

APPENDIX
Additional Guidelines Or Suggested Practices

PART IV: FAMILY ASSESSMENT AND INVESTIGATION

**SUGGESTED PRACTICES WHEN AUDIO TAPING AN INTERVIEW WITH A CHILD:
INCLUDING STORAGE, RETENTION, DUPLICATION AND EDITING AUDIO TAPES**

1.0 CPS Worker's Immediate Objectives

In order to accomplish the task of audio taping, the worker should always remember to be patient, observant, flexible and a good listener during the interview with a child. In conducting an audio taped interview with a victim child, the following goals may be met:

- a. Minimize trauma to the child
- b. Maximize the amount and quality of the information obtained while minimizing any contamination of that information
- c. Maintain the integrity of the investigation process for the agencies involved.

2.0 General Operating Procedure & Equipment

The worker, before each interview with the subject child, should ensure the audio taping equipment is in operating order.

- a. A new tape is to be used for each incident investigated.
- b. The worker may record more than one interview with the subject child on the tape; however, care needs to be taken to leave sufficient space between each interview.
- c. If the investigation involves more than one child, each child shall have his own tape. Each tape should be labeled and identified by the child's name, the date of the complaint, complaint number, the worker's name, location of the interview, and show the dates of all interviews included on the tape.
- d. Whenever possible, the worker should note the location on the tape of information related to identification of the complainant. This can be done by looking at the number on the tape counter on the tape recorder.

3.0 Pre-Interview Information Gathering

Prior to conducting the interview, the worker should gain as much information about the child and the alleged incident as possible. The worker should know the child's age, verbal skills, developmental level, and vocabulary. For example, if the allegation is sexual abuse, the worker should know if the child has any prior founded reports of sexual abuse and what are the names the child uses to describe body parts. Never assume that

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you know what a child means by the use of a particular word. Always ask if the meaning is not obvious. Make certain that you are using words and concepts which the child understands.

1.0 Location of Interview

Determine the location of the interview. It is preferable to interview the child in a neutral setting that provides privacy and no inward or outward stimuli or cause for interruption. However, there may be no opportunity when dealing with an emergency situation to have all these elements in place. Should the worker be faced with this, every effort should be made to incorporate as many of the above elements as possible.

2.0 Prepare Questions

Given the time allowed, the worker should plan the interview and write down some of the questions that he/she wants to ask the child.

3.0 Who may be Present for the Interview

- a. The worker has the authority to determine who is to be present during the interview.
- b. If an interview room is equipped with a two-way mirror or a video monitor, the worker may permit a parent, guardian, or therapist to observe the interview. Be sure that support is given to the parent(s) observing the interview.
- c. If the worker is investigating with a law enforcement officer, a decision should be made prior to conducting the interview who will be the lead interviewer. The person not interviewing may, instead, operate the tape recorder.
- d. It is preferable if a joint investigation is not being conducted, that only the child and the worker be present at the interview; however, should the child's comfort depend on another person being present in the room during the interview, the worker should impress on the person the importance of not interfering with the interview.
- e. All persons observing the interview should remain silent. Observers present in the room should be seated out of the visual site of the child. Observers be advised that they may hear information that could illicit a

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non-verbal reaction and that it is essential they show no reaction at all as it could contaminate the interview.

7.0 The Interviewing Worker Needs to be Aware of Circumstances

- a. The CPS worker should also be aware of their own reactions.
- b. The CPS worker should always be aware of the child's physical needs and capabilities such as:
 - (1) Attention span
 - (2) Nutritional requirements
 - (3) Body functions

For example, do not try to conduct the interview with a young child when they would normally nap or when it is time for them to eat.

- c. It is okay to allow the young child to draw, play with a toy, move about the room, etc. while the interview occurs.
- d. The CPS worker should always keep in mind that this is a fact finding interview not a therapeutic one, yet that does not mean the investigative interview needs to be a traumatic experience.

8.0 Beginning the Recording of the Interview

- a. After the recording device has been turned on, the interviewer should state the date, time, location, and names of those present in the room.
- b. The CPS worker should explain his/her role to the child and the role of anyone else present in the room and state the purpose of the interview.
- c. The worker should then engage the child in general conversation asking him to state his name and age. The worker may ask the child to talk about his favorite subject in school, a favorite hobby, or how they like to spend their free time. Have him describe a favorite event, i.e., last birthday or special trip. Here is where it is important to be flexible and know the child you are interviewing. For instance, if you are interviewing an older child, they may want to minimize this stage and get straight into the discussion of the allegation.

9.0 General Interviewing Questions & Techniques

- a. If I misunderstand something you say, please tell me. I want to know. I want to get it right.

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- b. If you don't understand something I say, please tell me and I will try again.
- c. If you feel uncomfortable at any time, please tell me or show me the stop sign (determine what that is to be).
- d. Even if you think I already know something, please tell me anyway.
- e. If you are not sure about an answer, please do not guess. Tell me you're not sure before you say it.
- f. Please remember when you are describing something to me that I was not there when it happened. The more you can tell me about what happened, the more I will understand what happened.
- g. Please remember that I will not get angry or upset with you.
- h. Only talk about things that are true and really happened.
- i. Stress that you, the interviewer, will follow these rules.

10.0 Determine the Child's Capacity for Truthfulness

The worker needs to determine the child's concept of telling the truth and lies. The worker should ask the child to describe the meaning of truth and the consequences of telling lies. If the child clearly does not have the concepts of truths and lies, the worker should continue the interview, but with caution.

11.0 Initiate Free Narrative

Introduce the topic of concern asking open-ended questions allowing the child to talk in a free narrative. Allow the child to go at their own pace. Do not interrupt the child. The child may be prompted by the worker by asking: "What happened next?" or "You were saying—relate the last thing they were saying." Do not interrupt the child no matter how verbose or inconsistent the story.

12.0 Ask Open-Ended Questions

After the child has exhausted his/her free narrative for one incident the worker may begin to ask open-ended questions. This will enable the worker to assist the child in recalling

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more details. If the child discloses a new incident, the worker should again allow the child to talk in the free narrative style about the new incident. Then begin the process of the open-ended questions again. An example of an open-ended question is: Do you remember any more about the time it happened in the kitchen?

When the worker is asking open questions, it is absolutely imperative that the child knows that, "I don't remember" is an acceptable answer.

13.0 Keep Track of Multiple Incidents or Allegations

Should the child disclose several incidents of abuse the worker may want to label them so that the worker can refer the child back to them in order to get more detail. (Labeling incidents should become readily apparent for example where the incident occurred may provide a label, i.e., the kitchen incident or the park incident.)

14.0 Use Specific Questions

The CPS worker may use specific questions. This would clarify and extend previous answers. This form of questioning is used when previous types of questioning has not resulted in getting sufficient information to assess the credibility of the allegations.

15.0 Avoid Multiple Choice Questions

The CPS worker should avoid multiple choice questions, but if you must use this type of question, include more than two choices. For example, did the park incident happen in the fall, winter, spring, or summer?

16.0 Avoid Using Other Sources When Asking Questions

The CPS worker should never include information he/she has obtained from another source. For example, do not begin a question with, "I understand from your mother that your Uncle Sam took some pictures of you." If you have been informed that the child was photographed, yet that information has not been forthcoming in the child's free narrative or during open questioning, you may ask, "Do you remember anything about some pictures?"

17.0 Address Inconsistencies Toward End of Interview

The CPS worker should address any inconsistencies in the child's statement toward the end of the interview. This is an area of questioning that should be approached cautiously and gently. If the child displayed language and/or knowledge that seems inappropriate

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for their age, this would be the time to determine where the child learned that knowledge of those words.

18.0 Ending the Interview

The worker should ask the child if he/she has any questions. The worker should explain to the child what will happen next in the investigation process.

19.0 Storing Audio Tapes

- a. Once the audio tape has been made, the worker should ensure it is properly labeled, as indicated earlier, then place the tape in an envelope, label the envelope with the case name, seal the envelope, and secure it to the case record.
- b. Tapes are to be stored in the case record for the same length of time as CPS policy requires for other case documentation. For example, in unfounded cases, tapes must be retained for one year from the complaint date. Tapes are required to be retained for longer periods in founded cases. (Level 3 – three years, Level 2 – seven years, and Level 1 – 18 years).

20.0 Who Can Receive Copies of the Taped Interviews?

- a. Interviews with the victim child can only be released during the appeals process. If a copy of the audio tape is needed, based on CPS policy governing the release of information during the appeal process, it must be determined if any statutorily protected information is contained on the tape. If so, a duplicate tape will be needed. (The original tape must never be redacted.) Identification of the area(s) to be edited, indicated by tape counter number(s), must be provided to the entity copying the tape. As an option, the local department may wish to type a transcript of the tape. This is not a requirement, however.
- b. Audio taped interviews with the alleged abuser can be duplicated by the local department by playing the audio tape on one tape recorder while recording the tape on a second tape recorder. Local departments also have the option of typing a transcript of the interview.

