

12

IDENTIFYING SERVICES TO BE PROVIDED

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IDENTIFYING SERVICES TO BE PROVIDED

12.1 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.
- *Meeting the social and emotional well-being needs of children, including addressing:*
 - *Needs from experiencing maltreatment, trauma, and/or exposure to violence.*
 - *Health needs (developmental, physical, medical, and dental needs).*
 - *Behavioral health needs (mental health & substance abuse needs).*
 - *Educational needs.*
- 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

12.2 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.

12.2.1 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.

¹ Adapted from the "[Child Welfare League of America Statement on Optimal Child Welfare Service Delivery](#)".

- All stakeholders share responsibility for child safety, permanence, and well-being.

12.2.2 Legal citations

The legal framework and specific requirements for providing services to families are delineated in state law. See the law for complete language by clicking on the citations.

- **Foster care services**
 - [§ 63.2-905](#)
- **Comprehensive Services Act for At-Risk Youth and Families (CSA)**
 - §§ [2.2.5200](#) through [2.2-5214](#)
- **Education requirements when placing child**
 - **Ensure educational stability for the child**
 - [Social Security Act, Title IV, § 475 \(1\) \(G\) \[42 USC 675\]](#)
 - [The Child and Family Services Improvement and Innovation Act; Public Law 112-34](#)
 - [§ 63.2-900.3](#)
 - [§ 22.1-3.4](#)
 - **Notify new school of placement; records; enrollment**
 - [§ 63.2-900](#) D
 - [§ 22.1-3.4](#)
 - [§ 22.1-289](#) E

12.2.3 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 *leave* foster care *and* achieve permanency.
- Children achieve permanency with shorter lengths of stay *in foster care*.
- 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 adequate services to meet their physical and mental health needs.

- *Children's health needs are assessed upon entering foster care.*
- Children's physical health needs are met consistently.
- *Children's dental health needs are met consistently.*
- *Children's trauma needs are met consistently.*
- Children's behavioral health needs are met consistently.

Outcome 5. Children receive appropriate services to meet their educational needs.

- Children's educational needs are assessed and met.

12.3 Identifying services based on strengths and needs

Once a comprehensive assessment of the child and family has been completed, the service worker, the Family Partnership Team, and/or the Family Assessment and Planning Team (FAPT) should brainstorm creative ways to build upon the strengths, resources, and natural supports of the child and family to meet their unique needs.

Additional resources that can help identify services based on the child's needs include:

- Virginia Commission on Youth's [Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs](#) and its [Reference Chart of Disorders and Evidence-based Practices](#).
- SAMSHA's [National Registry of Evidence-based Programs and Practices \(NREPP\)](#) provides a searchable online registry of mental health and substance interventions available for implementation.
- California Evidence-Based Clearinghouse for Child Welfare (CEBC) [Topic Areas](#) provide child welfare professionals with easy access to information about selected child welfare related programs. This interactive search enables the service worker to search based on specific criteria and then browse through a wide range of programs that match that criteria.
- Blueprints for Healthy Youth Development [Program Selector](#) on model and promising programs, includes problem behavior, education, emotional well-being, physical health, and positive relationships.
- [Evidence-Based Treatments for Children and Adolescents: An Updated Review of Indicators of Efficacy and Effectiveness](#) by Bruce Chorpita, et al. 2011. This updated review of evidence-based treatments follows the original review performed by the Hawaii Task Force. Over 750 treatment protocols from 435 studies were coded and rated on a 5-level strength of evidence system. Results showed large numbers of evidence based treatments applicable to anxiety, attention, autism, depression, disruptive behavior, eating problems, substance use, and traumatic stress. Provides a list of options and information available to guide decisions about treatment selection.

12.4 Wraparound approach

LDSS should use a wraparound approach to help achieve the child's permanency goal and well-being and to address the child and family's needs. The process involves an intensive, individualized process for planning, implementing, and managing care to achieve positive outcomes with the child and family.

A team of people, relevant to the child's life, collaboratively develops and implements a creative wraparound plan. This holistic plan is designed based on an assessment of the needs of the child, caregivers, and siblings. A wraparound set of services and supports is individually designed with the child and family to meet their identified needs. The services creatively build upon and enhance the unique strengths, resources, and natural supports of the child and family.

The planning process, as well as the services and supports provided, are individualized, family-driven, culturally-competent, youth-guided, and community-based. The process and plan are strengths-based, including activities that purposefully help the child and family recognize, use, and build their talents, assets, and positive capacities.

The process strives to develop the coping skills, problem-solving skills, and self-efficacy of the child and family members. It increases the "natural support" available to the family by strengthening their interpersonal relationships and using other available resources in the family's network of social and community relationships. It emphasizes integrating the child into the community and building the family's social support network.²

For more information and practical tools on the wraparound process:

- The [CSA website](#) has training slides developed by expert consultants in wraparound strategies that were used in Virginia. It also provides links to national resources.
- The [National Wraparound Initiative](#) (NWI) convened national experts to define the wraparound practice model, develop standards, compile resources, strategies and tools, and disseminate guidance and information on high quality wraparound implementation to achieve positive outcomes for youth and families.
- The NWI "[Resource Guide to Wraparound](#)" provides information on the basics, principles, theory and research, wraparound practice, and supports for implementation.

12.5 Serving children in their homes and communities

Children who have significant emotional, behavioral, and mental health needs can successfully live in family homes and communities with the support of effective behavioral health services. Over the past twenty years, two major federal initiatives addressed the needs of children and youth with significant mental health conditions: Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative (CMHI) and the Centers for Medicare & Medicaid Services (CMS) Psychiatric Residential Treatment Facility (PRTF) Demonstration Program. Results from these programs across the country have consistently found that the implementation of home and community-based services for this population have made significant improvement in the quality of life for these children, youth, and their families.

² Adapted from Wraparound Basics on the [National Wraparound Initiative website](#).

