the possibility of other permanent options. Concurrent planning means that early in the process of serving the family the worker identifies possible caregivers who would be willing to care for the child on a permanent basis if the child is unable to be reunified with his/her birth family.

Conditions: For the purpose of a Special Needs Adoption, means a physical, mental or developmental disability that existed prior to the finalization of the adoption.

Conflict Resolution: A method or technique for settling disagreements or disputes among individuals of agencies.

Consent to Place a Child for Adoption: A document that, once signed by the parent, gives the Arizona Department of Economic Security permission to place a specific child for adoption and is irrevocable unless obtained by fraud, duress or undue influence. See also, relinquishment.

Contact: Face-to-face meetings, telephone calls, correspondence and any other means of communication between case participants and associates, providers, department staff, service team members, and any other person regarding the case.

Contact and Visitation Plan: The arrangement for providing contact between a child in out-of-home placement and his parent/caregiver, siblings, family members, other relatives, and other significant persons such as friends and former foster parents. This is accomplished as a cooperative effort among these persons, the case manager, the out-of-home care provider and the child, if age appropriate.

Continuity of Care: The provision of services with minimal or no interruption of time, provider, location, or modality, as appropriate for the welfare of the DES eligible child/client, including transitioning that person between service categories or mental health systems.

Contract Personnel: Individuals employed by contract providers to deliver services under the terms of the contract.

Contract Provider: Any private agency, institution, public agency or vendor which has executed an agreement with the department to furnish services for monetary reimbursement.

Counseling: Professional guidance of a nonmedical nature which assists individuals and families in dealing with a wide range of personal, situational and functional problems.

Court: The Juvenile Division of the Superior Court.

Courtesy Supervision: Supervision by a receiving district for a child who is placed outside of his or her home district.

CPS Mental Health Specialist: A district level mental health coordinator who serves as a liaison to the DHS Regional Behavioral Health Authorities (RBHAs) for behavioral health services.

Custodian: A person, other than a parent or legal guardian, who stands in loco parentis to the child or a person to whom legal custody of the child has been given by order of a court of competent jurisdiction [ARS §8-201(8)].

DDD: The Division of Developmental Disabilities, Department of Economic Security

Delay of Placement: Placement of a child in an adoptive home more than 90 days after the Home Study Case Conference resulting in the identification of the placement.

Delinquent Act: An act by a juvenile that if committed by an adult would be a criminal offense or a petty offense, a violation of any law of this state, or of another state if the act occurred in that state, or a law of the United States, or a violation of any law that can only be violated by a minor and that has been designated as a delinquent offense, or any ordinance of a city, county or political subdivision of this state defining crime. Delinquent act does not include an offense under section 13-501, subsequent A or B if the offense is filed in adult court. Any juvenile who is prosecuted as an adult or who is remanded for prosecution as an adult shall not be adjudicated as a delinquent juvenile for the same offense. [ARS §8-201(10)]

Delinquency Hearing: A proceeding in the juvenile court to determine whether a juvenile has committed a specific delinquent act as set forth in a petition. [ARS §8-201(9)]

Denial of License: The act of refusing to issue a license to an applicant.

Department: The Arizona Department of Economic Security (DES).

Department of Law: The Office of the Arizona Attorney General, and/or designated Assistant Attorney General staff.

Dependency Petition: The formal legal petition requesting the Court to adjudicate a child dependent.

Dependent Child: A child who is adjudicated one or more of the following:

- in need of proper and effective parental care and control and has no parent or guardian, or one who has no parent or guardian willing to exercise or capable of exercising such care and control.

- destitute or who is not provided with the necessities of life, including adequate food, clothing, shelter or medical care, or whose home is unfit for him by reason of abuse, neglect, cruelty or depravity by either of his parents, his guardian or other person having his custody or care.

- under the age of 8 years who is found to have committed an act that would result in adjudication as a delinquent or incorrigible child if the act was committed by an older child.

- Incompetent or not restorable to competency and who is alleged to have committed a serious offense as defined in Section 13-604. [Applies to delinquent children under ARS § 8-201(11)]

A dependent child does not include a child who in good faith is being furnished Christian Science treatment by a duly accredited practitioner if none of the circumstances described above exists. [ARS §8-201(13), ARS §8-201.01(1)]

A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered a dependent child for that reason alone[ARS §8-201.01(2)]

DES: The Arizona Department of Economic Security.

DES Fee Schedule: Allowable amounts established by the department to pay for the provision of medical, dental, psychological and psychiatric care for client children.

Detention: The temporary confinement of a juvenile who requires secure care in a physically restricting facility that is completely surrounded by a locked and physically secure barrier with restricted ingress and egress for the protection of the juvenile or the community pending court disposition or as a condition of probation. [ARS §8-201(14)]

Detoxification Services: treatment services that are provided to reduce physical dependence on alcohol, drugs or other substances through the use of therapeutic procedures, including medications, rest, diet, counseling or medical supervision.

Developmental Disability: Either a strongly demonstrated potential that a child under the age of six years is developmentally disabled or will become developmentally disabled, as determined by a test performed pursuant to ARS §36-694 or by other appropriate tests, or a severe, chronic disability which is:

- attributable to mental retardation, cerebral palsy, epilepsy, or autism;
- manifested before age 18;
- likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services which are lifelong or extended in duration. [ARS §36-551(15)]

Disposition: The point at which the decision is made to process a CPS report as "Case Assigned for Investigation," "Alternative Investigation," "State or Federal Statute, or Court Order Prevents CPS Investigation," "Referred to Family Builders," or "Not Investigated."

Dually Adjudicated Child: a child who is found to be dependent or temporarily subject to court jurisdiction pending an adjudication of a dependency petition and who is alleged or found to have

committed a delinquent or incorrigible act.

Educational Voucher: The mechanism for transferring funds for a child's education from the state's public school system to an approved private school in a residential facility (RTC). Vouchers cover funding for both special and nonspecial education.

Electronic Record: Maintained in CHILDS and includes window data and electronically created documents.

Eligibility: The requirements an individual or family must meet to receive services funded by the department.

