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PROVIDING FOSTER CARE SERVICES

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13.1 Introduction

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

- Preventing further abuse and neglect.
- Preventing unnecessary separation of children from their homes.
- Minimizing how long children stay in foster care.
- Finding and sustaining stable, permanent families for all children.
- Respecting the cultural heritage and connections to family, community, and social support networks of children.

Families should be at the center of services that prevent and remedy situations that lead to child abuse and neglect. An array of services for children and their families should be available, from the first awareness that a family is at risk, to early intervention, to foster care for those children whose safety and well-being is threatened, through permanency and the services necessary to sustain permanency.[1]

13.2 Framework

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

1 Adapted from the "Child Welfare League of America Statement on Optimal Child Welfare Service Delivery".

13.2.1 Practice principles

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

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

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

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

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

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

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

13.2.2 Legal excerpts

The legal framework and specific requirements for placing children are delineated in federal and state law. Key citations are provided below. See the law for complete language by clicking on the citations.

- **Foster care services**

> (§ 63.2-905). Foster care services are the provision of a full range of casework, treatment and community services, including but not limited to independent living services, for a planned period of time to a child who is abused or neglected as defined in § 63.2-100 or in need of services as defined in § 16.1-228 and his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or (iii) has been committed or entrusted to a local board or licensed child placing agency.

- **Comprehensive Services Act for At-Risk Youth and Families (CSA)**
  - **Purpose**

> (§ 2.2-5200). It is the intention of this law to create a collaborative system of services and funding that is child centered, family focused and community based when addressing the strengths and needs of troubled and at risk youths and their families in the Commonwealth. CSA strives to preserve families and provide appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public.

  - **Community policy and management teams**

> (§ 2.2-5206). The community policy and management team shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:
>
> 1. Develop interagency policies and procedures to govern the provision of services to children and families in its community;
>
> 2. Develop interagency fiscal policies governing access to the state pool of funds by the eligible populations including immediate access to funds for emergency services and shelter care; ….
>
> 4. Coordinate long-range, community-wide planning that ensures the development of resources and services needed by children and families in its community including consultation on the development of a community-based system of services established under § 16.1-309.3;

5. Establish policies governing referrals and reviews of children and families to the family assessment and planning teams or a collaborative, multidisciplinary team process approved by the Council and a process to review the teams' recommendations and requests for funding;

6. Establish quality assurance and accountability procedures for program utilization and funds management; …

12. Collect and provide uniform data to the Council …;

13. Review and analyze data in management reports … to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Comprehensive Services Act program.…

- **Family assessment and planning team**

(§ 2.2-5208). The family assessment and planning team, in accordance with § 2.2-2648, shall assess the strengths and needs of troubled youths and families who are approved for referral to the team and identify and determine the complement of services required to meet these unique needs.

Every such team, in accordance with policies developed by the community policy and management team, shall:

1. Review referrals of youths and families to the team;

2. Provide for family participation in all aspects of assessment, planning and implementation of services;

3. Provide for the participation of foster parents in the assessment, planning and implementation of services when a child has a program goal of permanent foster care or is in a long-term foster care placement. The case manager shall notify the foster parents of a troubled youth of the time and place of all assessment and planning meetings related to such youth. Such foster parents shall be given the opportunity to speak at the meeting or submit written testimony if the foster parents are unable to attend. The opinions of the foster parents shall be considered by the family assessment and planning team in its deliberations;

4. Develop an individual family services plan for youths and families reviewed by the team that provides for appropriate and cost-effective services; ….

> 7. Refer the youth and family to community agencies and resources in accordance with the individual family services plan;
>
> 8. Recommend to the community policy and management team expenditures from the local allocation of the state pool of funds; and
>
> 9. Designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies.

- **Managing residential services**

> (§ 2.2-5206 13). The CPMT "shall track the utilization and performance of residential placements using data and management reports to develop and implement strategies for returning children placed outside of the Commonwealth, preventing placements, and reducing lengths of stay in residential programs for children who can appropriately and effectively be served in their home, relative's homes, family-like setting, or their community;.."