Results from these federal initiatives have demonstrated that the provision of home and community-based services resulted in:

- *More stable living situations.*
- *Increased behavioral and emotional strengths.*
- *Improved clinical and functional outcomes.*
- *Reduced suicide attempts.*
- *Improved school attendance and performance.*
- *Improved attendance at work for caregivers.*
- *Decreased contacts with law enforcement.*
- *Reduced costs of care.*

Programs in these federal initiatives that helped achieve these results include:

- *Intensive Care Coordination - Wraparound Approach.*
- *Peer Services: Parent and Youth Support Services.*
- *Intensive In-Home services.*
- *Respite services.*
- *Mobile crisis response and stabilization services.*
- *Flex funds.*³

For more information on these results and services, see information bulletin on [Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions](#).

Examples of evidence-based programs that have also demonstrated results of serving children in the community include:

- [Multisystemic Therapy \(MST\)](#).
- [Functional Family Therapy \(FFT\)](#).

³ Information in this section excerpted and adapted primarily from Joint CMCS and SAMHSA Informational Bulletin on [Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions](#) dated May 7, 2013.

- *Multidimensional Treatment Foster Care.*
- *Attachment and Biobehavioral Catch-up (ABC)*
- *Trauma Focused Cognitive Behavioral Therapy (TF-CBT).*

12.6 Infant and toddler early intervention services

The [Infant & Toddler Connection of Virginia](#) provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. To determine eligibility, the child's development is evaluated by at least two professionals from different professions or areas of development. When eligible, the family and professionals develop an Individualized Family Service Plan (IFSP).

12.7 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.

12.8 Child care services

12.8.1 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

12.8.2 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 (5) 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.

12.8.3 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".

12.9 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.

12.10 Transportation services

12.10.1 Travel of children in foster care

12.10.1.1 Out of state travel

The director of the LDSS *or his designee* 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 *or his designee* 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 than the Commonwealth of Virginia, the foster parent should obtain written permission from the LDSS director *or designee* specific to each overnight trip.

12.10.1.2 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.

12.10.1.3 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](#)).

12.10.1.4 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.

12.10.2 Purchasing transportation services

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

12.10.2.1 Using Medicaid to purchase transportation

Transportation to obtain medical services for the child may be provided through *the child's Managed Care Organization (MCO)*. *Transportation to the nearest provider capable of rendering care for covered services is covered by Medicaid when no other transportation is available.* Logisticare is one Medicaid transportation service provider which coordinates drivers to transport members from their medical appointments anywhere in VA. *This and other transportation services are accessed through the child's MCO.* Additional information about covered transportation services and limitations can be found in the [Transportation Manual](#) of the Department of Medical Assistance Services.

12.10.2.2 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 placement change.*

Reimbursement of transportation costs may be made to foster parents, friends, relatives, neighbors, and employees of child placing agencies and residential programs. Public transportation, such as bus fare or other similar transportation, is paid at the established rate. Providers shall submit receipts for travel costs to LDSS in order to receive reimbursement. The LDSS may reimburse the local school district's school bus transportation fund. There shall be a documented agreement or contract between the LDSS and the local education agency (LEA) or the company that manages the school bus system and a copy placed in the child's file. All travel costs require receipts and/or other documentation as determined by the LDSS. The LDSS shall maintain these receipts/documents per foster care record retention. Reasonable and necessary transportation costs shall be defined as those costs that are equivalent to the state/ federal mileage reimbursement rate. For those situations where the LDSS must negotiate a higher rate, the LDSS should have documentation to support why this is needed to meet the child's needs for school transportation. (For example: flat rates such as \$70 per day without a breakdown of the costs is unacceptable.) Federal language does not define reasonable or set maximum rates, however, monthly amounts that exceed the child's maintenance rate would require justification. Approval of transporters other than foster parents is at the discretion of the LDSS utilizing the local approval standards for this practice. It is the service worker's responsibility to review and approve the transportation costs then provide the supporting documentation (negotiated rate and justification) to the eligibility worker to determine eligibility for title IV-E funds.

For more information on funding transportation costs, see [Section 12.12.2.1.1](#).

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.

12.10.2.3 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 12.12.2.1.1](#). 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.

12.11 Health and behavioral health care services

Improving outcomes for children in foster care requires addressing the social and emotional well-being needs of children, including addressing their:

- *Maltreatment, trauma, and/or exposure to violence needs.*
- *Health needs (developmental, physical, medical, and dental needs).*
- *Behavioral health needs (mental health & substance abuse needs).⁴*

12.11.1 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

⁴ [Information Memorandum: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services](#) (ACYF-CB-IM-12-04; April 17, 2012).

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.

12.11.1.1 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.

12.11.1.2 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](#)).

12.11.1.3 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](#)).

12.11.2 Medical care and treatment to be provided to child in foster care

The service worker shall ensure the child receives:

- A medical evaluation **within 72 hours** of initial placement in foster care, when the child has conditions that indicate such an evaluation is necessary ([22 VAC 40-201-50 C](#)). When the child has urgent health, mental health, or substance abuse needs upon entering foster care, the service worker shall

immediately refer the child to a licensed health or mental health professional for an appropriate evaluation to be completed within 72 hours.

- A medical examination **no later than 30 days** after *initial placement in foster care* ([22 VAC 40-201-50 C](#)). *The provider should be a Medicaid provider for the Medicaid eligible child or a provider covered by the child's health insurance.*
- Periodic screenings (*well-child visits*) at regular intervals based on Virginia's EPSDT periodicity schedule. *The child shall receive well-child visits while in foster care, including:*
 - *At birth, at age 3-5 days, and by 1 month of age.*
 - *At age 2 months, 4 months, 6 months, and 9 months.*
 - *At age 12 months, 15 months, 18 months, 24 months, and 30 months.*
 - *Annually at age 3 years up to 18 years.*

The Virginia Department of Medical Assistance Services (DMAS) uses the American Academy of Pediatrics and Bright Futures guidelines to develop the schedule. See:

- *Well Child Visit Schedule, see [EPSDT Periodicity Chart](#).*
- *[American Academy of Pediatrics \(AAP\) Recommendations for Preventive Pediatric Health Care](#).*
- *[American Committee on Immunization Practices \(ACIP\) Child & Adolescent Immunization Schedules](#).*
- *Inter-periodic screenings when any caregiver or professional who interacts with the child requests an unscheduled check-up or problem focused assessment at anytime because of illness or change in the child's condition while in foster care.*
 - *When it appears the child may have trauma, mental health, or substance abuse issues, as identified through the medical examination or comprehensive assessment conducted within the first thirty (30) days of entering foster care, the child shall receive a comprehensive mental health evaluation with a licensed mental health professional **within 60 days** of entering foster care.*

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 needs.