Eligible Person(s): An individual or family who meets all the requirements for receiving a service.

Emergency Intervention: Services provided in coordination by the department to protect a child who is at imminent risk of maltreatment.

Emotional Disturbance: A condition which impedes the ordinary developmental progress of the child as defined by accepted psychiatric or psychological standards and as diagnosed by one or more psychiatrists or psychologists approved by the department. [ARS §8-141(A)(7)]

Entity: The Department of Economic Security, Department of Juvenile Corrections or a Child Welfare Agency that has been granted legal care, custody and control of a child by order of the juvenile court and that is responsible for securing inpatient psychiatric acute care services or residential treatment services for a child. Entity includes a probation department or juvenile detention center that either recommends or is ordered by the court to provide inpatient psychiatric acute care services or residential treatment services for a child.

EPSDT: A 1972 amendment to Title XIX (Medicaid) requiring screening, diagnostic, and treatment services at periodic intervals and as medically necessary to be offered, upon request, to all eligible children. A 1989 amendment to Title XIX expanded EPSDT to include additional medical services, mental health and substance abuse services.

Evaluation: A study of a home for an identified purpose which describes family members, the home and community, and relates its findings and recommendations to the needs of the child or children for who the study is requested.

Explain: A CHILDS window function that allows for narrative entry for further details.

Exploitation: Use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities.

Extreme Serious Conduct Allegation: An allegation of conduct by a parent, guardian or custodian of a child that, if true, would constitute any of the following:

a) A violation of section 13-3623 involving child abuse.

b) A felony offense that constitutes domestic violence as defined in section 13-3601.

c) A violation of section 13-1404 or 13-1406 involving a minor.

d) A violation of section 1405, 13-1410 or 13-1417.

e) Any other act of abuse that is classified as a felony. [ARS §8-801(2)]

Family: Persons, including at least one child, related by blood or law, or who are legal guardians of a child, or who reside in the same household. Where persons related by blood or law do not reside in the same household and where adults other than spouses reside together, each may be considered a separate family when it is to the benefit of the child. Family includes both parents regardless of whether they are living together for case planning purposes.

Family Care Provider: Any person providing out-of-home care in a family home. Includes relatives, significant persons and licensed foster homes.

Family Care Settings: Includes relative, significant person/other, family foster home, and treatment foster homes.

Family Foster Home: A home maintained by any individual or individuals having the care or control of minor children, other than those related to each other by blood or marriage, or related to such individuals, or who are legal wards of such individuals [ARS §8-501(A)(4)].

Family Group Foster Home: A family foster care facility licensed for placement of more than five minor children but not more than ten minor children. Licensed under A.A.C. R65-59, Group Foster Home Licensing Standards. [ARS §8-501(A)(6)]

Family Preservation Services (Federal funds): Family Preservation services are directed to reduce risk factors and stabilize a family unit in response to a crisis event when there is significant risk to the family. These services include an intensive level of intervention to successfully meet the crisis needs of the family or to reunify children who are in non-permanent placement. The services are provided through contracts with private providers.

Family Support Services (Federal funds): Family Support Services are preventative services provided on a proactive basis to improve the well being of families, enhance family functioning, and foster a sense of self reliance. The services are provided through contracts with private providers.

Findings: Result of an investigation stated as propose substantiated, substantiated or unsubstantiated.

Fiscal Year: The period of time from July 1st through June 30th.

Foster/Adoptive Applicant: A person who requests consideration as a prospective foster or adoptive parent by completing the required application forms. Foster Care licensing includes both spouses of the adult household, if caregivers are married.

Foster-Adoptive Placement: The placement of a child whose case plan goal is adoption and who is not legally free for adoption, in a home of a family that is certified as acceptable to adopt and licensed as a foster home by the department.

Foster Care: Alternative care for children in non-parent relative placements, family foster homes, group homes or child welfare agencies. See also Out-Of-Home Care.

Foster Care Facility: A setting licensed to provide out-of-home care to children, including licensed relative placements, foster homes, group homes and child welfare agencies.

Foster Care Provider: Any person or agency licensed to provide out-of-home care for children.

Foster Child: A child placed in a foster home or child welfare agency. [ARS §501(A)(3)]

Foster Parent: Any adult individual or individuals maintaining a licensed foster home. [ARS §8-501(A)(5)]

Foster Parent Adoption: The adoption of a child by his or her current foster parents who became certified to adopt after the child was placed in the home for foster care purposes.

Group Care Setting: A licensed, agency-administered group home, therapeutic group home, residential treatment center (RTC) or mobile program.

Group Home: A group care facility that provides 24 Hour supervision within a group setting. Therapeutic services are generally provided off site.

Guardian: A person who has qualified as a guardian of a minor pursuant to testamentary or court appointment, but excludes one who is merely a guardian ad litem. [ARS §14-5201 et seq. and ARS §8-531(9)]

Guardian Ad Litem: A person appointed by the court to protect the interest of a minor or an incompetent person in a particular case before the court. [ARS 8-531(7)]

Guardianship of the Person: With respect to a minor, means the duty and authority to make important decisions in matters affecting the minor including but not necessarily limited either in number or kind to:

a) The authority to consent to marriage, to enlistment in the armed forces of the United States and to major medical, psychiatric and surgical treatment, to represent the minor in legal actions, and to make other decisions concerning the child of substantial legal significance.

b) The authority and duty of reasonable visitation, except to the extent that such right of visitation has been limited by court order.

c) The rights and responsibilities of legal custody, except where legal custody has been vested in another individual or in an authorized agency.

d) When the parent-child relationship has been terminated by judicial decree with respect to the parents, or only living parent, or when there is no living parent, the authority to consent to the adoption of the child and to make any other decision concerning the child which the childs parents could make. [ARS §8-531(8)]

HLCI: The High Level Client Index Number. A unique identification number assigned to each participant in CHILDS who is the recipient of a service.

Hard Copy Record: A paper file that is maintained at the local office and includes: Documents generated outside the Division of Children, Youth and Families (DCYF); Documents that require signatures from individuals outside DCYF; and Hard Copy forms not maintained electronically.