> (§ 2.2-2648 D22). The FAPT "shall provide, in collaboration with the family, intensive care coordination services for children at risk of entering, or are placed in, residential care" (§ 2.2-5208 5), "in accordance with the Community Policy and Management Team policies" (§ 2.2-5206 17) that are "consistent with State Executive Council mandatory uniform guidelines"

13.2.3 Outcomes

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

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

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

Outcome 2: Children have permanency in their living situations.

- More children in foster care achieve permanency.
- Children achieve permanency with shorter lengths of stay.

- Increased timeliness to permanency.
- Fewer placement moves and disruptions.
- Fewer children in out-of-home care.
- More children placed in family-based care.
- More children placed in relative foster homes.
- Fewer children placed in residential care.
- Fewer children re-enter out-of-home care.

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

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

Outcome 4. Children receive appropriate services to meet their educational needs.

- Children's educational needs are assessed and met.

Outcome 5. Children receive adequate services to meet their physical and mental health needs.

- Children's physical health needs are met consistently.
- Children's mental health needs are met consistently.

13.3 Services to prevent or eliminate foster care placement

Foster care prevention services shall be provided to children and their families in their homes and communities to prevent or eliminate the need for foster care placements.

Any service in the home or community that is available to a child in foster care placement and his family shall be available to a child and his family as prevention services to prevent or eliminate the need for foster care placement based on an assessment of the child's and family's needs.

These services are available to children who are abused or neglected as defined in

§ 63.2-100 or in need of services as defined in § 16.1-228. The CSA guidelines specify the criteria for the Family Assessment and Planning Team (FAPT), or an approved multi-disciplinary team, to use in determining when a child meets the statutory definition of a "child in need of services" and is eligible for foster care services, consistent with CPMT policies. (See the CSA Policy Manual.)

Out-of-home placements are not considered prevention services. Short-term stays outside of the home are only considered prevention services when children temporarily leave their homes for short stays of less than 14 days for the purposes of crisis stabilization, respite, hospitalization to meet acute physical or medical needs, or short-term psychological or psychiatric evaluations.

13.4 Head Start and Early Head Start

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

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

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

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

13.5 Child care services

13.5.1 Choosing allowable child care provider

The LDSS holding custody of a child shall consult with the foster/adoptive parent when selecting a child care provider. Considerations when making decisions about which provider to use include such things as the special needs of the child, travel distance from the foster/adoptive home, availability of the provider, provider costs in relation to other providers in the area, approval status of the provider, and the

foster/adoptive parent request for specific services. Children's special needs include characteristics such as developmental disabilities, mental retardation, emotional disturbance, sensory or motor impairment, or significant chronic illness which require special health surveillance or specialized programs, interventions, technologies, or facilities.

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

- Voluntary registered family day homes.
- Licensed family day homes.
- Licensed child day centers.
- Certified pre-schools.
- Religiously exempt child day centers.
- Department of Education-approved child care facilities.
- Local ordinance-approved providers (available in Fairfax County, Alexandria, Arlington).
- Family day system homes

13.5.2 Rates for child care

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

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

- **Provider type**. Two levels of maximum reimbursable rates shall be used based on the type of provider. The LDSS shall have a written agreement with the provider for child care services. The types of providers for each rate level are listed in Appendix E of the Child Care Guidance manual.

- **Number of hours in care**. The unit price for services shall be based on whether the child is in child care for a full day (five (5) or more hours a day) or a part day (fewer than five hours for a day).

- **Age groupings**. Rates shall be based on the age of children, as defined by the VDSS Division of Licensing Programs for child day centers:

  - Infants - children from birth up to 16 months.

  - Toddlers - children from 16 months up to 24 months.

  - Preschool - children from 24 months up to the age of eligibility to attend public school (five years by September 30). Children turning five after September 30 are considered pre-school until they start school the following year.

  - School age - children eligible to attend public school, age five or older by September 30 of that same year. Children turning five after September 30 are considered pre-school until they start school the following year. The School Age rate is effective starting the first Monday in September for all children who turn age 5 before September 30th.

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

- Level 1 rates are listed in Appendix L.

- Level 2 rates are listed in Appendix M.

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

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

13.5.3 Funding sources

Allowable Title IV-E expenditures:

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

- Provides daily supervision during the foster parents working hours when the child is not in school.