21.0 Redacting/Editing Sensitive Information from a Tape

The Department is investigating the option of entering into a contract with a professional service to copy and/or redact (edit) audio tapes. Should this occur, procedures will be developed and distributed to all local agencies. Until that time, the local agency is responsible for the editing of duplicate tapes. The original tape must never be edited.

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The worker is the most knowledgeable about the content of the tape and is therefore the most logical individual to edit the duplicate tape.

22.0 Reuse of Audio Tapes

Audio tapes are never to be reused. This would potentially compromise the tape being reused by possibly having the earlier interview “bleed through” on the next interview. It would also pose a privacy protection issue by having confidential tapes available for further use.

23.0 Destruction of Used Tapes

Once the length of time has passed for retaining the case record, from one to 18 years, depending on the disposition of the investigation, the audio tape(s) must be destroyed. A tape eraser box will be provided to each agency in order for tapes to be erased. Once erased, the tape cassettes should be broken, or the tape cut in order to ensure the complete eradication of information on the tape. Some tape recorders have an ‘erase’ feature that will void the information on the tape. This should be tested, however, to ensure it is actually erasing the tape.

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How To Proceed With Investigation When Initial Entry Into The Home Is Denied

1.0 Authority The worker has the authority to enter the home if permitted to enter by a person who resides in the home.

2.0 Alleviate Fear, Anxiety, Anger

The CPS worker should try to alleviate the fear and anxiety of the occupant, and/or defuse any anger. It is not appropriate to engage in a power struggle.

3.0 Alternatives to Immediate Entry

Should the CPS worker be denied entry, the CPS worker has several options:

- a. The CPS worker may suggest the occupant speak with them on the porch, deck, or in the yard, or even through the door, while at the same time acknowledging the feelings of the occupant (anger, fear, suspicion) in his reluctance to allow entry.
- b. The CPS worker may explain the law and the parameter of their responsibilities and mandates, and ask the occupant how the CPS worker may alleviate the skepticism or fear of the occupant so that then or in the future the CPS worker may be allowed to enter.
- c. The CPS worker may invite the occupant and any person of his choice (including an attorney) to meet with him first at the local DSS office, to further explain the CPS system.
- d. The CPS worker may suggest a first meeting at a neutral spot, such as a local fast-food restaurant, or other public place.
- e. The CPS worker may suggest a first meeting at a friend or family member's home, or a meeting in the occupant's home when a friend, neighbor or family member is present.
- f. The CPS worker may suggest mediation with the occupant to negotiate entry.
- g. The CPS worker may contact his supervisor for direction.
- h. The CPS worker may follow-up a denial of entry with a letter citing the Virginia Code responsibilities.

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**GUIDELINES FOR INVESTIGATIONS WHERE CHILDREN ARE ALLEGED TO BE PRESENT
DURING THE SALE OR MANUFACTURE OF DRUGS**

The intent of adding a clause to the definition of physical abuse, which was enacted by the General Assembly 2004, is to give recognition to the danger for children when a caretaker exposes the child to the manufacture or sale of drugs. The additional language in the definition references Schedule I & II controlled substances, which include, but are not limited to heroin, cocaine, and methamphetamines. Appendix A-11 provides a copy of Schedules I & II.

There is reason to be concerned about both the safety of the child and the CPS worker when there is the possibility that a “meth lab” is on the premises. The vapors may attack mucous membranes and some chemicals may react with water or other chemicals to cause a fire or explosion.

Since these situations may be dangerous, it is imperative that the local department of social services collaborate with local law enforcement and emergency services. CPS should not be the first on the scene if there is reason to believe someone may be manufacturing drugs on the premises. The following is a sample protocol developed by a locality in North Carolina that has experienced a large number of “meth lab” situations. It is offered for your consideration in developing your own local protocol.

**Response Protocol For Children Found In Clandestine Drug Lab Situations
Adopted by the Watauga County (North Carolina) Drug Endangered Child
Program on April 2, 2004**

1. In the event that a Clandestine Lab is about to be raided and there is a possibility of children in the residence law-enforcement will contact the Watauga County Department of Social Services to begin preparations for responding to the scene if children are found.
2. Watauga County DSS will place two social workers on standby prepared to respond to the scene if a lab is found and children are present.
3. After law-enforcement verifies a lab is found in a residence and children are present they will then contact Watauga County DSS to respond to the scene. Watauga County DSS will respond immediately.
4. Watauga County DSS will contact the Watauga County Fire Marshal's Office to report to the scene to assist in assessing for the need of on-site decontamination of the children.
5. The Watauga County Fire Marshal and Watauga County DSS will determine if decontamination on scene is needed by using The Decontamination Field Assessment.

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- 5A. If decontamination is needed on the scene for the children the Watauga County Fire Marshal will coordinate the needed procedures based on where the scene is in the county.
6. If decontamination is needed on scene and possibly if not needed Watauga County DSS will provide a change of clothes for the child.
7. Watauga County DSS will make a determination of whether a child needs to be placed into protective custody or if a placement with a safety agreement can be used.
- 7A. Placement in the home where a lab was found cannot occur under any circumstance until the home is cleaned, tested, and decontaminated using State prepared guidelines.
- 7B. The child will not be allowed to have contact with any item that was in the home where a meth lab was found due to contamination concerns.
8. After decontamination has been assessed or done the child will be transported to Watauga Medical Center for evaluation. Watauga County Medical Center requires decontamination at the emergency room prior to the child entering the hospital. Transportation will be provided either by Watauga County DSS, relative, or EMS (if there is a medical concern). The transportation concern will be assessed on a case-by-case basis.
- 8A. If the child is located at the scene and has been in the home within the past 72 hours or is displaying medical concerns the child does need to be taken to Watauga Medical Center for first or secondary decontamination and evaluation.
- 8B. If the child has not been in the home where the meth lab was located within the past 72 hours the child can be taken to their pediatrician for evaluation. 8B would be used in cases where the child was not found at the scene but was known to be living there and cases where the child has been out of the home for 72 hours. Also, 8B would be used in cases where children were found to be in the home with the lab but were unknown at the time the meth lab was found and 72 hours is passed.
- 8C. Someone with legal custody must be present at the emergency room or pediatrician office to sign for medical checks to be done. If parents are arrested then DSS may have to take custody to authorize medical evaluations.
9. Watauga County DSS will provide the physician at the Medical Center being used with a copy of the Medical Protocol developed by the Drug Endangered Child Program.
- 9A. Social Workers will need to make sure they get a copy of the Medical Protocol back after evaluations have completed. With each test that has been completed document the form. This is done so that social workers can provide information at the follow-up evaluations as to what testing was done for comparison data.
- 9B. All drug testing evidence will follow the chain of custody between physician/medical office and the drug testing lab they use.
10. After the child is released from the medical center the following steps will take place:

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10A. If DSS is not taking custody and using a Safety Plan a social worker will need to go to the placement resource and conduct the Kinship Care Assessment before allowing the child to stay there. This will also be done if DSS takes custody and places the child with a relative. Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future

10B. If D.S.S. takes custody of the child and is not using a relative placement the foster placement will be decided at this time. Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future.

11. Watauga County Department of Social Services accepts all cases where children are alleged to be in homes with meth labs as abuse. As soon as possible Watauga County DSS will submit written notification to the District Attorney a report of abuse.

12. Other steps that will be taken are:

- All the child's belongings will be replaced to protect from repeated contamination.
- The child will receive counseling services either through Individual Counseling, Family Counseling, or Family Preservation. Determination of which or all of the services to be used will be made on a case-by-case basis.
- The parents involved in meth lab production with their children present will take part in a Meth Lab Hazard Training provided by the Watauga County Fire Marshal. This needs to be done prior to any Substance Abuse Assessment.
- The parents will be required whether they are incarcerated or not to take part in a complete Substance Abuse Evaluation and follow all recommendations. If possible it is preferred that there be A Family Substance Abuse Assessment that includes the children. Use of the Family Substance Abuse Assessment will be determined based on relationship between child and parent and age of the child.
- Parents will have to take part in drug screens at DSS request and at the Substance Abuse Treatment provider's request.
- Children age 3 and under will need to have Developmental Evaluations performed.
- The child will need a follow-up medical evaluation at or around 30 days from the initial evaluation that was completed. At this evaluation hair samples will be taken if urine screens were negative at the initial medical evaluation.