Health service provider: A practitioner licensed by the State of Arizona or other state to provide physical or mental health services, or others approved by the department as having the appropriate credentials to carry out the service, practicing within the scope of such credentials.

Healthy Families Arizona: Healthy Families Arizona (HFAz) is a community-based, multi-disciplinary program serving families of newborns, and is designed to reduce stress, enhance

family functioning, promote child development, and minimize the incidence of abuse and neglect within a multi-cultural environment. Family Support Specialists visit new parents in their home anywhere from weekly to quarterly according to their level of need. Participation may continue until the child reaches five years of age.

High Risk of Physical or Mental Disease: A potentially debilitating condition, as defined by accepted standards of the health service profession, as certified by one or more health service providers approved by the department. [ARS §8-141(A)(9)]

High Risk of Severe Emotional Disturbance if Removed from the Care of Foster Parents or Relatives: The development of significant emotional ties to the foster family as documented by the child's case manager and as diagnosed by a psychiatrist or psychologist approved by the department [ARS §8-141(A)(10)]. These ties include:

- Identification of the child as a member of the foster family or relative family
- Identification by the foster family or relative family of the child as belonging to that family
- The likelihood that the child will not establish significant emotional ties to another family if denied permanent placement with the foster family, or relative family. [ARS § 8-141(A)(8)]

HIV: Is the acronym for human immunodeficiency virus. This is the name for the virus which causes AIDS. The virus causes a deficiency in the human immune system, the body's natural defense against disease. HIV progressively damages the immune system and leaves its victims unable to fight off even small infections.

HIV/AIDS Field Representative: the person in each district designated to be a resource person regarding HIV/AIDS issues. This person is to be included in all decisions regarding HIV/AIDS testing, should be made aware of test results, and should be consulted regarding placement of children who are HIV positive or diagnosed with AIDS.

HIV/AIDS Risk Factors: Are those behaviors and/or reasons that put an individual at risk for contracting the AIDS virus:

a. Voluntary risk behaviors

i. The sharing of needles and syringes ("works") for the purpose of intravenous drug use since 1978.

ii. Unprotected sexual activities with single or multiple partners who are infected or whose HIV status is unknown.

b. Non-behaviorial reasons that put an individual at risk

i. Children of mothers who are infected and/or whose mothers engaged in high risk behaviors

ii. Children and youth who have been involuntary sex partners (victims of sexual assault, rape, sexual abuse, etc.) of individuals who are infected.

iii. Hemophiliacs, because of their need for transfusions or blood products; the risk to this population, however, has been greatly reduced since the testing of all blood and blood products was instituted in March, 1985.

HIV Positive: Means that a blood test has indicated the presence of antibodies to the HIV virus. This means that at some point the person has been infected with the virus and the immune system has responded by producing antibodies. People who have the antibody but are otherwise asymptomatic for AIDS are referred to as "HIV positive only". This condition does not inevitably begin a progression to AIDS, although it may. These people are capable of transmitting the virus through high risk behaviors.

Home Management Tasks: Training and/or instruction in activities related to routine household maintenance and family functioning.

In-Home Placement: The placement of a child in the home of the child's parent or legal guardian.

In-Home Respite care: Respite care provided by a licensed foster parent in a home that is not that individual's own home.

In-home Voluntary Child Protective Services Case: A case in which all children remain within the family home while the department provides services and in which a dependency petition has not been filed.

Incoming Communication: Verbal, written, or in-person contact to Child Protective Services.

Incorrigible Child: A child who is:

a) Is adjudicated as a child who refuses to obey the reasonable and proper order or directions of a parent, guardian or custodian and who is beyond the control of that person.

b) Is habitually truant from school as defined in section 15-803, subsection C.

c) Is a runaway from the childs home or parent, guardian or custodian.

d) Habitually behaves in such a manner as to injure or endanger the morals or health of self or others.

e) Commits any act constituting an offense that can only be committed by a minor and that is not designated as a delinquent act.

f) Fails to obey any lawful order of a court of competent jurisdiction given in a non-criminal action. [ARS §8-201(15)]

Independent Living Services Program: An array of services that prepare young adults for attaining independence and self-sufficiency in the community.

Independent Living Subsidy: A program for young adults in foster care which offers them the opportunity to experience community living while still receiving services from the department. This placement option, authorized by ARS §§8-845(A)(8) and 8-521, serves dependent youth 17 years of age and older and young adults who remain in care voluntarily after age 18.

Individual Service Plan: A specific plan developed by the RBHA case manager and the clinical case management team, with the participation of the DES case manager, to identify and facilitate appropriate mental health services for a DES eligible child. It must include treatment goals, specific services and units of delivery, service cost, anticipated time frames, and identified providers. The ISP will be incorporated as the mental health portion of the child welfare case plan and is subject to authorization and approval as required.

Individuals with Disabilities Education Act (IDEA): A federal law which mandates a free appropriate public education in the least restrictive environment for children with disabilities. It outlines services and procedural safeguards for children needing special education.

Infant: A child under the age of one year.

Information and Referral: An incoming communication without sufficient identifying information or content to constitute a report. Information is given, and/or an individual is directed to an appropriate resource.

In-Home Intervention: A program of services provided while the child is still in the custody of the parent, guardian or custodian. (ARS §8-891)

Initial Report: Information as entered on the CHILDS Case Management Information System pertaining to a particular report, up to the point of disposition.

Initial Response: An action by CPS, law enforcement or other emergency personnel to determine that the child victim is currently safe. The initial response is determined by the highest risk level.

Inpatient Assessment: includes all of the following:

a. the observation of a childs behavior while the child is in an inpatient assessment facility.
b. psychological or psychiatric testing, if indicated.
c. a determination as to whether a child needs inpatient psychiatric acute care services and whether inpatient psychiatric acute care services are the least restrictive available alternative.
d. the administration of psychotropic medication and medication monitoring, if necessary to complete the assessment or to prevent the child from being a danger to self or others.
e. a written report that summarizes the results of an inpatient assessment, including specific

recommendations for follow-up care.

f. a psychiatric or psychological assessment, including a clinical interview with a child.

g. an explanation to a child of the least restrictive alternatives available to meet the childs mental health needs.

h. a determination as to whether the child may be suffering from a mental disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled as defined in section 36-501.

i. a review of a childs medical, social and psychological records, if available.