- Facilitates the foster parent's attendance at activities which are beyond the scope of "ordinary parental duties."
- Is provided in a licensed day care facility or home.

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

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

Not allowable Title IV-E expenditures:

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

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

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

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

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

13.6 Respite care services

Respite care is a therapeutic support service designed to offer short-term relief to families caring for children by providing substitute care for children. The purpose of respite care for families, including foster families, is to reduce foster home disruption

and provide a stable foster care placement for the child. It can be provided on an emergency or planned basis. The following requirements shall be met:

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

13.7 Transportation services

13.7.1 Travel of children in foster care

13.7.1.1 Out of state travel

The director of the LDSS may grant approval for a child or youth to travel out of state. This approval shall be in writing and maintained in the child or youth's file and an original given to the adoptive, foster or resource parent.

It is at the discretion of the LDSS director to determine if blanket permission for out of state travel will be given to those foster, adoptive or resource parent(s) that reside in the Commonwealth of Virginia but conduct the business of daily living in neighboring states.

When foster parents anticipate an overnight stay in a state other then the Commonwealth of Virginia, the foster parent should obtain written permission from the LDSS director specific to each overnight trip.

13.7.1.2 Out-of-country travel

Approval for such travel is the option of the LDSS.

- The LDSS director shall give written approval for a child going out of the country.

- The LDSS should obtain written approval from the parent(s) or guardians if whereabouts are known and parental rights have not been terminated.

- The sponsor of the out-of-country trip (residential facility, school, foster parent) shall provide the LDSS with the itinerary and telephone numbers where the child and/or sponsor can be contacted.

- Proper passports, visas, or other requirements for traveling out of the country shall be obtained.

- Written assurances that the sponsor will provide for the health, safety, and legal needs of the child during the trip shall be obtained.

- The LDSS should provide the sponsor with authorization to obtain medical care.

13.7.1.3 Requirement for approved child restraint devices

- Children through age seven (until their 8th birthday)**,** transported in a vehicle by LDSS staff, foster care providers, or any adult transporting a child, shall be properly secured in a child-restraint device of a type approved by the United States Department of Transportation. There is no height or weight requirement; age is the only requirement.

- Rear-facing child restraint devices shall be placed in the back seat. If the vehicle does not have a back seat, the child-restraint device may be placed in the front seat if the passenger side does not have an air bag or if it has been deactivated (§ 46.2-1095).

  Safety seat installation videos are available in English and Spanish at the Virginia Department of Health website.

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

  - If a physician states that use of a child-restraint device would be impractical because of the child's weight, physical unfitness, or other medical reasons. The driver shall carry or keep in the vehicle a statement signed by the physician giving the child's name and the grounds for exemption (§ 46.2-1096).

  - A seat belt which is standard equipment in automobiles may be used for children at least four (4) years old but less than eight (8)

year old when the driver carries or keeps in the vehicle a signed written statement of a physician that the child's weight, physical fitness, or other medical reasons makes the use of a child-restraint system impractical. The statement shall give the child's name and the grounds for exemption (§ 46.2-1100).

Violation is sufficient for ticketing; no other violations need be committed prior to ticketing. There is a civil penalty of $50.00 for failure to have a child in a child restraint device. Subsequent violations on different dates will be fined up to $500.00.

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

- Children age eight (8) and through age 17 (until their 18th birthday), transported in a vehicle by LDSS staff, foster care providers, or any other adults transporting the children shall be correctly secured by an appropriate safety belt (§ 46.2-1095).

- Violation is sufficient for ticketing; no other violations need be committed prior to ticketing. There is a civil penalty of $25.00 for failure to have a child correctly buckled.

- Children through age 15 (until 16th birthday) shall not be transported in the rear cargo area of a pickup truck, except for certain parades and farming activities (§ 46.2-1156.1).

13.7.1.4 How to pay for restraint devices

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

- Parent, legal guardian, or foster parent of the child.

- Medicaid or FAMIS eligible or meet program income eligibility guidelines.

- Resident of Virginia.

- Last trimester of pregnancy, or provided for children seven (7) years old or younger who fit within the program safety seat manufacturer's guidelines.