Members of the response Team:

Watauga County Department of Social Services
Watauga County Sheriff's Department
New River Behavioral Health Care Substance Abuse Services
New River Behavioral Health Care Family Preservation
Watauga County Schools
The Watauga County Developmental Evaluation Center
New River Behavioral Health Care PACT Program
Blue Ridge Pediatric Clinic
Northwestern Housing HUD
Watauga County Office of Juvenile Justice
Watauga County Fire Marshal

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Mountain Times Newspaper
Watauga County District Attorney's Office
Watauga County Medical Center Emergency Room Staff
Watauga County Medical Center Infectious Disease Control
Watauga County EMS
Watauga County Health Department Early Childhood Intervention
Watauga County Health Department of Environmental Sciences
The Guardian ad Litem Program
Watauga County Foster Parents Representatives
Forensic Toxicologist Dr. Andrew Mason

Schedules I & II

(As referenced in §18.2-248)

§ 54.1-3446. Schedule I. The controlled substances listed in this section are included in Schedule I:

1. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Acetylmethadol; Allylprodine; Alphamethylfentanyl; Alphacetylmethadol (except levo-alpha-cetylmethadol, also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM); Alphameprodine; Alphamethadol;

Benzethidine; Betacetylmethadol; Betameprodine; Betamethadol; Betaprodine;
Clonitazene; Dextromoramide; Diampromide; Diethylthiambutene; Difenoxin;
Dimenoxadol; Dimepheptanol; Dimethylthiambutene; Dioxaphetylbutyrate; Dipipanone;

Ethylmethylthiambutene; Etonitazene; Etoxadine; Furethidine; Hydroxypethidine;
Ketobemidone; Levomoramide; Levophenacilmorphan; Morpheridine; Noracymethadol;
Norlevorphanol; Normethadone; Norpipanone; Phenadoxone; Phenampromide;
Phenomorphane; Phenoperidine; Piritramide; Proheptazine; Properidine; Propiram;
Racemoramide; Trimeperidine.

2. Any of the following opium derivatives, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:

Acetorphine; Acetyldihydrocodeine; Benzylmorphine; Codeine methylbromide; Codeine-N-Oxide; Cyprenorphine; Desomorphine; Dihydromorphine; Drotebanol; Etorphine;
Heroin; Hydromorphinol; Methyl-desorphine; Methyl-dihydromorphine; Morphine methylbromide; Morphine methylsulfonate; Morphine-N-Oxide; Myrophine;
Nicocodeine; Nicomorphine; Normorphine; Phoclodine; Thebacon.

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3. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this subdivision only, the term "isomer" includes the optical, position, and geometric isomers): Alpha-ethyltryptamine (some trade or other names: Monase; a-ethyl-1H-indole-3-ethanamine; 3-[2-aminobutyl] indole; a-ET; AET);

4-Bromo-2,5-dimethoxyphenethylamine (some trade or other names: 2-[4-bromo-2,5-dimethoxyphenyl]-1-aminoethane; alpha-desmethyl DOB; 2C-B; Nexus);

3,4-methylenedioxy amphetamine; 5-methoxy-3,4-methylenedioxy amphetamine; 3,4,5-trimethoxy amphetamine; Bufotenine; Diethyltryptamine; Dimethyltryptamine; 4-methyl-2,5-dimethoxyamphetamine; 2,5-dimethoxy-4-ethylamphetamine (DOET);

Ibogaine; Lysergic acid diethylamide; Mescaline; Parahexyl (some trade or other names: 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenzo [b,d] pyran; Synhexyl); Peyote; N-ethyl-3-piperidyl benzilate; N-methyl-3-piperidyl benzilate; Psilocybin; Psilocyn; Tetrahydrocannabinols, except as present in marijuana and dronabinol in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the U.S. Food and Drug Administration;

Hashish oil (some trade or other names: hash oil; liquid marijuana; liquid hashish); 2,5-dimethoxyamphetamine (some trade or other names: 2,5-dimethoxy-a-methylphenethylamine; 2,5-DMA); 3,4-methylenedioxymethamphetamine (MDMA), its optical, positional and geometric isomers, salts and salts of isomers; 3,4-methylenedioxy-N-ethylamphetamine (also known as N-ethyl-alpha-methyl-3,4 (methylenedioxy)phenethylamine, N-ethyl MDA, MDE, MDEA); 4-bromo-2,5-dimethoxyamphetamine (some trade or other names: 4-bromo-2,5-dimethoxy-a-methylphenethylamine; 4-bromo-2,5-DMA); 4-methoxyamphetamine (some trade or other names: 4-methoxy-a-methylphenethylamine; paramethoxyamphetamine; PMA); N-ethyl analog of phencyclidine; Pyrrolidine analog of phencyclidine; Thiophene analog of phencyclidine.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

Gamma hydroxybutyric acid (some other names include GHB; gamma hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutanoic acid; sodium oxybate; sodium oxybutyrate); Mecloqualone; Methaqualone.

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5. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

Aminorex (some trade or other names; aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4, 5-dihydro-5-phenyl-2-oxazolamine); Fenethylamine; Ethylamphetamine; Cathinone (some trade or other names: 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone, norephedrone), and any plant material from which Cathinone may be derived; Methcathinone (some other names: 2-(methylamino)-propiofenone; alpha-(methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-N-methylaminopropiophenone; monomethylpropion; ephedrone; N-methylcathinone; methylcathinone; AL-464; AL-422; AL-463 and UR 1432).

6. Any material, compound, mixture or preparation containing any quantity of the following substances:

3-methylfentanyl-(N-[3-methyl-1-(2-phenylethyl)-4-piperidyl] N-phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers; 1-methyl-4-phenyl-4-propionoxypiperidine (MPPP), its optical isomers, salts and salts of isomers; 1-(2-phenylethyl)-4-phenyl-4-acetyloxypiperidine (PEPAP), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-phenylethyl)-4-piperidyl]-N-phenylacetamide (acetyl-alpha-methylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-(2-thienyl)ethyl)-4 piperidyl]-N-phenylpropanamide (alpha-methylthiofentanyl), its optical isomers, salts and salts of isomers; N-[1-benzyl-4-piperidyl]-N-phenylpropanamide (benzylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-hydroxy-2-phenyl) ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxyfentanyl), its optical isomers, salts and salts of isomers; N-[3-methyl-1-(2-hydroxy-2-phenyl)ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxy-3-methylfentanyl), its optical and geometric isomers, salts and salts of isomers; N-[3-methyl-1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanamide (3-methylthiofentanyl), its optical and geometric isomers, salts and salts of isomers; N-[1-(2-thienyl)methyl-4-piperidyl]-N-phenylpropanamide(thenylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanamide(thiofentanyl), its optical isomers, salts and salts of isomers.

§ 54.1-3448. Schedule II.

The controlled substances listed in this section are included in Schedule II:

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1. Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrophan, nalbuphine, nalmefene, naloxone naltrexone and their respective salts, but including the following:

Raw opium; Opium extracts; Opium fluid extracts; Powdered opium; Granulated opium; Tincture of opium; Codeine; Ethylmorphine; Etorphine hydrochloride; Hydrocodone; Hydromorphone; Metopon; Morphine; Oxycodone; Oxymorphone; Thebaine.

Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in this subdivision, but not including the isoquinoline alkaloids of opium.

Opium poppy and poppy straw. Concentrate of poppy straw, the crude extract of poppy straw in either liquid, solid or powder form, which contains the phenanthrene alkaloids of the opium poppy.

Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine; cocaine or any salt or isomer thereof.

2. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Alfentanil; Alphaprodine; Anileridine; Bezitramide; Bulk dextropropoxyphene nondosage forms); Dihydrocodeine; Diphenoxylate; Fentanyl; Isomethadone; Levo-alpha-acetylmethadol (levo-alpha-acetylmethadol) (levomethadyl acetate) (LAAM); Levomethorphan; Levorphanol; Metazocine; Methadone; Methadone - Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane; Moramide - Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid; Pethidine; Pethidine - Intermediate - A, 4-cyano-1-methyl-4-phenylpiperidine; Pethidine - Intermediate - B, ethyl-4-

phenylpiperidine-4-carboxylate; Pethidine - Intermediate - C, 1-methyl-4-phenylpiperidine-4-carboxylic acid; Phenazocine; Piminodine; Racemethorphan; Racemorphan; Remifentanil.

APPENDIX
Additional Guidelines Or Suggested Practices

3. Any material, compound, mixture or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

Amphetamine, its salts, optical isomers, and salts of its optical isomers; Phenmetrazine and its salts; Any substance which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers; Methylphenidate.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

Amobarbital; Glutethimide; Secobarbital; Pentobarbital; Phencyclidine.

5. The following hallucinogenic substance: Nabilone.

6. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances which are immediate precursors to amphetamine and methamphetamine or phencyclidine: Phenylacetone; 1-phenylcyclohexylamine; 1-piperidinocyclohexanecarbonitrile.

APPENDIX
Additional Guidelines Or Suggested Practices

SAFETY ASSESSMENT Checklist

Family _____ **Worker** _____ **Date Completed** _____

Definition of Safety: The social worker perceives no immediate threat of severe harm to the child.