Inpatient Assessment Facility: Refer to Psychiatric acute care facility.

Intensive Treatment Program: Treatment services that are outlined in a childs individual treatment plan and that provide planned, structured and coordinated therapeutic goals

Inquiry Form: A pre-application form given to prospective applicants that compiles information used to evaluate the prospective applicants interest, commitment and desire to make application to adopt or foster children through DES.

Intake: The initial process of screening, receiving, investigating and recording information for the purpose of determining risk to children and the need for protection and services.

Intensive Family Services (Arizona Family Preservation Services): Intensive Family Services (also known as AFPS) is a program that provides services to families whose children are at immediate risk of foster care placement due to abuse or neglect. The program uses a crisis intervention approach providing a range of intensive, behaviorally-oriented services such as counseling, family therapy, communication skills, and parent education services in the family's own home. The services are provided through contracts with private providers.

Interested Parties: A person granted the right to notice of and participation in any review or hearing concerning the child, the right to review all pleadings, and the right to receive reports submitted to the court by the case manager.

Intergovernmental Agreement/Interagency Service Agreement: A written contract between two separate agencies or departments, obligating designated employees of the agencies/ departments to follow specified procedures, standards, roles, and duties for a specified time. These collaborative documents are reviewed and refined by legal representatives of both departments/agencies and are signed by the administrators of those departments/agencies.

Interstate Placement: Any movement of a child from one state to another state for the purpose of establishing a suitable living environment and providing necessary care.

Investigation: The process by which allegations of abuse or neglect, abandonment or exploitation are either found propose substantiated, substantiated or unsubstantiated. The process includes determining:

- the nature, extent and cause of any condition which would tend to support or refute the allegation that the child should be adjudicated dependent;
- the name, age and condition of other children in the home; and
- whether any child is in need of protective services

Investigation/Safety Assessment Process: Gathering information to assess current risk to a child which includes, but is not limited to:

- Review of prior CPS reports/other records
- Worker's observation(s) and/or assessment
- Face-to-face and/or phone interviews
- Collateral sources which may be persons or documents
- Documentation of the process, review and approval by the CPS Unit Supervisor

Juvenile: See child

Juvenile Court: The juvenile division of the superior court when exercising its jurisdiction over children in any proceedings relating to delinquency, dependency or incorrigibility. [ARS §8-201

(17); ARS 8-531(9)]

Kinship Care: means the full time care of a child, who is in the care, custody and control of the department, who is placed with a kinship foster caregiver.

Kinship Foster Caregiver: means an adult relative or person who has a significant relationship with a child, who is caring for a child, who is under the care custody and control of the department. A relative means grandparent; great grandparent; brother or sister, whole or half blood; aunt or uncle; or cousin.

Law Enforcement Officer: A peace officer, sheriff, deputy sheriff, municipal police officer or constable. [ARS § 8-201(18)]

Least Restrictive Environment (LRE): That setting which offers the most family-like atmosphere which is compatible with the needs of the child.

Legal Custody: A status embodying all the following rights and responsibilities:

a) The right to have physical possession of the child.

b) The right and the duty to protect, train and discipline the child.

c) The responsibility to provide the child with adequate food, clothing, shelter, education and medical care, provided that such rights and responsibilities shall be exercised subject to the powers, rights, duties and responsibilities of the guardian of the person and subject to the residual parental rights and responsibilities if they have not been terminated by judicial decree. [ARS §531(5)]

Legal Father: A man who was married to the mother of a child at the time of the child's birth or who was married to the child's mother any time in the ten months immediately preceding such birth.

Legally Free: A child who is eligible for adoption because all legal parents or guardians have either consented to adoption, had their parental rights terminated by the court, or died.

Level One Behavioral Health Facility: A behavioral health service agency that is licensed by the Department of Health Services and that provides a structured treatment setting with twenty-four hour a day supervision and an intensive treatment program

Level of Supervision: The degree of monitoring and directing required based upon the age, level of maturity, and the special needs of the child as agreed upon by the child's case manager and the care provider. The "level of supervision" required can range from being left alone for short periods of time to a need for the child to have constant monitoring and direction.

License: A document issued by the department confirming that the applicant(s) have met the standards for the provision of foster care or group care and are authorized to conduct specified services.

Licensed Family Foster Parent: means a person or persons licensed under A.A.C. R5-6-5801 et. seq., Family Foster Parent Licensing Requirements, to provide care for up to five children who are in the care, custody and control of the department.

Licensed Family Group Foster Parent: means a person or persons licensed under A.A.C. R5-6-5901 et. seq., Group Foster Home Licensing Standards, to provide care for more than five children but not more than ten children who are in the care, custody and control of the department.

Licensing Specialist: A person designated by the department or an agency to perform specific work activities and functions related to licensing, supervision, support, and monitoring of foster or group care homes.

Locked (Secured) Residential Treatment Center: A residential treatment center, Level I facility, licensed to care for children and provide behavioral health services, on a 24 hour basis, which utilizes secure settings or mechanical restraints. A court order for inpatient treatment is required for placement of a dependent child within such a facility.

Maintenance Payments: Monthly money payments for the cost of care and supervision of the foster child, or monthly money payments for the extra time and expense of caring for a special needs child on Adoption Subsidy.

Mandated Reporter: An individual who is required to report child abuse or neglect under ARS §13-3620.

Maltreatment: Abuse, neglect, exploitation, or abandonment of a child.

Medical Identification Card: The card issued by the Contract Provider for use in the purchase of all covered services.

Medical Need or Chronic Illness Means: An inherent, long-lasting severe physical or mental condition which often interferes with daily functioning and/or requires special attention and on-going medical, surgical or psychiatric care.