- *Dental examinations while the child is in foster care **beginning at whichever is later, six (6) months of age or when the child gets teeth and every six (6) months** thereafter. This schedule is based on guidelines by the American Academy of Pediatric Dentistry, the American Dental Association, and the American Academy of Periodontology. For Medicaid enrolled children, this schedule is in accordance with DMAS' Smiles for Children Program.*
 - See Dental Visit Schedule, see [Dental Health Guidelines](#).

Prior to the child being placed on a new psychotropic medication, the child should receive the following inter-periodic screens/assessments:

- *A pediatric medical examination to ensure symptoms are not indicative of a medical problem, except in the case of an emergency. In an emergency, a physical examination should be conducted as soon as possible.*
- *A comprehensive child and adolescent behavioral health evaluation by a licensed mental health professional to identify psychosocial interventions.*

Note: When the child's condition has already been evaluated and the doctor is changing treatment or psychotropic medication after a treatment or psychotropic medication did not work, these examinations are not necessary (see [Section 12.11.8](#)).

Medical examinations are provided in accordance with the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, whether or not the child has Medicaid coverage. EPSDT is a comprehensive and preventive child health program for individuals under age 21 through the Medicaid program ([see Section 5.9.3](#)).

The service worker should involve the birth parents in attending the child's medical appointments when appropriate. Participating in these visits helps educate the birth parents on the child's needs and health care and helps provide continuity of care when the child returns home.

The service worker shall document in OASIS and the foster care paper case record that the medical and dental examinations were obtained for the child as required. Documentation shall include the date, type of examination, name and address of health care provider, results, and any follow-up instructions. The service worker should use the [Child Health Information Form](#).

12.11.3 Bright Futures resources on children's health information

The service worker should inform the child's birth parent or guardian, family members, foster care provider, and/or caregiver of Bright Futures resources that provide comprehensive information and guidelines on children's health.

- Bright Futures is the American Academy of Pediatrics' standard reference book on children's health information for pediatricians. It is a set of principles, strategies and tools that are theory-based, evidence-driven and systems oriented that can be used to improve the health and well-being of children. It provides a comprehensive set of expert guidelines, as well as a practical developmental approach to providing health supervision for children from birth to age 21 in the context of family and community. The guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention.
 - [American Academy of Pediatrics website on Bright Futures.](#)
 - For information about Virginia's Bright Futures, see the [Virginia Department of Health website.](#)
 - The [Healthy Futures website](#) is an online version of Bright Futures *designed for parents and caregivers of all children, from newborns to older teens. It shares children's health information from Bright Futures through short videos and text. Parents and caregivers can use this website to learn about what to expect at routine doctor's visits, child development milestones, and specific topics like nutrition and mental health. They can also learn how to be active participants in promoting a child's health and well-being.*

12.11.4 Trauma focused treatments

Complex trauma affects a child's sense of safety, ability to regulate emotions, and capacity to relate well to others. Since complex trauma often occurs in the context of the child's relationship with a caregiver, it interferes with the child's ability to form a secure attachment. Consequently, an important goal of service delivery is to help children and youth develop positive social emotional functioning, restore appropriate developmental functioning, and reestablish healthy relationships.⁵

Trauma-informed care redirects attention from treating symptoms of trauma (e.g., behavioral problems, mental health conditions) to treating the underlying causes and context of trauma. Trauma-specific interventions include medical, physiological, psychological, and psychosocial therapies provided by a trained professional that assist in the recovery process from traumatic events. Treatments are designed to

⁵ Excerpted from the [Tri-Agency Letter on Trauma Informed Treatment](#) dated July 11, 2012 from the United States Department of Health and Human Services' Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS), and Substance Abuse and Mental Health Services Administration (SAMHSA).

*maximize a child's sense of physical and psychological safety, develop coping strategies, and increase a child's resilience.*⁶

Examples of evidence-based therapies for trauma include:

- *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).*
- *Cognitive Behavioral Intervention for Trauma in Schools (CBITS).*
- *Parent-Child Interactive Therapy (PCIT).*
- *Child-Parent Psychotherapy (CPP).*
- *Dialectical behavioral therapy (DBT).*
- *Trauma and Grief Component Therapy for Adolescents (TGC T-A).*

Examples of other types of therapy used with trauma include:

- *Behavioral therapy.*
- *Play therapy.*
- *Group therapy.*
- *Parent coaching.*

For resources to address trauma, see:

- The [National Child Traumatic Stress Network](#) and the [National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices](#).
- SAMSHA's [National Registry of Evidence-based Programs and Practices \(NREPP\)](#) searchable online registry of mental health and substance interventions available for implementation.
- National Institute of Justice: [Children Exposed to Violence](#).

Providing trauma-specific interventions is one component of serving children who have experienced traumatic stress. The LDSS and child-serving systems need to collaborate in instituting trauma-informed practices. All stakeholders (e.g., the child, parents, caregivers, service workers, supervisors, administrators, service providers, judges, attorneys) should be involved in recognizing and responding to the impact of

⁶ Information in this section excerpted and adapted from [Implementing Trauma-Informed Practices in Child Welfare](#). Klain, Eva J. White, Amanda R. State Policy Advocacy and Reform Center (SPARC). First Focus. American Bar Association Center on Children and the Law. 2013.

traumatic stress on children and their caregivers. They should all be involved in helping to facilitate resiliency and recovery.

12.11.5 Children with Special Health Care Needs Program

The [Children with Special Health Care Needs \(CSHCN\) Program](#) by the Virginia Department of Health promotes optimal health and development of Virginia's children with special health care needs by working in partnership with families, service providers, and communities.