- Available to attend a safety seat installation and use class.

- Sign a waiver of liability release form.

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

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

13.7.2 Purchasing transportation services

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

13.7.2.1 Using Medicaid to purchase transportation

Transportation to obtain medical services for the child may be provided through the Logisticare Program. Logisticare coordinates volunteer drivers to transport Medicaid recipients from their medical appointments anywhere in VA. Additional information about covered transportation services and limitations can be found in the Transportation Manual of the Division of Medical Assistance Services.

13.7.2.2 Using Title IV-E funds for transportation

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

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

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

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

  Transportation costs for a child to remain in the same school are allowable maintenance costs and shall be made available when the LDSS and school jointly determine that remaining in the same school is

in the child's best interests. Reasonable costs of transportation include mileage (paid at the state rate with proof of miles driven), bus fare, or other similar and reasonable transportation costs. The LDSS may reimburse the local school district's school bus transportation fund. If the LDSS chooses to reimburse for travel on the school bus, a documented agreement or contract between the LDSS and the LEA or the company that manages the school bus system shall be obtained and a copy placed in the child's file.

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

13.7.2.3 Using State Pool Funds to purchase transportation

Transportation expenses for a non-Title IV-E eligible child to remain in the school in which he or she was enrolled at the time of an initial or change in foster care placement are allowable maintenance costs and shall be purchased from State Pool Funds according to the criteria described in section 6.17.2.1. These payments are made in addition to the basic maintenance payments paid on behalf of the child. The LDSS and school shall have jointly determined that remaining in the same school is in the child's best interests.

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

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

Payment may be made to specific providers as follows:

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

- Public transportation paid at the established rate.

- Friends, relatives, and neighbors of the child or foster parent are paid at the state mileage rate. They shall have a valid driver's license and automobile insurance and shall submit proof of miles driven to the LDSS for reimbursement.

13.8 Medical and treatment services

13.8.1 Consent for medical treatment for children in custody

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

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

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

13.8.1.2 When a minor may consent to medical and health services

A minor's consent is needed to:

- Determine the presence or treatment of venereal disease or any infections or contagious disease reportable to the state health department.

- Receive service for birth control, pregnancy, family planning, and out-patient care.

- Receive services for treatment or rehabilitation for substance abuse, mental illness, or emotional disturbance (§ 54.1-2969 E).

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

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

13.8.1.4 Medical care and treatment to be provided to a child in foster care placement

- A medical examination of the child, using EPSDT, should be obtained no later than *30* days after placement, commitment, or entrustment.
- Periodic routine medical and dental examinations at least annually for children three years of age and over shall be provided. For children less than three, the LDSS shall follow the EPSDT check-up chart or document in the record reasons why it is not being followed.
- Medical care shall be provided for the child who is ill or injured and ongoing medical treatment for the child with physical, mental, or emotional disabilities.

For information on the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, see Section 5.8.3.

13.8.2 Paying for medical care

For the Medicaid eligible child, Medicaid shall be used to pay for medical needs including transportation to the Medicaid provider.

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

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

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

13.8.3 Medicaid services

The Medicaid Program is managed by the Virginia Department of Medical Assistance Services.

13.8.3.1 Medicaid eligibility

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

13.8.3.2 Residency requirements for Medicaid

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

- A IV-*E foster care child receiving a maintenance payment is a resident of the state in which he is living.*
- *A IV-E adoption assistance child is a resident of the state in which he is living whether or not a maintenance payment is being made.*
- *An SSI child is a resident of the state in which he is living.*
- *A non-IV-E foster care child who is not an SSI recipient is a resident of state which holds his custody.*

13.8.3.3 Medicaid out-of-state

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

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

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

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

13.8.3.4 Extension of Medicaid for children in adoptive placement

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

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

Medical coverage is extended past the final order if:

- The child is Title IV-E eligible with a subsidized adoption assistance agreement in effect, regardless of the existence of an interlocutory order or final judicial decree; or
- The adoptive family meets the financial requirements of Medicaid; or
- The child is not Title IV-E eligible, but has special medical rehabilitative needs and there is an adoption assistance agreement in effect.