Medically Necessary: Under the statutory limitation of the Adoption Subsidy Program, medically necessary services are provided to prevent the progression of disease, disability and other adverse health conditions identified on the subsidy agreement, which are provided by a qualified service provider within the scope of his/her practice under state law or certification, whichever is applicable.

Medication Adjustment and Monitoring: Medication review for adjustment and/or continuing treatment for an individual, as performed by a qualified professional, including Physician, Nurse Practitioner, Physician's Assistant, or Registered Nurse who is licensed in accordance with A.A. C. Title 20.

Mental Disability: A lifelong condition which is characterized by impaired intellectual development and impedes the ability to function independently. [ARS §8-141(A)(11)]

Mental Health Standards: Standards established by AHCCCS, Department of Human Services, federal law, state statutes and rules and any subsequent amendments, defining the policies and procedures applicable to Title XIX mental health and substance abuse services.

Mitigate: Specific circumstances that may allow an increase in a standard response time for Risk Level 1, 2, and 3 reports.

Mobile Program: A group care facility that provides 24 hour care, and which is situated in and utilizes the outdoors to provide a recreational and educational opportunity in group living.

Monitor: The process of reviewing service providers for compliance with requirements.

Multidisciplinary Case Consultation Teams (MDT): A team of professionals which may include, but is not limited to, a physician, psychologist, law enforcement representative, assistant attorney general and district program manager or designee. This group meets regarding selected cases with the assigned case manager, supervisor, other service team members and the family, as appropriate. The purpose is to share information and to assess and diagnose particularly complex and difficult case situations in order to make recommendations regarding the development or review of a case plan.

Native American Child: A child who is a member of, or eligible for membership in a tribe, as defined by the tribe.

Near Fatality: Means an act that, as certified by a physician, places a child in serious or critical condition. [ARS 8-807(T)(2)]

Need to Know: Refers to the need for a person to know the HIV status of a child and is based on direct responsibility or accountability for care of the child, or involvement in an activity directly related to the child.

Neglect or Neglected: The inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, except if the inability of a parent or guardian to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services.[ARS §§8-201 (21)]. A child, who in good faith, is being furnished Christian Science treatment by a duly accredited practitioner shall not, for that reason alone, be considered to be a neglected child. [ARS §8-8201.01(1)] A child whose parent, guardian or custodian refuses to put the child on a psychiatric medication or questions the use of a psychiatric medication shall not be considered a neglected child for that reason alone. [ARS §8-201.01(2)]

Newborn: An infant from birth to 60 days of age.

Nonrecurring Adoption Expenses: Those reasonable and necessary adoption fees, court costs, attorney fees and expenses which are directly related to the legal process of adoption of a child with special needs, meet federal requirements, and are not reimbursed by other sources, including costs relating to the adoption study, health and psychological examinations, supervision of the placement before the adoption, transportation and reasonable costs of lodging, and food for the child or adoptive parents which are incurred to complete the adoption process.

Not Investigated: A disposition assigned to a report by a CPS Supervisor only when there is inadequate staff to complete a field investigation.

Opportunistic Illnesses: Are infections that are not a threat to a healthy immune system but that could be fatal to a person who has AIDS. The opportunistic infections most commonly associated with AIDS are: Pneumocystis carinii pneumonia (PCP); Kaposi's sarcoma (KS); candidiasis (yeast infections); disseminated cytomegolovirus (CMV); unusually extensive herpes of prolonged duration; toxoplasmosis; and mycobacterial disease due to illness, both tuberculosis (TB) and atypical mycobateria.

Orientation: Instructions and information provided to employees, volunteers, and contract personnel at the time they assume service responsibilities.

Out-of-Home Placement: The placement of a child with an individual or agency other than the child's parent or legal guardian. This includes the following:

- placement in temporary custody [ARS §8-221(A) or (B)]
- voluntary placement (ARS §8-806)
- placement due to dependency action. [ARS §8-501(A)(7)]

Out-of-Home Care Provider: A person or agency authorized by the department to provide care or control of a child in out-of-home care.

Out-of-Home Care: See Out-of-home placement.

Out-of-Home Respite Care: Respite care that is provided out of the child's home and in the home of the respite provider. This may include a shelter care facility.

Outpatient Assessment: Includes all of the following:

a. a psychiatric or psychological assessment, including a clinical interview with a child

b. an explanation to a child of the least restrictive alternatives available to meet the childs mental health needs.

c. a determination as to whether the child may be suffering from a mental disorder, is a danger to self or others or is persistently or acutely disabled or gravely disabled.

d. a review of a childs medical, social and psychological records, if available

e. a determination as to whether the child needs an inpatient assessment or inpatient psychiatric acute care services and whether an inpatient assessment or inpatient psychiatric acute care services are the least restrictive available alternative.

Parent: The natural or adoptive mother or father of a child. [ARS §8-531(A)(10)]

Parent Aide: A paraprofessional who functions as a member of a team to provide parent aide services in support of a case plan. Parent aides may be department employees, volunteers, or employees of a parent aide services contract provider.

Parent Aide Services: A range of support services which may include teaching and modeling of parenting and home management skills, teaching the use of informal and formal community resources, and transportation tasks.

Parent-Child Relationship: Includes all the rights, privileges, duties and obligations existing between parent and child, including inheritance rights. [ARS §8-531(11)]

Parental Involvement: Emphasis of parental participation throughout all phases of case planning.

Parenting Skills Training: The provision of instruction and/or modeling to enhance parental functioning.

Participant: A person who is a recipient of service and member of a case (see client).

Partial Care, Basic: Therapeutic activities including those which promote coping, problem-solving and socialization skills, and offer regular activities for individuals requiring supportive counseling, skills, training and rehabilitation. This service is provided as a half day (minimum 3 hours) or full day (minimum 5 hours).

Partial Care, Intensive: Regularly scheduled program of intensive therapeutic activities, including a variety of treatment modalities such as individual, group, and/or family therapy, cognitive and psychodynamic strategies addressing the individual's issues, and treatment related activities intended to reduce the need for more intensive services. This service is provided as a half day (minimum 3 hours) or full day (minimum 5 hours).