- [Care Connection for Children](#) is a statewide network of Centers of Excellence for children with special health care needs. The [centers](#) provide access to specialty medical services; assistance coordinating care and services; assistance in obtaining health insurance for the child; information and referral to community resources; family-to-family support; and training and consultation with community providers.
- [Child Development Services Program](#) is a specialized program for children and adolescents who are suspected of having developmental and behavioral disorders. A professional team, with a pediatrician, nurse, social worker, educational consultant, and psychologist, provides services. Core services of the [child development clinics](#) include diagnostic assessment and care planning, follow-up care coordination and referral.

12.11.6 Paying for medical care

For the Medicaid eligible child, Medicaid *may* be used to pay for medical needs including transportation to the Medicaid provider *when other transportation is not available*.

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 *under fee-for-service or the responsible managed care organization (MCO)*. (Note: Medicaid will pay for providers that are in the MCO provider network that are not in the DMAS Medicaid provider network.) *The foster care provider or service worker should ask the medical provider to verify eligibility prior to services being provided to ensure coverage of services.*

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

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

12.11.7 Medicaid services

The [Medicaid Program](#) is managed by the Virginia Department of Medical Assistance Services (DMAS). *Medicaid services most related to children and youth in foster care are identified in this section; not all Medicaid services are listed. For a complete listing and description of covered and non-covered services, see the [Medical Assistance for Families and Children Handbook](#).*

12.11.7.1 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.

12.11.7.1.1 Medicaid eligibility under age 26 for children in foster care

Effective January 1, 2014, the young adult who was formerly in foster care in Virginia (Title IV-E and non-Title IV-E eligible) may be eligible to receive Medicaid up to age 26. Effective July 1, 2014, former foster care youth from other states may also be eligible for Virginia Medicaid up to age 26. Youth must meet the following four (4) requirements. The youth:

- *Was under the care and responsibility of any state's foster care agency.*
- *Was receiving Medicaid until his discharge from foster care upon turning 18 years or older.*
- *Is not eligible for Medicaid in another mandatory Medicaid covered group; and*
- *Is under age 26 years.*

The young adult does not need to meet financial eligibility requirements. However, the young adult must meet all other Medicaid requirements. An application is not required, unless the youth is no longer receiving Medicaid through foster care. Former foster care status will be verified with documentation by the young adult, agency records, or contact with the local agency that held custody.

If the eligible youth was:

- *In foster care and enrolled in Medicaid during the month foster care ended, the youth is entitled to Medicaid coverage beginning the first day of the month following the month the child was no longer in foster care.*

- *If the eligible youth was a former foster care youth and Medicaid was previously discontinued when the youth turned 18, the youth may reapply for coverage and be eligible in this covered group when meeting eligibility requirements.*

12.11.7.1.2 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.

12.11.7.1.3 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 *meet the Virginia residency requirement and may* 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 *uncovered* medical expenses out of State Pool Funds.

The non-Title IV-E child may or may not receive Medicaid *under* the receiving *state's Medicaid Program*. 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://dmas.virginia.gov/> to enroll as Virginia providers.*

12.11.7.1.4 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-Title 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 non-Title IV-E eligible, but has special medical or rehabilitative needs *referenced in* an adoption assistance agreement *and meets the financial requirements for the Child Under Age 21 covered group as determined by Virginia's Medicaid program.*

12.11.7.2 Using Medicaid providers

Medicaid providers shall be used *for the Medicaid eligible child* whenever they are available *and accessible* for the appropriate treatment of children and youth *under fee-for-service*. *For the Medicaid eligible child receiving services under a responsible managed care organization (MCO), providers in that MCO provider network shall be used. (Note: Medicaid will pay for providers in the MCO provider network that are not in the DMAS Medicaid provider network.) The foster care provider or service worker should ask the service provider to verify eligibility prior to services being provided to ensure coverage of services.*

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.

12.11.7.3 Medicaid's Early Intervention Program

Services under Medicaid's Early Intervention Program include:

- *Case management and service coordination.*
- *Developmental services.*
- *Family training.*
- *Counseling.*
- *Speech-language pathology, including sign language and cued language services.*
- *Nursing services.*
- *Occupational therapy.*
- *Physical therapy.*
- *Psychological services.*
- *Social work services.*
- *Assistive technology related services (such as instruction or training on use of assistive technology).*

12.11.7.4 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. See [Section 5.9.3.1](#) on when EPSDT screenings shall be provided for child.
- Diagnosis of problems.
- Treatment of dental, eye, hearing, and other medical problems discovered during check-ups.

- Specialized services that are medically necessary treatment services that are not a routinely covered service through Virginia Medicaid. All such services must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS), as defined in 42. U.S.C. sec 1396d (r) (5).
- Examples of EPSDT specialized services include:
 - *Hearing and audiology.*
 - *Assistive technology devices.*
 - *Behavioral therapy and applied behavior analysis services*
 - *Personal care.*
 - *Private duty nursing.*
 - *Medical infant formula and medically necessary nutritional supplements.*
- See the (DMAS) website on the [EPSDT program](#) for information on specialized services, including:
 - *An overview to EPSDT Specialized Services.*
 - *EPSDT Fact Sheets on specific services.*
 - *Information and forms for service authorization.*

All EPSDT treatment services must:

- Be deemed medically necessary to correct or ameliorate a health or mental health condition.
- Be documented by a physician when the need is for specialist referral or treatment.
- Not be services that are considered experimental or investigational.

EPSDT services do not require a local match.

For more information on EPSDT services, see the EPSPT manual under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.5 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.

For more information on dental services, see

- [Dental services](#)
- [Dentists who accept Medicaid](#)
- Dental Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.6 Community Mental Health Rehabilitation Services

Medicaid provides coverage for *community* mental health *rehabilitation* services. These services are provided in the child's home or community and provide diagnosis, treatment, or care of children with mental illnesses or intellectual disability. Services shall meet service definitions, eligibility criteria, required activities, and service limitations. Providers of services shall meet qualifications specified under the "Provider Participation Requirements."