Elements underlying safety: THREAT, HARM, SEVERITY, VULNERABILITY, and IMMINENCE

SAFETY FACTORS	PROTECTIVE FACTORS
<p><input type="checkbox"/> Caretaker cannot meet child's basic needs for food, clothing and/or safe shelter.</p> <p><input type="checkbox"/> One or both caretakers cannot control behavior and/or are violent.</p> <p><input type="checkbox"/> Child sexual abuse is suspected.</p> <p><input type="checkbox"/> One or both caretakers perceive Child in predominately negative or unrealistic terms.</p> <p><input type="checkbox"/> Injury to child or threat of injury is severe.</p> <p><input type="checkbox"/> Caretaker(s) lacks knowledge, skill, or motivation to keep the child safe.</p> <p><input type="checkbox"/> Caretaker(s) refuses access to child or there is reason to believe they may flee.</p> <p><input type="checkbox"/> Living arrangements seriously endanger physical health of child.</p> <p><input type="checkbox"/> One or both caretakers failed to benefit from previous professional help related to safety issues</p> <p><input type="checkbox"/> Child is 0 to 6 years old.</p> <p><input type="checkbox"/> Child cannot protect self due to health or disability factors.</p> <p><input type="checkbox"/> Child has exceptional medical or emotional needs that caretaker cannot/will not meet.</p> <p><input type="checkbox"/> Child shows serious physical symptoms of maltreatment.</p> <p><input type="checkbox"/> Caretaker(s) overtly rejects any intervention.</p> <p><input type="checkbox"/> Explanation of child's injury is unconvincing or inconsistent.</p>	<p style="text-align: center;">• That Enable Caretakers to Protect:</p> <p><input type="checkbox"/> Caretaker can defer his/her own needs in order to meet the child's needs in timely, consistent, and effective manner.</p> <p><input type="checkbox"/> Caretaker intended to hurt child but shows remorse and expresses desire to prevent any future injury to child.</p> <p><input type="checkbox"/> Caretaker accepts and demonstrates the responsibility to nurture and provide for the well being of the child – shows skills associated with meeting these needs.</p> <p><input type="checkbox"/> Caretaker has the physical ability to intervene and/or has intervened in past to keep child safe from others.</p> <p><input type="checkbox"/> Caretaker demonstrates control of negative impulses or personal behaviors</p> <p><input type="checkbox"/> One caretaker can and will protect child from violent behavior or other caretaker.</p> <p><input type="checkbox"/> One or both caretakers demonstrate healthy emotional bonding with child</p> <p><input type="checkbox"/> At least one caretaker perceives child in predominately positive or realistic terms.</p> <p><input type="checkbox"/> Caretaker is facilitating access by CPS to child.</p> <p><input type="checkbox"/> Caretaker(s) is receptive to intervention.</p> <p><input type="checkbox"/> Caretaker can identify actions that are required to prevent harm to child</p> <p><input type="checkbox"/> Caretaker has capacity to learn from an experience and apply it to a new situation.</p> <p style="text-align: center;">• That Decrease Child's Vulnerability:</p> <p><input type="checkbox"/> Child is over 6 years old and has access to at least one person willing to provide protection</p>

APPENDIX
Additional Guidelines Or Suggested Practices

<p><input type="checkbox"/> Child is fearful of caretaker(s) or home situation.</p> <p><input type="checkbox"/> Caretaker(s) whereabouts are unknown.</p> <p><input type="checkbox"/> Paramour or other adult unrelated to child is serving as caretaker.</p> <p><input type="checkbox"/> Caretaker's alleged/observed substance use may affect his/her ability to protect or care for the child.</p> <p><input type="checkbox"/> Caretaker's alleged/observed mental illness may affect his/her ability to protect or care for the child.</p> <p><input type="checkbox"/> Caretaker may be perpetrator or victim of DV to extent that child is at risk of serious, imminent harm.</p> <p><input type="checkbox"/> Caretaker intended to hurt child and does not show remorse.</p>	<p><input type="checkbox"/> Explanation of child's injury is convincing and consistent.</p> <p><input type="checkbox"/> Injury to child is not severe or imminent.</p> <p><input type="checkbox"/> Observation of interactions of the child and the adult are appropriate.</p> <p><input type="checkbox"/> Living arrangements that endangered physical health of child have been ameliorated.</p> <p><input type="checkbox"/> Child with special needs is connected to appropriate services to meet those needs</p> <p style="text-align: center;">• That Enable Others to Protect:</p> <p><input type="checkbox"/> Paramour or other adult unrelated to child and serving as caretaker expresses strong attachment to the child.</p> <p><input type="checkbox"/> Child sexual abuse is suspected but uninvolved caretaker is supportive and will protect child.</p> <p><input type="checkbox"/> Family can meet child's basic needs for food, clothing and/or safe shelter</p> <p><input type="checkbox"/> Family member or friend has agreed to take an active part in protection of the child.</p> <p style="text-align: center;">• Other Protective Factors:</p>
--	---

SAFETY DECISION:

A. Safe

There are no children likely to be in immediate danger of moderate to serious harm.

B. Conditionally Safe

Safety interventions are in place and have resolved the Unsafe situation for the present time. (See required SAFETY PLAN)

C. Unsafe

Without controlling intervention(s) a child is in immediate danger of moderate to serious harm. Emergency removal or court action is required to insure safety of the child(ren).

Action(s) Taken:

APPENDIX
Additional Guidelines Or Suggested Practices

SAFETY ASSESSMENT CHECKLIST
INSTRUCTIONS

How to use this form: All valid CPS reports must have a Safety Assessment Checklist on file after the first meaningful contact of the Investigation or Family Assessment. (A copy may be given to the family, but this is not required.) The purpose of the checklist is to provide a quick and consistent method of documenting the initial safety assessment that has been required in all Investigations in Virginia for over a decade.

1. The Date Completed of the Initial Assessment is documented in OASIS and must be the date on the form. The checklist is to be completed as soon as possible after receiving a valid report.
2. The Definition communicates that the Safety Assessment is about imminent threats of severe harm that need to be controlled in order for the child to be safe now and for the short-term.
3. Safety Factors are behaviors or conditions that cause a threat of immediate harm. Any factors identified should be checked. If none are identified, simply check the "Safe" Safety Decision below.
4. Protective Factors are behaviors or resources within a family or community that can control the threats of harm, at least for the short-term. If any Safety Factor is checked, there must be a Protective Factor to balance it in order for the child to be deemed Safe or Conditionally Safe.
5. One of the Safety Decisions must be checked and must be supported by the items checked in the Safety and Protective Factor columns. If all children in the home are "Safe" no other action is required. If any child in the home is "Conditionally Safe" there must be a Safety Plan. If any child is "Unsafe" a Safety Plan documenting immediate action or a Court Order is required.
6. The Actions Taken section can be used to describe activities of the parent or social worker that prevent the need for intervention or precede the initiation of the Safety Plan.
7. The form is carbonized so that a copy may be given to the family, but this is not required if it is not in the best interests of the child.

APPENDIX
Additional Guidelines Or Suggested Practices

SAFETY PLAN

AGENCY: _____ DATE: _____

PARENT(S)/CARETAKER(S): _____ CHILD(REN): _____

Initial Report, Related to Child Safety: _____

Summary of safety factors identified and any protective factors that address the safety concerns: _____

Immediate Needs identified by family and/or social worker: _____

Caretaker(s) actions/referrals/safety plan: _____

Social Worker plans/actions: _____

Caretaker(s) _____ Date _____

Social Worker _____ Date _____

Others _____

APPENDIX
Additional Guidelines Or Suggested Practices

SAFETY PLAN
INSTRUCTIONS

How to use this form: This form is intended to be used with the family to determine and document what is needed to keep a child or all the children in the home safe for a limited amount of time. It is designed to be used in conjunction with the Safety Assessment Checklist, and is required to be completed if the Safety Decision is Conditionally Safe or Unsafe. (A court order can substitute for the Plan when the child is deemed Unsafe and court intervention is needed.)

1. The first Date should correspond to the Date on the Safety Assessment Checklist.
2. The Child Safety Concerns will usually briefly state the allegations in the complaint. However, if the CPS worker immediately identifies other concerns upon first meaningful contact, these should be included here.
3. Initial Assessment of Safety provides space to briefly note the primary safety concerns and any balancing protective factors identified on the Safety Assessment Checklist.
4. Immediate Needs should relate to needs that must be met in order to keep the children safe, not generic needs that may be expressed by family members and met through a prevention case opening or referral.
5. Steps to Be Taken by Caretaker again refers to steps or actions needed to keep the children safe, not a full-blown service plan that may address a multitude of needs and services.
6. Social Worker Plans/Actions should list any actions the worker has agreed to take to keep the child(ren) safe. This is also the place to note any consequences the worker must take if the Caretaker does not follow through on agreed upon steps listed in # 5.
7. Signature lines are provided so that this form can be an agreement for short-term actions to be taken by all parties to keep the child(ren) safe.