Parties: Includes the child, the petitioners and any parent of the child required to consent to the adoption pursuant to section 8-106. [ARS §8-531(12)]

Permanent Guardian: For the purpose of adoption petitioning and guardianship subsidy, a legal guardian appointed by the court pursuant to ARS §8-871.

Person About Whom a Report is Made: An alleged abusive caregiver or other person, a child victim or a child victim's parent or legal guardian.

Personally Identifiable Information: Includes the name, address, date of birth, social security number, tribal enrollment number, telephone or fax number, driver license number, places of employment, school identification or military identification number or any other distinguishing characteristic that tends to identify a particular person.

Petition: A written statement of the essential facts that allege delinquency, incorrigibility or dependency. [ARS §8-201(22)]

Physical Disability: Chronically debilitating, progressive or fatal disease which requires assistance for the child in daily living, or requires the assistance of another person or mechanical device for movement from place to place, and is diagnosed by one or more health service providers [ARS § 8-141(A)(12)].

Physician: An individual licensed to practice medicine or medicine and surgery (including an osteopathic practitioner), a podiatrist or an optometrist. The term shall include such individuals who have been granted a license to practice by the appropriate regulatory board of the State of Arizona and shall include them only when they are practicing within the scope of such license.

"Physician" means a person who is licensed pursuant to Title 32, Chapter 13 or 17.

Physician's Assistant: A person licensed with this title by a state.

Protective Services: A specialized child welfare program that is administered by the Department and that investigates allegations of and seeks to prevent, intervene in and treat abuse and neglect, to promote the well-being of the child in a permanent home, and to coordinate services to strengthen the family. [ARS§8-801(4)]

Psychiatrist: A person who is licensed pursuant to Title 32, chapter 13 or 17.

Psychiatric Acute Care Facility: A facility that is licensed by the Department of Health Services as a level one behavioral health facility and that provides psychiatric acute care services.

Psychiatric Acute Care Services: Any of the following:

(a) emergency or crisis behavioral health services

(b) psychiatric and psychological assessments and short-term intensive behavioral health counseling and treatment for acute episodes or mental disorders

(c) medication stabilization and twenty-four hour a day nursing care for a child who suffers from acute psychiatric or mental disorders or who needs to have a chronic mental illness stabilized

Psychologist: A person who is licensed pursuant to Title 32, chapter 19.1.

Placement: The current residence or location of a child. This includes the parent's home, a foster home, significant person's home, adoptive home, child care agency, institution, hospital or medical facility.

Pre-Existing Conditions: One or more special needs which existed before the finalization of adoption.

Primary Care Unit: The place where the child resides on a 24 hour basis.

Prior Authorization: Authorization required by the contract provider before certain covered services are rendered.

Probable Cause: Facts which provide a reasonable ground to believe that abuse or neglect occurred.

Proposed Substantiated Perpetrator Unknown: The department shall consider a report proposed substantiated perpetrator unknown after an investigation when there is insufficient evidence that abuse and neglect occurred; and the alleged perpetrator is unknown. (In**S**ufficient evidence is equivalent to the legal standard of probable cause).

Provisional: A foster home license established on a conditional basis, not to exceed six months, when the foster parent applicant(s) have completed all licensing requirements other than initial or ongoing training. [ARS §8-509(D)]

Psychiatric Evaluation: A specific assessment performed by a psychiatrist (M.D. or D.O.) meeting state licensure requirements in accordance with ARS, Title 32. The assessment shall determine and address behavioral health problems and may recommend intervention and/or treatment. The evaluation shall include a review of referral materials, a clinical interview with the client and other key informants, recommendations and orders for any necessary laboratory or other diagnostic tests, and a written report. Medications may be prescribed, modified or terminated as indicated.

Psychological Evaluation: A specific assessment conducted by a licensed psychologist to determine and address behavioral health problems and may include treatment recommendations

or advise certain interventions. Psychological assessments shall include a review of referral materials, assessment of the individuals's readiness for testing, a clinical interview, and may include intellectual testing, personality testing, educational testing, projective testing, and specialized testing for specific disabilities. Neuropsychological assessments will also delineate between the neurologically based causes for behavior versus an emotional dysfunction.

Psychosocial Rehabilitation: A comprehensive program of remedial treatment to rehabilitate skill deficits in all activities of community and daily living, training in interpersonal communication, and use of and self administration of medication.

Race/Origin: See Racial or Ethnic Factors

Racial or Ethnic Factors: Black, Hispanic, Native American, Asian, or other heritage which may prevent a child from being adopted [ARS §8-141(A)(13)].

RBHA Case Coordination: A lower intensity of case management provided to children who do not have a serious mental illness, but who are in need of mental health services. Case coordination activities include: coordination of services, development of the ISP, identification of service providers, implementation of services, and provision of follow-up as necessary.

RBHA Case Manager/Treatment Coordinator: A RBHA employee or contracted provider who meets the qualifications in the AHCCCS Mental Health Policy Manual and is responsible for collaboration with the DES case manager and the RBHAs clinical case management team in the developing, arranging, and monitoring of the most cost-effective and clinically appropriate Individual Service Plan for delivering mental health services to an eligible child/client.

Reasonable Efforts: A term used in the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) that emphasizes the need to support and preserve families through the provision of services which address remediating the risk to the child in the family. These services are to be directed towards preventing the removal of a child from a family or, if removal is unavoidable, to expedite return of the child to the family. When service provision has not accomplished return of the child to the family, services are then to be directed towards providing another permanent plan for the child.

Receiving Agency: Related to an interstate placement, the local agency in the receiving state which receives the referral, does the evaluation and if placement is made provides supervision and other services as necessary and appropriate.

Receiving Home: A licensed foster home available for a child in need of immediate placement, when taken into custody or pending medical examination and court disposition. [ARS §8-501(A)(9)]

Receiving State: Related to an interstate placement, the state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private persons or agencies, and whether for placement with state or local public authorities or for placement with private agencies or persons.

Redacting: Editing of case records to remove confidential material prior to release of the records to an individual.

Referral: A written request for the provision of services which includes all required information.