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid-enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Registering a service with Magellan as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

These services are managed by [Magellan](#). They are provided primarily by Community Services Boards and private providers:

- Crisis Intervention – *requires registration.*
- Crisis Stabilization – *requires registration.*
- Mental Health Support Services - *requires authorization.*

- Intensive In-Home Services for Children and Adolescents - requires authorization.
- Therapeutic Day Treatment for Children and Adolescents - requires authorization.
- Community-Based Residential Services for Children and Adolescents under 21 - Level A.
- Therapeutic Behavioral Services for Children and Adolescents - Level B - requires authorization.
- *Services for older youth approved on case by case basis:*
 - Day Treatment/*Partial Hospitalization* - requires authorization.
 - Psychosocial Rehabilitation - requires authorization.
 - Intensive Community Treatment - requires authorization.
 - *Mental Health Targeted Case Management* - requires registration.

For more information, see the Community Mental Health Rehabilitation Services Manual under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.7 Medicaid Substance Abuse Treatment Services

- Substance Abuse Crisis Intervention - *requires registration.*
- Substance Abuse Intensive Outpatient - *requires registration.*
- Substance Abuse Day Treatment - *requires registration.*
- Opioid Treatment - *requires registration.*
- Substance Abuse *Targeted Case Management* - requires registration.
- Substance Abuse Day Treatment for Pregnant Women - requires registration.
- Substance Abuse Residential Treatment for Pregnant Women.
- *Expanded Prenatal Services (BabyCare) – Substance Abuse Treatment Services for Pregnant and Postpartum Women.*

For more information, see the *Community Mental Health Rehabilitation Services Manual* under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.8 Medicaid Psychiatric Services

- Outpatient Psychiatric Services - Individual therapy, family therapy, or group therapy.
- *Outpatient Psychiatric Substance Abuse Services - requires authorization.*
- *Inpatient Acute Psychiatric Services (Acute Hospital and Acute Freestanding Hospitals – requires authorization.*
- *Psychiatric Residential Treatment Facility Level C – requires authorization.*
- *Treatment Foster Care Case Management – requires authorization*

For more information, see the *Psychiatric Services Manual* under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.9 Medicaid Rehabilitation Services

- Intensive Rehabilitation Services include:
 - *Physician.*
 - *Rehabilitative Nursing*
 - *Physical Therapy*
 - *Occupational Therapy*
 - *Speech-Language Pathology*
 - *Cognitive Rehabilitation Therapy*
 - *Psychology*
 - *Social Work*
 - *Therapeutic Recreation*

- *Prosthetic/Orthotic Services*
- *Durable Medical Equipment*
- Outpatient Rehabilitation Services

For more information, see the *Rehabilitation Services Manual* under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov. The following chapters may be most helpful: Chapter 2 - Provider requirements; Chapter 4 - Covered services; and Chapter 6 - Documentation requirements.

12.11.7.10 Medicaid Durable Medical Equipment

- Listing of covered supplies can be found in the “Appendix B” documents under [Provider Manuals](#) on the DMAS Web Portal link at www.virginiamedicaid.dmas.gov.
- Wheelchairs.
- Communication devices.
- Diabetic supplies.
- Incontinence supplies.

12.11.7.11 Medicaid Long-Term Care Services

Medicaid pays for long-term care services in some institutional settings, such as in nursing facilities and Intermediate Care Facilities, and in 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:

- *Intellectual Disabilities (ID) Waiver.*
 - Eligibility: An individual shall be age 6 or older and have a diagnosis of *ID* or be under age 6 and at developmental risk. The person should be eligible for placement in an intermediate-care facility for persons with *intellectual disabilities* or other related conditions (ICF-ID).

- Services available: Residential support services, day support, supported employment, prevocational services, personal assistance (*agency and consumer directed*), respite (*agency and consumer directed*), companion services (*agency and consumer directed*), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, *transitional services*, and personal emergency response systems (PERS). Support coordination is also provided.
- Visit the [Department of Behavioral Health and Developmental Services \(DBHDS\)](#) website for additional information on this waiver.
- 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 *intellectual disability*. Individuals also should require the level of care provided in an intermediate-care facility for persons with *intellectual disability* or other related conditions (ICF/MR). Children who do not have a diagnosis of *intellectual disability*, and have received services through the ID Waiver, become ineligible for the 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 (*agency and consumer directed*), supported employment, in-home residential support, therapeutic consultation, personal care services (*agency and consumer directed*), respite care (*agency and consumer directed*), skilled nursing services, attendant services, family and caregiver training, crisis stabilization, environmental modifications, assistive technology, personal emergency response system (PERS), and prevocational services. *Case management* is also provided.
 - Contact the [Department of Behavioral Health and Developmental Services \(DBHDS\)](#) for additional information on this waiver.
- 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.

12.11.8 Psychotropic medications

For some children in foster care who have complex mental health needs, psychotropic medications can be one important component of comprehensive care. There has been a steady increase nationally in the use of psychotropic medications to address the emotional and behavioral problems of children in foster care over the past decade. Data reported from empirical studies show that children in foster care:

- *Have higher rates of psychotropic medication use compared to other children in Medicaid and in the general population.*
- *Are more likely to be prescribed psychotropic medications as they age.*
- *Often receive more than one class of psychotropic medications when they take such medications.*
- *Are most likely to receive psychotropic medications in the most restrictive placements, such as group homes or residential treatment programs.*

Children in foster care have disproportionately high rates of emotional, behavioral, and mental health needs that require intervention. They also use disproportionately more behavioral health services. Therefore, the higher use of psychotropic medications may in part reflect the increased emotional and behavioral distress for children in foster care.

However, the dramatic increase and use of psychotropic medications may at times exceed clinical practice standards supported by empirical research. There are concerns when children in foster care are prescribed too many or too much psychotropic medication or prescribed medications when they are too young. There are also significant geographic variations within and across states in the prevalence of psychotropic use. While some children in foster care may be prescribed too many medications, others may not have access to needed medications.⁷

For information on psychotropic medications, see:

- [Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care](#) (ACYF-CB-IM-12-03; April 11, 2012).
- [A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents](#) (2012) by the American Academy of Child & Adolescent Psychiatry.
- [Mental Health Medications](#) by the National Institute of Mental Health.
- [List of Psychotropic Medications by Class](#). Note: this list is not all inclusive.