13.8.3.5 Medicaid services

Medicaid covers services including, but not limited to:

- Clinic Services.
- Eye Examinations.
- Eyeglasses.
- Hospital Care – Inpatient/Outpatient.
- Hospital Emergency Room.
- Maternal and Infant Care Coordination (BabyCare).
- Nursing Facility.

- Personal Care.
- Physician's Services.
- Prenatal Care Expanded Services (BabyCare).
- Prescription Drugs when ordered by a Physician
- Rehabilitation Services.
- Transportation Services for Medical Treatment.

These services do not require a local match.

For a complete listing and description of covered and non-covered services, see the Medicaid and FAMIS-Plus Handbook.

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

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

- Regular medical, dental, vision, and hearing check-ups.
- Diagnosis of problems.
- Treatment of dental, eye, hearing, and other medical problems discovered during check-ups.

EPSDT services do not require a local match.

13.8.3.7 Dental services

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

- Dental services
- Dentists who accept Medicaid

13.8.3.8 Mental health treatment and intellectual disability services

Medicaid provides coverage for mental health treatment and intellectual disability services. Services shall meet service definitions, eligibility criteria, required activities, and service limitations. Providers of services shall meet qualifications specified under the "Provider Participation Requirements." Covered services are grouped below based on whether or not they require local matching funds.

Services that <u>do not</u> require local match:

- Outpatient psychiatric or psychological services: Individual therapy, family therapy, or group therapy provided by specified licensed professionals.
- Physician services: Outpatient and inpatient therapy services.
- Community mental health rehabilitative services:

  Services provided in the child's home or community that provide diagnosis, treatment, or care of children with mental illnesses or intellectual disability. The following services are provided primarily by Community Services Boards and private providers:

  - Crisis Intervention.
  - Crisis Stabilization
  - Intensive Community Treatment (requires authorization).
  - Intensive In-Home Services for Children and Adolescents (requires authorization).
  - Therapeutic Day Treatment for Children and Adolescents (requires authorization).
  - Therapeutic Behavioral Services for Children and Adolescents (requires authorization).
  - Mental Health Support (requires authorization).
  - Mental Health Case Management (requires authorization).
  - Psychosocial Rehabilitation (requires authorization).
  - Substance Abuse Services.

- Crisis Intervention.
- Day Treatment.
- Case Management
- Opioid Treatment.
- Day Treatment for Pregnant Women.
- Residential Treatment for Pregnant Women.

For more information on community mental health services, see the DMAS Provider Manual.

DMAS Medicaid Memo on Changes to Children Community Mental Health Rehabilitative Services dated July 23, 2010.

- Acute Inpatient Psychiatric Services.
- Children's Mental Health Program.

  Funds intensive community-based services for Medicaid eligible children who have been in a Psychiatric Residential Treatment Facility (PRTF) for 90 or more days and for whom community-based services under the program are the critical services that enable the children to remain at home rather than reside in a PRTF. The objectives of the program are to: shorten stays in PRTFs by offering a community alternative; provide access to an array of community based services designed to promote independence and support for children with serious emotional disturbances (SED); and improve outcomes for children and their families by allowing children to live at home with their natural support system. For more information on the Children's Mental Health Program, see the DMAS Provider Manual.

- Intermediate Care Facilities for the Intellectually Disabled.

Services that <u>do</u> require a local match:

- Treatment Foster Care – Case Management.
- Community-Based Residential Services for Children and Adolescents under 21(Level A).
- Therapeutic Behavioral Services (Level B).
- Residential Treatment Services (Level C).

13.8.3.9 Long-term care services

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

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

Children may be eligible for the following waivers:

- Mental Retardation/Intellectual Disabilities (MR/ID) Waiver.
    - Eligibility: An individual shall be age 6 or older and have a diagnosis of MR or be under age 6 and at developmental risk. The person should be eligible for placement in an intermediate-care facility for persons with mental retardation or other related conditions (ICF-MR).
    - Services available: Residential support services, day support, supported employment, prevocational services, personal assistance, respite, companion services, assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, and personal emergency response systems (PERS). Support coordination is also provided.
- Individual and Family Developmental Disabilities Support (IFDDS or DD) Waiver.
    - Eligibility: The DD Waiver provides services to individuals 6 years of age and older who have a diagnosis of a developmental disability and do not have a diagnosis of mental retardation. Individuals also should require the level of care provided in an intermediate-care facility for persons with mental retardation or other related conditions (ICF/MR). Children who do not have a diagnosis of mental retardation, and have received services through the MR/ID Waiver, become ineligible for the MR/ID Waiver when they reach the age of 6. At that time, they can be screened for eligibility for the DD Waiver; if found eligible they will receive a DD waiver slot without being placed on the DD waiver waiting list.