A copy of the form shall be provided to the caretaker and any other parties to the plan. (It has an original and two copies and can be photocopied.)

APPENDIX
Additional Guidelines Or Suggested Practices

FAMILY NEEDS ASSESSMENT

I. IDENTIFYING INFORMATION

Family Name: _____ Number: _____
Referral Date: _____ Assessment Date: _____
Social Worker: _____ Locality: _____

II. REASON FOR ASSESSMENT

III. MAJOR ASSESSMENT FACTORS

CHILD(REN)

Address at least child's age, development, functioning, temperament, relations with caretaker and others, any history of A/N, other significant child-related issues.

Strengths or Protective Factors:

Services Needs or Interventions:

APPENDIX
Additional Guidelines Or Suggested Practices

PARENT/CARETAKER(S)

Address at least parents' physical, emotional and intellectual status, any history of A/N, any DV, any substance abuse, parenting strengths & concerns, other significant parent-related issues

Strengths or Protective Factors:

Services Needs or Interventions:

ENVIRONMENT

Address living conditions, including the home, neighborhood

Strengths or Protective Factors:

SERVICES NEEDS OR INTERVENTIONS:

APPENDIX
Additional Guidelines Or Suggested Practices

SUPPORT SYSTEMS

Address formal and informal supports, such as family, neighbors, community organizations and service providers. Also address resource utilization issues, such as finances, transportation, child care, etc.

Strengths or Protective Factors:

SERVICES NEEDS OR INTERVENTIONS:

IV. RISK ASSESSMENT

CONSIDERING ALL THE IDENTIFIED STRENGTHS AND NEEDS, WHAT IS THE LIKELIHOOD OF PHYSICAL, EMOTIONAL, OR SEXUAL HARM TO THE CHILD(REN) IN THIS FAMILY? (EXPLAIN AND CHECK THE APPROPRIATE DEGREE OF RISK BELOW.)

- No Reasonably Assessable Risk**
Child(ren) not in jeopardy; no intervention needed
- Moderate Risk**
Possible jeopardy; possible change likely to occur with minimal intervention
- High Risk**
Child(ren) in jeopardy; intervention needed in order for child to be protected from abuse/neglect

Is a plan needed to ensure the protection of one or more children and/or to prevent future abuse/neglect?

If Yes – see Family Service Agreement

If No – Note any referrals or services requested that do not relate to protection of children

APPENDIX
Additional Guidelines Or Suggested Practices

V. PARENT/CARETAKER PERCEPTIONS OR OPINIONS REGARDING THE FAMILY'S SITUATION, NEEDS & RESOURCES

VI. PARENT/CARETAKER COLLABORATION
Check the following as appropriate:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	FNA discussed/reviewed with caretaker
<input type="checkbox"/>	<input type="checkbox"/>	Copy of FNA given to caretaker
<input type="checkbox"/>	<input type="checkbox"/>	Caretaker desires services
<input type="checkbox"/>	<input type="checkbox"/>	Family Service Agreement attached
<input type="checkbox"/>	<input type="checkbox"/>	Caretaker declines services
<input type="checkbox"/>	<input type="checkbox"/>	No services needed

Parent/Caretaker: _____	Date: _____
Parent/Caretaker: _____	Date: _____
Social Worker: _____	Date: _____
Other Person Involved in the Assessment: _____	Date: _____
Other Person Involved in the Assessment: _____	Date: _____
Social Work Supervisor: _____	Date: _____

APPENDIX Additional Guidelines Or Suggested Practices

INSTRUCTIONS

How to use this form: This is a form developed by the Virginia Department of Social Services to facilitate the Family Assessment process. Its use is optional, but agencies that choose to use it should be clear with staff about its purpose. The space for writing is designed for brevity. If the worker will be using the form as a note-taking tool, there is ample space. If the form will be used with the family and signed by participants in the assessment process, the worker will need to give thought as to wording and capturing only the most important points discussed and agreed upon.

I. IDENTIFYING INFORMATION

The items in this section are self-explanatory. The Assessment Date should be no later than 45 days (or 60 days if extended) from the Referral Date.

II. REASON FOR ASSESSMENT

Summarize the report and any additional information that provides the rationale for completing an assessment with the family.

III. ASSESSMENT FACTORS

A comprehensive family assessment should address at least the family's strengths and needs related to the following issues:

- Child(ren): age and ability to self-protect; presence of any disability or developmental delay; temperament; responsiveness to caretaker(s); prior history of abuse/neglect.
- Parent/caretaker: physical, emotional, and intellectual status; prior history of abuse/neglect; potential for violence; substance abuse or dependency; neglectful acts or omissions, allegations of abuse/neglect.
- Environment: any hazardous living conditions. Domestic violence may be included here or in the Caretaker section.
- Support Systems: informal and formal available or needed; resource utilization.

Information in this section is provided as a result of interviews with and/or observation of the child(ren) in the home, the alleged abuser, other household members and pertinent collaterals.

Describe behaviors, interactions, conditions that increase or decrease the likelihood of abuse or neglect of any or all children in the home, as reported by family or collaterals or observed by the social worker. There is space to record the strengths or protective capacities currently being utilized to protect the child(ren) or that could be mobilized to ensure child safety and enhance family functioning. There is also space to identify any needs for services or other interventions to reduce the risk of abuse or neglect. If no need is identified, Not Applicable (N/A) is acceptable.

APPENDIX
Additional Guidelines Or Suggested Practices

The Family Service Agreement will be based on the needs identified. Services and expected results should directly relate to the needs.

IV. RISK ASSESSMENT

The decision on risk of future harm should be based on the assessment of individual, family, and other risk factors. Any service planning with and service provision to the family should be based on the needs and resources identified in the overall Family Assessment. The outcome of the Risk Assessment will influence the type and intensity of services to be provided.

V. PARENT/CARETAKER PERCEPTIONS OR OPINIONS

The purpose of this section is to provide a description of the caretaker's views and response to the allegations, the assessment, and the proffered services, if any.

VI. PARENT/CARETAKER COLLABORATION

This section provides an opportunity to document the caretaker(s)' involvement in the needs assessment. It also provides a place to document the acceptance or refusal of services or that no services appear to be needed at this time.

SIGNATURES

Since this is an optional form, all the signatures are optional. If the form is used as a base for the Family Service Agreement or to document that the caretaker declined services, signatures of at least the caretaker and worker are needed. The others are provided to be used at the discretion of the agency.

APPENDIX
Additional Guidelines Or Suggested Practices

Who	What	When	Where	Why

Comments or other information:

This **agreement will be reviewed on** _____ (date) or sooner if requested earlier by local department, family, or service provider.

This is not a legally binding document. However, it is:

_ A statement of mutually identified child and family service needs, agreed to by the family and the local department of social services and others.

And/Or

_ Notice to the family of child safety concerns and needed actions/services to protect the child(ren), prevent abuse or neglect, and/or strengthen the family.

Parent/Caretaker Date

Parent/Caretaker Date

Social Worker Date

Service Provider Date

Other Resource Date

APPENDIX
Additional Guidelines Or Suggested Practices

**FAMILY SERVICE AGREEMENT
INSTRUCTIONS**

How to use this form: This form is required when services are to be provided as a result of a CPS Family Assessment. All parties to the plan should sign and date the agreement and receive a copy of the agreement. This form may be used as a Service Application Form.

Family Name: Complete name of head of household.
CASE NUMBER: OASIS OR LOCALLY ASSIGNED NUMBER
Social Worker: Name of the assigned social worker
Locality: Name of the local department of social services

Check Primary Goal: Check one goal and write in the anticipated date of achievement.

Immediate and Long-Term Needs:

Although the worker and the family may identify many needs, the worker must assist the family to prioritize so that the family is not overwhelmed. Addressing no more than three short-term and three long-term needs at any given time will enhance the likelihood of a successful outcome.

Immediate needs will describe actions or services needed to keep the child(ren) safe or to address an issue the family has identified as very important to them.

Long-term needs will describe actions or services that cannot be accomplished quickly but are essential to address underlying causative factors, such as drug treatment.

Who: Write in the name or initials of the person(s) who is to participate in the service or action

What: Describe the service or name the service provider

When: Note the date the service is to begin

Where: Either write "in home" or give the location where the service will be delivered

Why: Describe the expected change or result related to this service

Comments or other information:

May use this space for any pertinent information needed to expedite the plan, such as transportation arrangements, who to call to set up the service, etc.

APPENDIX
Additional Guidelines Or Suggested Practices

Agreement review date:

Note the date that the worker and family will evaluate the plan - should be no later than three months from the date the plan is initiated.

Check statement when all parties agree to the plan. Check notice when parties cannot agree but a plan is required to protect the child.