Regional Behavioral Health Authority (RBHA): An organization under contract with Department of Human Services to implement, coordinate, maintain, and monitor the delivery of a unified system of behavioral health services for a geographic area.

Relative: means grandparent; great grandparent; brother or sister, whole or half blood; aunt or uncle; or cousin [ARS 8-501(A)(12)].

Relative: for purposes of placement, a great grandparent, grandparent, brother or sister, whole or half blood, aunt or cousin. [ARS 8-501(A)(11)]

Relative: For the purpose of adoption, means the spouse of the natural or legal parent of the child, aunt, uncle, adult sibling or grandparent of the child by the whole or half-blood or by marriage or adoption.

Relinquishment: See Consent to place a child for adoption.

Removal Review Team: At a minimum, the Removal Review Team shall consist of:

- The CPS Specialist, the CPS supervisor, and two members of the local Foster Care Review Board;
- The district ICWA liaison if the child is or may be Indian;
- The childs physician if the child has a medical need or chronic illness.
- Staff from the directors Family Advocacy Office; and other professionally qualified persons who confer regarding alternatives to continued out-of-home placement and other case planning issues may be included in the Removal Review.

Report: An incoming communication containing an allegation that a person under the age of 18 is the subject of abuse or neglect, which a parent, guardian or custodian has inflicted, may inflict, permitted another person to inflict, or had reason to know another person may inflict, and containing sufficient information to locate the child.

Resident: A person who is residing in the state of Arizona with the intent of establishing a home here.

Residential Treatment Center: A group care facility that is licensed as a Level I behavioral health facility through the Arizona Department of Health Services (ADHS). The residential treatment center (RTC) provides a structured treatment setting with daily 24 hour supervision and an intensive treatment program. Onsite schooling is typically provided within this setting.

Residential Treatment Services: Services that are provided by a level one behavioral health facility, a program that provides detoxification services or an intensive treatment program.

Resource: Any service within the department or the community which is available and potentially of benefit to the client.

Respite: Short term care and supervision of a child to relieve caregivers.

Response: Initiation of investigation of a report, which includes direct or indirect contact with the child and/or alleged abusive caretaker or person which may be by telephone, or be in person onsite.

Response Time: The length of time from when the report information is received by the local office to when the local office initiates an investigation and determines the safety of the child victim.

Restricted: A licensed foster home for a specific, identified child(ren).

Revocation: The act of terminating an existing foster care or group care license.

Screening: The initial process of determining if an allegation of abuse, neglect, abandonment, or exploitation exists.

Sending Agency (Referring Agency): Related to an interstate compact, a person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought any child to another state.

Serious Emotional Injury: An injury that is diagnosed by a medical doctor or a psychologist and that does any one or a combination of the following:

a) Seriously impairs mental faculties.

b) Causes serious anxiety, depression, withdrawal or social dysfunction behavior to the extent that the child suffers dysfunction that requires treatment.

c) The result of sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, child prostitution pursuant to section 13-3212, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553 or incest pursuant to section 13-3608. [ARS §8-201(27)]

Serious Physical Injury: An injury that is diagnosed by a medical doctor and that does any one or a combination of the following:

a) Creates a reasonable risk of death.

b) Causes serious or permanent disfigurement.

c) Causes significant physical pain.

d) Causes serious impairment of health.

e) Causes the loss or protracted impairment of an organ or limb.

f) The result of sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, child prostitution pursuant to section 13-3212, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553 or incest pursuant to section 13-3608. [ARS §8-201(28)]

Service Delivery: The functions, activities, and tasks directed at controlling and removing barriers so that the identified goals may be achieved.

Service Provider: Any person, institution or entity which provides covered services to an eligible child recipient under the program.

Service Team: Individuals directly involved in the provision of services to a child or parent. The service team includes the case manager, out-of-home care provider, licensing worker, Court Appointed Special Advocates (CASA), Regional Behavioral Health Authority (RBHA), persons providing services (i.e., physicians, psychologists, therapists, and parent aides). This may also

include the entity case manager, physicians, school personnel, law enforcement and probation personnel, and attorneys.

Severance: See Termination of Parent-al Rights

Severance Specialist: A person employed by DES or under contract with the department to review the appropriateness of a plan for termination of the parent/child relationship, to assess readiness for such a plan and to write the social study as required by ARS §8-536.

Shelter: A licensed agency administered group care setting which is available for a child in need of immediate placement.

Shelter Care: A type of care provided to a child in need of immediate placement.

Sibling Group: See Sibling Relationship

Sibling Relationship: Two or more children related by blood or in law.

Significant Person: An individual who has a substantial relationship with the child.

Special Needs: One or more of the following factors which may impede the adoption of a child:

- Physical, mental or developmental disability
- Emotional disturbance
- High risk of physical or mental disease
- High risk of developmental disability
- Age of six or more years at the time of application for adoption subsidy
- Sibling relationship
- Racial or ethnic factors
- High risk of severe emotional disturbance if removed from the care of foster parents or relatives [ARS §8-141(A)(14)].

Special Services Subsidy: Payments to the adoptive parents or the providers of services for expenses incurred in the provision of medical, dental, psychiatric, psychological, or other services, as approved by the Adoption Subsidy Review Committee, to meet the preexisting health related conditions or risks of the child. This does not include routine medical, routine dental,

social or recreational services.

State or Federal Statute or Court Order Disposition (SFC): A disposition assigned to a report in which a state or federal statute or a court order prevents CPS from investigating. This disposition is usually assigned to a report concerning a child or family that resides on an Indian reservation or military base.

State Placing Agency: A state agency responsible for the care and placement of children and responsible for the submission of the special education voucher application when residential placement is necessary. DES/DCYF/DES/DDD, AOC (JPO), AZ Department of Juvenile Corrections (ADJC), and DHS are the state placing agencies.

Substantial Care Payments: Monthly special services payments for professional nursing provided by an adoptive parent to their medically fragile child, above and beyond the level of care that is reasonable or usual for a parent to provide to a child with special needs.