12.11.8.1 Responsibilities of service worker in managing child's medications

The service worker is responsible for ensuring psychotropic medications are administered and monitored for the child in foster care, including:

- Involving the child, parents or guardians, and caregivers in ongoing decision-making as appropriate, including obtaining appropriate consents (See [Section 12.11.1](#)).
- Keeping the child's team informed of the child's psychotropic medications as one component of the overall service plan for the child and family.
- Updating the [Child Health Information Form](#) to ensure the information is current and accurate. This information should be obtained primarily from information on evaluations and assessments conducted by the child's health and behavioral health care providers. Some information may be available through communicating with the managed care case manager, when applicable. The MCO's have 60 days to complete an assessment. Information should be available within 30-65.
- Providing the [Child Health Information Form](#), or information on this form, to all health care professionals working with the child.

⁷ Excerpted and adapted from [Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care](#) (ACYF-CB-IM-12-03; April 11, 2012).

- *Arranging for the child to have the following examinations prior to the child being placed on a new psychotropic medication. The child should receive:*
 - *A pediatric medical examination to ensure symptoms are not indicative of a medical problem, except in the case of an emergency. In an emergency, a physical examination should be conducted as soon as possible.*
 - *A comprehensive child and adolescent mental health evaluation by a licensed mental health professional. Information should be requested on:*
 - *The child's diagnosis.*
 - *Psychosocial supports and/or behavioral health services to help meet the child's needs, build on the child's strengths, and help create resiliency in the family, as appropriate.*
 - *The appropriate sequencing of psychosocial and/or pharmacologic interventions.*

Note: When the child's condition has already been evaluated and the doctor is changing treatment or psychotropic medication after a treatment or psychotropic medication did not work, these examinations are not necessary.

- *Identifying the specific individual where the child is living who is responsible for the management, administration, and monitoring of the child's medications.*
- *Helping prepare the child and family members, as appropriate, for doctor visits, including:*
 - *Sharing information on the child's emotions, behavior, and symptoms with the doctor.*
 - *Asking questions about the child's medication and treatment.*

See [Preparing for Visit with Doctor to Discuss Child's Psychotropic Medication](#).

- *Ensuring caregivers and providers are informed about the child's medication. Sources of information for caregivers and providers include:*
 - *The drug information provided by the doctor or pharmacist.*

- *Any black box warning labels with potential adverse effects placed on the prescription medication by the Food and Drug Administration (FDA).*
- *The [Medication Guide](#) for the specific medication on the FDA website. These guides are the paper handouts included with many prescription medicines. They address issues specific to particular drugs and drug classes, and they contain FDA-approved information that can help patients avoid serious adverse events.*
- *Calling the doctor's office or pharmacist with any questions or concerns.*
- *Communicating to the child, family, foster care provider, other caregivers, and other significant individuals (e.g. teacher), as appropriate, the importance of:*
 - *The child adhering to the medication regimen prescribed by the doctor.*
 - *Monitoring the child's emotions, behavior, and symptoms.*
 - *Reporting any side effects and issues related to the medication.*
- *Discussing the child's medication with the child and caregivers during ongoing monthly visits, including:*
 - *How does the child feel about being on the medication?*
 - *Is the child taking the medication as prescribed? If not, what are the issues and how are they being resolved?*
 - *Have there been any changes in the child's behavior, mood, appetite, sleep, school performance, and relationship with others?*
 - *Is the child having any side effects? How are they being managed? Are these strategies working or not?*
 - *Has the child attended all medical appointments? What are the dates of upcoming appointments with the doctor?*
- *Arranging for the child to obtain all necessary tests and attend all medical appointments.*
- *Contacting the prescribing doctor when there are concerns about the medication. May also contact the pharmacist and the primary care*

provider. Should contact a child and adolescent psychiatrist when there are significant concerns.

12.12 School placements and education

For children and youth in foster care, a change in foster care placement has frequently resulted in a change in school placement. The educational impact of every school change is significant. Each time children enter new schools they must adjust to different curricula, different expectations, new friends, and new teachers. These changes may create several negative outcomes for children placed in foster care:

- They may make less academic progress, falling behind their peers.
- They may experience less opportunity for academic achievement, increasing the risk for dropping out of school.
- They may face challenges in developing and sustaining supportive relationships with teachers and peers.

Keeping children in the same school:

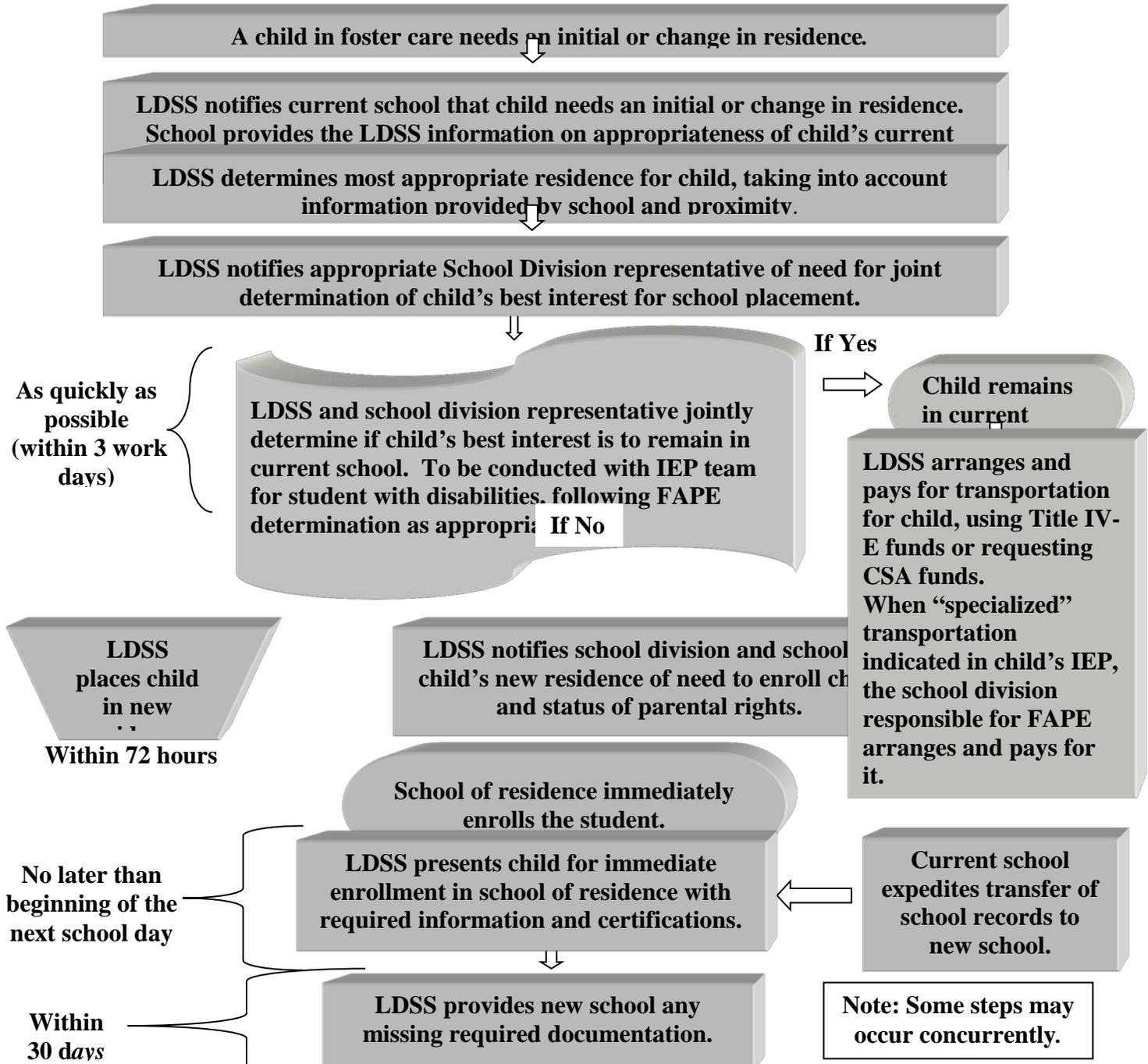
- Provides continuity in education.
- Maintains important relationships at school.
- Provides stability during a traumatic time for the children.
- Improves educational and life outcomes.

The joint guidance document, [Virginia Department of Education and Virginia Department of Social Services Fostering Connections: Joint Guidance for School Stability of Children in Foster Care](#), represents collaboration of these two State departments to promote school stability for children in foster care. This section provides guidance consistent with the joint guidance. The joint guidance may also be found on the Virginia Department of Education's website under [Enrollment of Students in Foster Care](#).

The joint guidance applies to all school age children in both initial and subsequent foster care placements. The joint guidance requirements also apply when the parent retains custody of the child and has entered into a noncustodial foster care agreement with the LDSS to voluntarily place the child in foster care.

When the LDSS is considering placement of a school age child in a new residence (i.e., foster care placement), the flow chart on the next page provides a visual summary of the sequence of activities and timeframes for the school placement process.

School Placement Process for Child in Foster Care



* This provision and the subsequent provisions in this document apply also to students with disabilities who are served under a 504 Plan pursuant to the Rehabilitation Act of 1973, as amended. (FAPE) refers to Free & Appropriate Public Education.

12.12.1 Determining child's best interest for school placement

After the LDSS determines the most appropriate home for a school age child (see [Section 6.3](#) through [Section 6.7](#)), the LDSS and the school division shall work together to jointly determine the child's best interest for school placement. For general education students and for students with disabilities (after the free and appropriate public education (FAPE) determination is made that the child can be enrolled in either school), the service worker and appropriate school division representative/Individualized Education Program (IEP) team shall work together to determine the child's best interest for school placement and ensure educational stability for the child.

The presumption is that the child will remain in the current school where the child was last enrolled at the time of the foster care placement to provide school stability and educational continuity for the child, unless contrary to the child's best interests. The service worker and school division representative/IEP team, in collaboration with the child and other key partners, make a determination as to whether the child should:

- Remain in the school where the child was enrolled at the time of placement in the new residence, taking into account the appropriateness of the educational setting; or
- Change schools and enroll in the school of residence for the child's new foster care placement, if remaining in the current school is not in the child's best interests. The service worker and the school division shall ensure that the child is immediately and appropriately enrolled in the new school. The current school shall provide all educational records to the new school ([Social Security Act, Title IV, § 475 \(1\) \(G\) \[42 USC 675\]](#)). The educational records should be received within five days of enrollment. See [Section 12.12.2.2](#) on school enrollment requirements.

When placing the school age child in a foster care placement, the LDSS shall document in writing the joint determination with the appropriate school division of whether it is in the child's best interest to remain enrolled in the child's current school ([§ 63.2-900.3](#)). The [Best Interest Determination for Foster Care School Placement Form](#) should be completed as quickly as possible (e.g., **within three (3) business days**) after the service worker notifies the school division of the child's new placement.

The joint determination for school placement must not delay the child's foster care placement in the new residence. If the joint determination process cannot be completed prior to the placement in the new residence (e.g., an emergency placement to ensure the child's safety), the presumption is that the child will remain enrolled in the current school, until the best interest determination process is completed.

For general education students:

- The LDSS shall contact the child's current [school division foster care liaison](#) to convene the best interest determination meeting.
- The LDSS and the school division foster care liaison where the child is enrolled coordinate to jointly determine the child's best interest for school placement, in consultation with the child and other key partners.
- The child should remain in the current school, unless contrary to the child's best interests.

For students with disabilities served under the Individuals with Disabilities Education Act (IDEA), the responsibility for school placement determination and the mechanism for making the determination are driven not only by the Fostering Connections Act, but also by state and federal regulations under IDEA. Thus, in determining which school division to involve in the best interest determination, the school division and LDSS must determine which school is responsible under IDEA for the student's free and appropriate public education (FAPE), and the student's IEP team must participate in the determination.