APPENDIX
Additional Guidelines Or Suggested Practices

INITIAL SCREENING ASSESSMENT

Domestic Violence

Ask the client:

Is there a person in your life who might do any of the following:

1. Physically hurt you or threaten to hurt you or someone else close to you?

Yes No Don't know

2. Check up on you or follow you?

Yes No Don't know

3. Make all or most decisions for you?

Yes No Don't know

4. Withhold money for food, clothing, or other needs?

Yes No Don't know

5. Tell you who you can see or talk to?

Yes No Don't know

6. Tell you where you can go?

Yes No Don't know

If the client answers YES to any of these questions, a referral for a more complete assessment or for domestic violence services is indicated.

APPENDIX
Additional Guidelines Or Suggested Practices

AOD SCREENING TOOL

(CAGE Instrument adapted to include Drugs – CAGEAID)

Ask:

- Have you ever felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

A “yes” answer to any of these questions indicates the probable need to refer for a more in-depth evaluation of drug and/or alcohol use.

APPENDIX
Additional Guidelines Or Suggested Practices

INITIAL SCREENING ASSESSMENT
Domestic Violence

Ask the client:

Is there a person in your life who might do any of the following:

7. Physically hurt you or threaten to hurt you or someone else close to you?

Yes No Don't know

8. Check up on you or follow you?

Yes No Don't know

9. Make all or most decisions for you?

Yes No Don't know

10. Withhold money for food, clothing, or other needs?

Yes No Don't know

11. Tell you who you can see or talk to?

Yes No Don't know

12. Tell you where you can go?

Yes No Don't know

If the client answers YES to any of these questions, a referral for a more complete assessment or for domestic violence services is indicated.



RECEIVED

APR 30 2010

OFFICE OF THE COMMISSIONER
DEPT. OF SOCIAL SERVICES

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

JAMES W. STEWART, III
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

April 21, 2010

Margaret Schultze, Interim Commissioner
Department of Social Services
801 E. Main Street
Richmond, VA 23219-2901

Dear Ms. Schultze:

In 2004, the Individuals with Disabilities Education Improvement Act reauthorized and made changes to the early intervention program for infants and toddlers with disabilities and their families under Part C of the Individuals with Disabilities Education Act (IDEA). In order to address the 2004 changes to Part C and accurately reflect the current Part C system in the Commonwealth, it is necessary to revise Virginia's Memorandum of Agreement Among the Agencies Involved in the Implementation of Part H of the Individuals with Disabilities Education Act (IDEA) to Meet Full Implementation Requirements, which was signed in September 1996.

Section 640 of the 2004 statute reauthorizing Part C provides stronger and more specific requirements associated with the State interagency agreement than did previous legislation. States are required to have an interagency agreement or other mechanism for interagency coordination in effect between each public agency and the designated lead agency, the Department of Behavioral Health and Development Services (DBHDS) in order to ensure:

- The provision of, and financial responsibility for, services provided under Part C; and
- Such services are consistent with the requirements for a statewide system under Part C and statewide assurances, including provision of such services during pendency of any dispute.

The interagency agreement must include all additional components necessary to ensure meaningful cooperation and coordination and must be consistent with the terms and conditions of the State's agreement for Part B of IDEA. The revised agreements for Part C will be submitted to the U.S. Department of Education along with Virginia's annual Part C Application due May 10, 2010.

Margaret Schultze
April 21, 2010
Page 2

If you have questions please feel free to contact Mary Ann Discenza at maryann.discenza@dbhds.virginia.gov or at 804-371-6592. I appreciate your continued commitment to Virginia's Part C early intervention system.

Sincerely,

A handwritten signature in black ink, appearing to read "James W. Stewart, III". The signature is fluid and cursive, with a prominent horizontal line at the end.

James W. Stewart, III
Commissioner

Copy: Frank L. Tetrick, III
Janet S. Lung
Mary Ann Discenza

**Virginia Interagency Memorandum of Agreement
Among the Agencies Involved in the Implementation
of Part C of the Individuals with Disabilities Education
Act (IDEA)**



**Infant & Toddler
Connection of Virginia**

Parties to the Agreement:

**Department of Behavioral Health and Developmental Services
Department of Education
Department of Health
Department of Medical Assistance Services
Department of Social Services
Department for the Deaf and Hard-of-Hearing
Department for the Blind and Vision Impaired
Virginia Office for Protection and Advocacy
State Corporation Commission – Bureau of Insurance**

May 2010

I. PURPOSE

This agreement among the parties, hereinafter referred to as "participating agencies", documents the understandings and commitments of the participating agencies to meet the statutory and regulatory requirements of Part C of the Individuals with Disabilities Education Act (IDEA) and the Virginia statutory requirements related to Part C.

The purpose of this agreement is to ensure collaboration and coordination in the implementation of Virginia's statewide, comprehensive, family-centered system of Part C early intervention supports and services for infants and toddlers with disabilities and their families. It is the intent of this agreement to ensure optimal use of resources and prevent duplication of effort by detailing each participating agency's commitment and financial responsibility related to Part C systems components (e.g., public awareness, child find, data collection, training) and provision of Part C early intervention supports and services. This agreement replaces the agreement signed in 1996.

II. PARTIES TO AGREEMENT

The parties to this agreement are the participating agencies set forth in Virginia Code § 2.2-5300.

III. AUTHORITY

Virginia Code §§ 2.2-5303

IV. FUNDAMENTAL PRINCIPLES

The participating agencies shall coordinate and implement a comprehensive system of early intervention supports and services that shall be:

- A. Family-centered
 1. Parents/caregivers shall be the primary agents of change in their child's development.
 2. Families identify outcomes that are important to them and how supports and services can fit into the family's life and build effectively on the resources and supports already in place.
 3. The focus of supports and services shall be on increasing the child's participation in family and community activities identified by the family.
 4. Language and cultural differences shall be respected and appropriately addressed.
- B. Accessible
 1. All eligible infants, toddlers and their families shall be identified and referred to the Part C early intervention system as soon as a delay or disability is suspected.
 2. Supports and services shall begin in a timely manner.
 3. Ability to pay shall not be a barrier to receiving supports and services.
- C. Community-based
 1. Supports and services shall be individualized and provided within the context of and integrated into the everyday routines, activities and environments of each child and family.
 2. Children with disabilities are children first and to the extent possible shall be enabled to participate in the full range of activities in integrated settings with their typically developing peers.
- D. Coordinated
 1. Interagency coordination shall ensure the responsible use of public money.
 2. Service coordination shall ensure that children and families receive necessary supports and services and reduce duplication of effort.
- E. Effective
 1. Family involvement and support is a critical component of effective services for children.

2. Supports and services shall reflect evidence-based practice.
3. Outcomes shall be measured and monitored to determine the effectiveness of early intervention supports and services in making a positive impact on children and families.
4. System improvement shall be ongoing and based on timely and accurate data
5. Stakeholders shall have access to state and local performance data in accordance with applicable federal and state confidentiality laws.

V. DEFINITION OF TARGET POPULATION

Part C early intervention supports and services shall be available to all eligible infants and toddlers with disabilities and their families, including Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in Virginia, infants and toddlers with disabilities who are homeless children and their families, and infants and toddlers with disabilities who are wards of the State. In Virginia, children are eligible if they have (1) a 25% delay in one or more areas of development; (2) atypical development; or (3) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

VI. MUTUAL AGREEMENTS

All participating state agencies agree to the following:

A. General Agreements

Each participating agency shall:

1. Designate a representative with sufficient authority to engage in policy planning and implementation on behalf of the agency to participate on the Virginia Interagency Coordinating Council (VICC);
2. Provide leadership, direction and coordination, as appropriate, regarding the local planning and provision of services to children and families;
3. Assist local counterparts, if any, in fulfilling their obligations to children and families;
4. Assist in the development of local agreements that will provide guidance to local interagency collaborative efforts;
5. Coordinate the provision of Part C system components and supports and services to avoid duplication of effort;
6. Share and review any contemplated policies related to services for infants, toddlers and their families with the other participating agencies; and
7. Share information about resources that are available within each agency that are mutually helpful. Resources may include material, staff expertise, space, data, training, and/or technology.

B. Financial Agreements

Each participating agency shall:

1. Jointly identify and coordinate use of all available public and private resources to ensure availability of supports and services to all eligible children and their families and to ensure Part C funds are used as payor of last resort;
2. Provide the State Lead Agency annually with expenditure and budget information as part of the annual assessment of State Part C expenditures inclusive of Medicaid and for calculation of maintenance of effort;
3. Adhere to Part C's maintenance of effort requirements within its agency's financial expenditures, in addition to the State's aggregate expenditures;
4. Assure a clear audit trail for all Part C income and expenditures as required by Federal law;
5. Ensure that State and Federal Part C funds are not used for children past their third birthday;
6. Abide by the Part C requirement that the following Part C system functions and services are provided at no cost to families:
 - a. Child find;

- b. Evaluation for eligibility determination and assessment;
 - c. Service coordination; and
 - d. Administrative and coordinative activities related to the development, review and evaluation of Individualized Family Service Plans (IFSPs) and implementation of procedural safeguards;
7. Follow the Family Cost Participation procedures, as identified in the *Infant & Toddler Connection of Virginia Practice Manual*, when providing Part C supports and services to ensure that the inability of the parents of an eligible child to pay for services will not result in the denial of Part C early intervention services to the child or the child's family; and
 8. Assist in the development of joint agency budget requests when appropriate.