- Services available: Day support, companion services, supported employment, in-home residential support, therapeutic consultation, personal care services, respite care, supported employment, skilled nursing services, attendant services, family and caregiver training, crisis supervision, environmental modifications, assistive technology, personal emergency response system (PERS), and prevocational services. Support coordination is also provided.

- Elderly or Disabled with Consumer Direction (EDCD) Waiver

  - Eligibility: This waiver serves the elderly and persons of all ages with disabilities. An individual must meet nursing facility eligibility criteria, including both medical needs and functional capacity needs (assistance with activities of daily living). An individual can remain on the waiting list for another waiver while being served by the EDCD Waiver and then transfer to the preferred waiver once a slot becomes available.

  - Services available: Personal care aide services, adult day health care, respite care, skilled respite care, personal emergency response system (PERS), and medication monitoring.

For more information on these and other waivers, see the DMAS Guide on "Virginia's Medicaid Waivers for Persons with Disabilities, Their Parents, and Caregivers."

Waivers are funded per "slot." A slot is an opening of waiver services available to a single individual. For some waivers, there are waiting lists of persons who have already applied or who have been assessed as eligible and are still waiting to receive a waiver slot. It is important to put the child on the waiting list as early as possible, even if no slots are currently available. Waiting lists also help document the unmet need for services when funding priorities are decided.

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

13.8.3.10 Using Medicaid providers

Medicaid providers shall be used whenever they are available for the appropriate treatment of children and youth.

State pool funds shall not be spent for any service that can be funded through Medicaid for Medicaid eligible children and youth except when Medicaid funded

services are unavailable or inappropriate for meeting the needs of a child. (Appropriation Act Item 274E)

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

See information provided in the DMAS Medicaid Memos to Providers.

13.9 CSA services

13.9.1 Access to State Pool Funds

The Comprehensive Services Act establishes a collaborative source of funding for at risk youth and families including those children and youth involved in the child welfare system. Access to funds is governed by state and local policies which require multi-agency planning, uniform assessment, utilization review, and authorization of funds. The LDSS service worker should become familiar and comply with policies established by their local Community and Policy Management Team for access to CSA funding.

13.9.2 Role of LDSS when collaborating with FAPT

The LDSS shall refer the child and family to the FAPT or approved multi-disciplinary team, consistent with CMPT policies. As part of this process, the LDSS shall ensure the child is assessed using the mandatory uniform assessment instrument (§ 2.2-5212). See Section 5.8.1 for information on the Child and Adolescent Needs and Strengths (CANS) tool.

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

- Engaging the family to participate in all aspects of assessment, planning, and implementation of services.
- Assessing the unique strengths and needs of the child and family.
- Identifying and/or creating the services and/or supports to be provided to the child and family. This process involves exploring:
    - Family and community based services first.
    - Placements with extended family and individuals who can effectively care for the child whenever possible, if family based services are not in the child's best interest.

- Family like homes when there are no viable placements for the child with extended family and individuals.

- Short term residential treatment programs when these are the most appropriate, least restrictive, and cost effective services for the child.

- Ensuring all appropriate community services for the child have been explored before placing the child across jurisdictional lines (§ 2.2-5211.1 2).

- Maximizing and pooling resources across agencies and sectors by helping to explore all available family, private insurance, community, LDSS, and other public resources that may assist in funding the services and supports.

- Developing the individual family services plan (IFSP) or using the foster care service plan.

- Referring the child and family to services delineated in the plan, when appropriate.

- Helping to coordinate services with the child and family, when designated to serve this role by the FAPT (§ 2.2-5208).

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

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