Substantiated: The department shall consider a report substantiated, after an investigation, when there is sufficient evidence to a support finding of abuse or neglect. (Sufficient evidence is equivalent to the legal standard of probable cause.)

Substance Exposed Newborn (SEN): A newborn infant whose positive toxicology screens gives the professional reasonable grounds to believe that the newborn infant may be affected by the presence of alcohol or a substance.

Supervised Visit: A visit between a child in out-of-home placement and his parent/caretaker, sibling, or other relative that is monitored and supported through the physical presence of a third party (e.g. case manager, visitation facilitator, parent aide, etc.).

Supervision: The act of monitoring and directing the activities of the foster child. This includes situations where the foster parent(s) provide indirect monitoring of the foster youth such as when the youth goes to the movie or shopping mall with friends, is employed or spends an overnight with a friend. The provision of indirect supervision must be approved by the child's case manager as appropriate to the needs and ability of the foster youth. Indirect monitoring also includes the foster parent(s) being available to the youth in the case of an emergency.

Surrogate Parent: An individual appointed by the juvenile court to represent the interests of a

child requiring special education services when the child's parents are unwilling or unable to do so. [ARS §15-761(35)]

Suspension of License: The act of temporarily canceling an existing foster care or group care license.

Symptoms: Of disease due to HIV infection may include: unexplained weight loss; severe night sweats; swollen lymph nodes not attributed to another illness; profound, unexplained persistent cough; blurred vision and severe headaches; easy bruising; and rashes.

Temporary Custody Notice: A written notice by the department, or law enforcement to parents, guardians, or custodians outlining reasons why the child has been taken into temporary custody and advising the parent or guardian of the preliminary protective hearing to be held within 5 to 7 days. (ARS §8-823)

Temporary Investigative Custody: The removal of a child by a Child Protective Service Specialist when the family is uncooperative and it is necessary to protect the child away from the home while the report is adequately investigated.

Temporary Protective Custody: The removal of a child by a Child Protective Service Specialist or a peace officer for a period of time not to exceed 72 hours (excluding weekends and holidays) for the purpose of protection of the child.([ARS §8-823)

Termination of Parental Rights: An order of the superior court that divests the parent and the child of all legal rights, privileges, duties and obligations with respect to each other except the right of the child to inherit and receive support from the parent. This right of inheritance and support shall only be terminated by a final order of adoption. See also Severance.

Therapeutic Group Home: A group care facility which is licensed as a Level II behavioral health facility by Arizona Department of Health Services. The therapeutic group home (TGH) provides a structured residential treatment setting with 24 hour a day supervision and counseling or other therapeutic activities for clients who do not require onsite medical services.

Therapeutic Help to Reach Infants Very Early (T.H.R.I.V.E.): T.H.R.I.V.E. (also known as High Risk Infants) provides intensive in-home services address the problems of children at risk through prenatal substance abuse. These services allow children to be safely cared for in their own home or in homes of relatives; to ensure in these children's early stages of life that they meet developmental milestones. The services are provided through contracts with private providers. (This service is only available in District I.)

Therapeutic Visit: A visit between a child in out-of-home placement and his parent/caretaker or sibling that is monitored through the physical presence of a psychologist, therapist or counselor

for the purpose of assessing interactions, response to visits, teaching parenting skills and increasing the participants understanding of the family dynamics with the goal of solving family problems.

Title XIX: The Medicaid provision of the federal Social Security Act.

Title XIX Eligible Child: Children up to age 18, who are eligible under Title XIX eligibility categories, which include COBRA, SOBRA, SSI, and Ribicoff criteria.

Title XIX Provider/Facility: A person, clinic, or residential facility licensed by the Department of Health Services that meets the Arizona Health Care Cost Containment System (AHCCCS) requirements for receiving federal Title XIX reimbursement.

Tracking Characteristics: Specific situations identified as "TB" through "TSX" in Exhibit 9 which tracks the frequency of occurrence.

Treatment Plan: That portion of the authorization process which requires that the attending physician and other professional allied health personnel involved in the care of a recipient establish and review periodically a plan of treatment and care for each recipient.

Treatment-Oriented Foster Care: Foster family-based model that provides an intensive system of supportive and clinical services to special needs children.

Unable to Locate: The department shall consider the report finding unable to locate after an investigation when reasonable efforts were made to locate the child victim; the location of the child victim remains unknown and there is insufficient evidence to conclude that the child was abused or neglected without interviewing or observing the child. (Insufficient evidence is equivalent to the legal standard of probable cause).

Unsubstantiated: The department shall consider a report unsubstantiated, after an investigation, when there is insufficient evidence to support a finding of abuse or neglect. (Insufficient evidence is equivalent to the legal standard of probable cause.)

Unsupervised Visit: A visit between a child in out-of-home placement and his parent/caretaker, sibling or other relative that is not directly visually monitored.

Unusual Incident: An occurrence that involves death, severe personal injury, an "Infant Doe" report, or property damage involving clients, their relatives or DES staff; high profile cases; any situation that may incur potential liability to the State of Arizona.

Visitation: Face-to-face contact between a child in out-of-home care and his parent/caregiver,

siblings, family members, other relatives, and other significant persons such as friends and former foster parents.

Visitation Facilitator: Any person who is designated by the case manager to monitor a visit between a child in out-of-home placement and the parent/ caretaker, sibling or other relative. This may include a parent aide, transportation worker, volunteer, psychologist, therapist, out-of-home care provider, extended family member or other party.

Visitation Guidelines for Parents: Information provided to parents which outlines agency expectations of the parent/caretaker regarding visitation.

Voluntary Agreement: A written agreement, for a period not to exceed 90 days, between the parent, guardian or caretaker and the DES. If the child is over 12 years of age and not developmentally disabled, the child must also agree to and sign the voluntary agreement, unless the department determines that voluntary placement of the child is clearly necessary to prevent abuse (ARS §8-806).

Volunteer: An individual who contributes time and services to the department without monetary compensation.

Window: A screen display used to view an application or document.

Written agreement: A written agreement between the department and the family is composed of a completed Case Plan, recorded in the Case Plan Directory.

Youth: See Child