C. Service Delivery Agreements

Each participating agency shall:

1. Disseminate Part C public awareness materials, including, but not limited to, posters and brochures, during conferences, trainings, and other contacts involving the general public or professionals who have contact with and/or coordinate the medical or developmental care of young children and families or pregnant women;
2. Participate in child find activities designed to locate and identify children who may be eligible for Part C supports and services;
3. Refer and/or require local counterparts to refer all potentially eligible infants, toddlers and their families to the Infant & Toddler Connection of Virginia through the appropriate local single point of entry as soon as possible after identifying the child as potentially eligible;
4. Follow all Part C procedural safeguards, including confidentiality requirements, as identified in Virginia's Part C Policies and Procedures, during eligibility determination, assessment, individualized family service plan (IFSP) development, and the provision of supports and services;
5. Provide information to parents about ways to connect to family support resources, including related agencies, services, training, support groups, advocacy organizations and family leadership opportunities;
6. Support culturally diverse approaches to service delivery that reflect sensitivity to the different cultures involved in the Infant & Toddler Connection of Virginia system;
7. Make efforts to enhance the capacity of the participating agencies and their local providers to identify, assess, and meet the needs of under represented groups, including low income and minority populations, homeless children and families, wards of Virginia, and Indian children and families living on reservations;
8. Share information about eligible children and their families, to the extent consistent with State and Federal confidentiality requirements, including the requirements of the Health Information Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), in order to get accurate and unduplicated counts to meet Federal reporting requirements and to facilitate the effective and efficient delivery of services; and
9. For participating agencies that provide Part C services either directly or through local counterparts:
 - a. Ensure, to the maximum extent appropriate for each child, all early intervention services are provided in natural environments, which mean settings that are natural or normal for the child's age peers who have no disabilities. Early intervention services can occur in a setting other than a natural environment only if early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment and if the child's IFSP includes a (child-based) reason why the service can not be provided in a natural environment.
 - b. Ensure the timely start of services, within 30 calendar days of the date the family signs the Individualized Family Service Plan (IFSP), unless the IFSP

team determines that a later start date is necessary to meet the child's or family's needs.

D. Personnel Development, Training and Technical Assistance Agreements

Each participating agency shall:

1. Collaborate in planning, developing, and conducting training and providing technical assistance for service providers and families. Coordination of efforts will include, but not be limited to:
 - a. Sharing needs assessments;
 - b. Offering cooperatively sponsored or jointly attended training activities;
 - c. Blending funding streams for training when applicable policies allow;
 - d. Posting training events on the "Early Childhood Meeting Place;" and
 - e. Collaborating on scheduling, evaluation of training, and disseminating information about planned training;
2. Ensure trainings offered reflect culturally competent practices and promote family-centered practices; and
3. Encourage parental involvement in the planning and implementation of training, including parents as trainers and co-trainers.

E. Monitoring and Supervision Agreements

Each participating agency shall:

1. Participate in monitoring and supervision activities for the Infant & Toddler Connection of Virginia. Activities may include, but are not limited to:
 - a. Analysis of data for the purpose of monitoring, supervision and/or system planning and improvement;
 - b. On-site visits with local systems;
 - c. Fiscal monitoring and verification;
 - d. Desk audits;
2. Support local counterparts in the implementation of corrective action plans and service enhancement plans; and
3. Share results from agency/program monitoring or other quality assurance activities upon request.

VI. TRANSITION AGREEMENT BETWEEN THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES AND THE DEPARTMENT OF EDUCATION

In Virginia, children who reach the age of two on or before September 30 of any given year and who meet Part B eligibility requirements as defined in the *Code of Virginia* and in accordance with the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* are eligible to receive special education and related services through their local school divisions. In order to ensure a smooth and timely transition for children exiting the Infant & Toddler Connection of Virginia:

A. The Department of Behavioral Health and Developmental Services (DBHDS) shall:

1. Require local lead agencies, through the Local Contract for Participation in Part C, to:
 - a. Develop local interagency agreements with local school divisions that specify local roles and responsibilities for participation on the local interagency coordinating council and for accomplishing the transition planning and activities required under Part C and Part B of IDEA;
 - b. Ensure transition is discussed with the family at each IFSP meeting, beginning with the initial IFSP, and that appropriate transition steps and services to support a smooth transition are documented on each child's IFSP;
 - c. Notify the local school division of children residing in the community who are potentially eligible for Part B services by transmitting each child's name,

- address, phone number and birth date to the local school division as the child nears the age of eligibility for Part B;
- d. Refer children who are potentially eligible for Part B to the local school division, with parent consent, by April 1 or as soon as the parent gives consent, and transfer child-specific information (including eligibility and assessment information and copies of IFSPs) to ensure continuity of services;
 - e. Coordinate and ensure Part C participation in an individual transition planning conference between the family, the local Part C system and the local school division at least 90 days and no more than 9 months before the child's third birthday or the date on which the child will be eligible under Part B of IDEA. The purpose of the transition conference is to review the child's program options for the period from the third birthday through the remainder of the school year and establish a transition plan in accordance with requirements in Section 637 of the IDEA; and
 - f. Make reasonable efforts to convene a conference, with the approval of the family, among the local Part C system, the family, and providers of other appropriate services for children who may not be eligible for Part B services;
2. Share data including, but not limited to, the following:
 - a. Child outcome data, with parent consent; and
 - b. Other data as appropriate to meet reporting needs and improve services; and
 3. Work collaboratively with the Department of Education (DOE) towards a common identifier in the Part C and Part B data systems that will facilitate sharing of data and longitudinal tracking and data collection.

B. The Department of Education shall:

1. Require local school divisions to:
 - a. Enter into local interagency agreements with the Part C local lead agency to specify local roles and responsibilities for accomplishing the transition planning and activities required under Part C and Part B of IDEA;
 - b. Accept notification from the local Part C system of children who are residing in the community who are potentially eligible for Part B services;
 - c. Process referrals, including child-specific information from the local Part C system at any time during the calendar year, if the parent consents;
 - d. Participate in the individual transition planning conference between the family, the local Part C system and the local school division at least 90 days and no more than 9 months before the child's third birthday or the date on which the child will be eligible under Part B of IDEA;
 - e. Review the assessment data transmitted from the Infant & Toddler Connection of Virginia to determine if it is appropriate or sufficient to assist in determining the eligibility of a particular child for special education and related services. The local school division shall utilize this information whenever appropriate to avoid unnecessary reassessment and delays in services;
 - f. Invite the Part C service coordinator or other Part C representative to the initial Individualized Education Plan (IEP) meeting if the parent so requests;
 - g. Consider the child's IFSP when developing the initial IEP;
 - h. Develop an initial IEP specifying the child's program as of his/her third birthday or the earlier date on which the child is eligible to begin Part B services (e.g., the beginning of the school year in which the child is 2 years old by September 30); and
 - i. Accept financial responsibility of all special education and related services to an eligible child on the child's third birthday or the earlier date on which the child is eligible to begin Part B services (e.g., the beginning of the school year in which the child is 2 years old by September 30);

2. Share data including, but not limited to, the following:
 - a. Child outcome data, with parent consent;
 - b. Verified Section 618 child count data on children under three served through Part B to DBHDS in January of each year for reporting to OSEP; and
 - c. Other data as appropriate to meet reporting needs and improve services; and
3. Work collaboratively with DBHDS toward a common identifier in the Part C and Part B data systems that will facilitate sharing of data and longitudinal tracking and data collection.

VII. AGENCY-SPECIFIC AGREEMENTS

A. The Department of Behavioral Health and Developmental Services (DBHDS) shall:

1. Fulfill the responsibilities of State Lead Agency by:
 - a. Serving as a single line of responsibility for the Infant & Toddler Connection of Virginia system;
 - b. Administering the Infant & Toddler Connection of Virginia system in compliance with Part C of IDEA;
 - c. Taking appropriate action to identify and coordinate all available resources for early intervention services within the State, including those from Federal, State, local, and private sources;
 - d. Monitoring programs and activities used by the State to carry out its obligations under Part C, whether or not these programs or activities are receiving assistance under Part C, to ensure that the State complies with Part C;
 - e. Monitoring Part C compliance of agencies, institutions, and organizations used by the State to carry out Part C requirements, ensuring enforcement of any requirements imposed by law on those agencies, institutions and organizations; and providing technical assistance, if necessary;
 - f. Ensuring correction of deficiencies that are identified through monitoring and supervision activities;
 - g. Entering into formal interagency agreements with other State-level agencies involved in the State's early intervention program;
 - h. Establishing or adopting procedural safeguards that meet the requirements of Part C;
 - i. Ensuring effective implementation of procedural safeguards by each public agency in the State that is involved in the provision of early intervention services; and
 - j. Developing and implementing State regulations, policies and procedures and a Practice Manual to ensure consistent statewide program implementation among the participating agencies;
2. Develop public awareness materials about Virginia's early intervention system and the child find system including the purpose and scope of the system, how to make referrals, and how to gain access to an eligibility determination, services and the central directory. Materials shall be posted on the Infant & Toddler Connection of Virginia web site, www.infantva.org;
3. Accept joint responsibility with the Department of Education to locate and identify all infants and toddlers potentially eligible under Part C or Part B, given the parallel requirements for child find under Part B and Part C of IDEA. Local interagency agreements shall identify the specific responsibilities of local school divisions and the local Part C lead agency with regard to local child find procedures;
4. Contract with local lead agencies for administration of local early intervention systems across Virginia;
5. Ensure that local policies, procedures, and mechanisms are in place statewide to receive referrals through the Department of Social Services, in accordance with federal and state Child Abuse and Prevention Treatment Act (CAPTA) regulations,

and to make an individualized determination about the child's eligibility for Part C;
and

6. Provide ongoing training and technical assistance in collaboration with the Virginia Department of Education to local lead agencies, Part C service providers, local school division personnel and families on areas of joint responsibility, including but not limited to transition, child find and data collection.

B. The Department of Health (VDH) shall:

1. Provide families with information about Part C early intervention services as well as EPSDT and public health services through the Virginia Family Helpline and Children's Special Health Care Services (CSHCS);
2. Make available the services of the following programs and entities to infants, toddlers and their families who are eligible for each service, within available resources:
 - a. Care Connection for Children (CCC);
 - b. Child Development Services (CDS);
 - c. Bleeding Disorders Program (BDP);
 - d. Genetics and Newborn Screening (GNS);
 - e. Pediatric Comprehensive Sickle Cell Services; and
 - f. The thirty-three local health districts that are units of VDH; and
3. Work with other state and local agencies in child find activities and be involved in development of IFSPs as appropriate.

C. The Department of Education (DOE) shall:

1. Accept joint responsibility with DBHDS to locate and identify all infants and toddlers potentially eligible under Part C or Part B, given the parallel requirements for child find under Part B and Part C of IDEA. Local interagency agreements shall identify the specific responsibilities of local school divisions and the local Part C lead agency with regard to local child find procedures; and
2. Provide ongoing training and technical assistance in collaboration with the DBHDS to local lead agencies, Part C service providers, local school division personnel and families on areas of joint responsibility, including, but not limited to, transition, child find and data collection.

D. The Department of Social Services (DSS) shall:

1. Refer any child under the age of three who is the subject of a founded child abuse/neglect disposition to the local Infant & Toddler Connection of Virginia;
2. Encourage local Child Protective Services supervisors and workers to make referrals to the Infant & Toddler Connection of Virginia for any children under three who appear developmentally delayed or who have a physical or mental condition that has a high probability of resulting in delay, even for children for whom there is not a founded child abuse/neglect disposition.

E. The Department of Medical Assistance Services (DMAS) shall:

1. Added a new subsection, 5.0A entitled "Early Intervention Services" as more fully set forth in Interagency Agreement No. 137-07 (IAG No 137-07), signed between the parties March 28, 2007. The purpose of this Modification is to provide a means for service provision and reimbursement of Early Intervention Services between the two agencies, under the State Medical Assistance Plan for Medicaid, and under the State Child Health Plan for FAMIS.
2. This modification is subject to all applicable security and confidentiality limitation described in IAG 137-07, initially signed between the parties March 28, 2007.
3. Provide full reimbursement of Part C services that are covered under the State Medical Assistance Plan for Medicaid and under the State Child Health Plan for FAMIS.
4. DBHDS shall transfer to DMAS the state funds to cover the state share of services for early intervention performed by "non-traditional" providers designated as \$2.3 million in general funds every state fiscal year. DMAS shall draw Medicaid and FAMIS federal

funds as well as state general funds in order to cover the total cost of EI services, and make necessary payments to the providers. The expenses shall be reported on DMAS records as of year-end.

5. Except as provided herein, all terms and conditions of Interagency Agreement No. 137-07, originally signed between the parties on March 28, 2007 and heretofore amended, remain unchanged and in full force.

F. The Department for the Blind and Vision Impaired (DBVI) shall:

1. Refer to the Infant & Toddler Connection of Virginia infants, toddlers and families who become known to the Department through its regional offices who may be eligible under Part C; and
2. Provide Part C early intervention services including vision assessment, vision services, family training and counseling, assistive technology, and IFSP development, as follows, for children who are eligible for Part C and blind or vision impaired:
 - a. Assistive technology: DBVI shall offer assistive technology information related to infants with visual disabilities;
 - b. Family training and counseling: DBVI staff shall provide technical assistance and materials that parents use with their child;
 - c. Participation in multidisciplinary assessments: DBVI staff shall provide vision related assessments as part of the team;
 - d. Coordination of agency services: DBVI staff shall work with the family's service coordinator to coordinate agency services with those of other service providers in the community;
 - e. Vision services and developmental services: DBVI staff shall offer all vision services that are included in Virginia's Part C definition of vision services; and
 - f. Development of Individualized Family Service Plans (IFSP): DBVI staff shall participate on the IFSP team to help develop goals and strategies for eligible children and their families.

G. Department for the Deaf and Hard of Hearing (DDHH) shall:

1. Provide technical assistance and resources to local lead agencies, Part C service providers, and families on topics related to screening, assessment and services for children who are deaf or hard of hearing and their families.

VIII. DISPUTE RESOLUTION


In instances of interagency conflict, every effort shall be made to resolve the differences at the lowest level possible. In the event of a difference of opinion in any matter related to the implementation of this agreement, disagreements regarding systemic issues of responsibility for service provision or compliance with the interagency agreement, the participating agencies agree to the following procedures for resolution of disputes:

1. Participating agencies shall make every effort to resolve their own disputes according to the procedures within their agency. If a dispute involves two or more state agencies, resolution shall first be attempted through discussion between the state agencies involved.
2. If participating agencies are unable to resolve disputes in a timely manner, a participating agency may forward a written request to DBHDS, the State Lead Agency, to initiate a state-level interagency dispute. The written request shall include a written summary of the steps taken to resolve the interagency dispute and a written summary of findings.
3. Upon receipt of a written request from a participating agency to initiate an interagency dispute, the following steps shall be taken:
 - a. DBHDS shall review all materials submitted to determine if the request warrants the initiation of the state-level interagency dispute process or if the dispute needs to be resolved through other channels
 - b. If DBHDS determines the dispute needs to be resolved through the state-level

- interagency dispute process, the dispute shall be referred to the Commissioner of DBHDS, or his designee, for resolution.
- c. If the dispute cannot be resolved by DBHDS, then the dispute shall be referred to the Secretary of Health and Human Resources and/or the Secretary of Education for resolution.
 - d. If the dispute cannot be resolved by the Secretary(ies) within 30 days, the dispute shall be referred to the Governor.
 - e. When resolutions of disputes are reached at any level, the resolution, as well as any actions to be taken by the involved parties, shall be in writing and shall be binding on all parties.
4. During the pendency of a dispute, the Governor, who is responsible for assigning financial responsibility among the appropriate agencies, shall:
 - a. Assign financial responsibility to an agency; or
 - b. Assign DBHDS as the State Lead Agency to pay for the support or service, in accordance with Part C payor of last resort provisions.
 5. If, during resolution of the dispute by DBHDS, the Governor determines that the assignment of financial responsibility was inappropriately made, the:
 - a. Governor shall reassign the responsibility to the appropriate agency; and
 - b. DBHDS shall make arrangements for reimbursement of any expenditures incurred by the agency originally assigned responsibility.
 6. If a participating agency fails to provide or pay for the supports and services pursuant to the interagency agreement:
 - a. DBHDS shall provide or pay for the provision of such supports and services to the child.
 - b. DBHDS shall claim reimbursement for the supports and services from the participating agency that failed to provide or pay for such supports and services and such participating agency shall reimburse DBHDS pursuant to the terms of the interagency agreement.

IX. DURATION OF AGREEMENT

This agreement is effective on the date of signature. This agreement shall be reviewed periodically and revised as necessary with the agreement of all participating agencies.


Margaret Schultze, Interim Commissioner
Department of Social Services

James W. Stewart, III, Commissioner
Department of Behavioral Health and
Developmental Services