- When the special education child's new residence is in the current school division, the LDSS must contact the child's current [school division foster care liaison](#) to convene the best interest determination meeting. The child should remain in the current school unless contrary to the child's best interest. If a change in school placement is being considered, the IEP team from the child's current school, along with the school division representative, determines where the child can receive FAPE. If the child can receive FAPE in both settings, the IEP team, school division representative, and LDSS service worker collaborate on the best interest determination. If the child cannot receive FAPE in both schools, the child must be enrolled in the school where FAPE can be provided. The child's IEP team at the child's current school should be engaged in the best interest determination.
- When the special education child's new residence is in a different school division, the LDSS must contact the [school division foster care liaison](#) where the child is currently enrolled, and the school division foster care liaison for the child's new residence to convene the best interest determination meeting. Virginia's IDEA regulations provide that the school division where the child's new residence is located is responsible for FAPE. In these cases, an IEP team designated by the new (receiving) school division must be convened to participate in the best interest determination, as well as determine what constitutes FAPE for the child. If, however, the IEP team in the school division where the child's new residence is located determines that the child needs to be placed in a private day or residential facility for educational reasons, the responsibility for FAPE shifts back to the child's current (sending) school

division. Then that school division participates in the best interest determination process. The child stays in the current school during the best interest determination process.

Both Fostering Connections and the Virginia statutory provisions regarding educational stability support the need for collaboration between the sending and receiving school divisions to ensure educational stability for the child.

12.12.1.1 Engaging child in school placement determination

The service worker should engage the child in discussions to:

- Solicit his or her wishes related to school placement.
- Address constructively any concerns the child may have.
- Discuss the benefits of having someone attend the meeting to help ensure his or her wishes are communicated.
- Ask who the child would like to attend the meeting. The service worker should arrange for this person's participation in the meeting.

12.12.1.2 Engaging other key partners in determining child's best interest for school placement

Essential members of the team determination process for general education students include the:

- Child.
- Child's birth parent(s) or prior custodian.
- Individual(s) the child would like to participate.
- Service worker.
- School division representative/foster care liaison.

For student with disabilities, the LDSS service worker and the [school division foster care liaison](#)(s) must determine the parent for special education purposes in order to convene the child's IEP team (§ [22.1-213.1](#)). Some or all of the noted individuals may be included in accordance with the [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#) (8 VAC 20-81-110).

The service worker and the school division representative/foster care liaison should make all reasonable efforts to involve other individuals who have

knowledge of the child to attend and participate in the best interest determination meeting. The best interest determination meeting may occur during an IEP meeting for student with disabilities. Participation for IEP meetings may occur through teleconferences or other electronic means, and participants other than those required to attend under applicable special education regulations may submit written information. For general education students, participation may also occur through phone calls, teleconferences, emails, or other electronic means.

To share the workload, the service worker and the school division representative/foster care liaison may want to involve or consult with the following key partners in the best interest determination, as appropriate.

The service worker may involve:

- The child's birth parent(s) or prior custodian.
- Other family members.
- Resource parent(s) or current placement provider, and other service providers.
- Guardian ad litem.
- Other adults who are significant for the child and family.

The school division may involve:

- A school division representative from the school of residence for the child's new foster care placement or the child's current school at the time of placement, as applicable.
- Classroom teachers.
- School social workers.
- School counselors.
- Special education and related service personnel, as appropriate.
- Coaches.

12.12.1.3 Factors to assess in child's best interest determination

The child's safety and permanency plan shall be paramount in decision making, based on federal and state law.

Additional factors to assess in determining the child's best interests for school placement include, but are not limited to, the following:

- The preferences of the child, the birth parents or prior custodians as appropriate, and the resource parent(s) or current placement provider of the child.
- School stability and educational continuity for the child, as well as time in the school year and distance from the child's current school to the new foster care placement.
- Personal safety, attendance, academic progress, and social involvement of the child in the current school.
- The impact transferring the child to a new school may have on the child's needs and progress academically, emotionally, socially, and physically.
- Solutions addressing any practical issues identified, such as travel to the child's current school from the new placement.

The [Best Interest Determination for Foster Care School Placement Form](#) should be used to assist the service worker and school division representative in jointly determining the child's best interest for school placement. This form provides a series of questions that should be considered during the determination process.

12.12.1.4 Documenting school placement process and determination

The service worker shall document the best interest determination in the child's case plan, including factors considered, participants involved in the collaborative process, the team's determination for school placement, and the placement made. The [Best Interest Determination for Foster Care School Placement Form](#) documents compliance with federal and state law and shall be maintained in the child's foster care paper case record and the school's student cumulative record. If a change in school placement is determined to be in the child's best interest, the school where the child was previously enrolled must send this documentation to the new school as part of the student's cumulative record.

12.12.2 Subsequent actions implementing best interest determination

After the LDSS and the school division jointly determine the child's best interest for school placement, subsequent actions are taken to implement the determination. Either:

- Arranging and funding school transportation for the child to remain in his or her current school (see [Section 12.12.2.1](#)); or
- Immediately enrolling the child in the school of residence for the child's new foster care placement (see [Section 12.12.2.2](#)).

12.12.2.1 Arranging and funding transportation to remain in current school

When the LDSS and the school division jointly determine the child's best interest is to remain in the current school in which the child was enrolled prior to entry into foster care or prior to a placement change:

- For general education students and for students with disabilities who use regular school transportation, the LDSS shall arrange for transportation and payment of transportation expenses, using Title IV-E funds or requesting CSA state pool funds (see [Section 12.12.2.1.1](#)).
- For students with IEPs that require "specialized" transportation, including transportation to a private school program, the responsible school division arranges and pays for transportation (see [Section 12.12.2.1.2](#)).

The youth are transported without any interruption in attendance.

12.12.2.1.1 Regular school transportation

For the general education student and the student with disabilities who use regular school transportation, when it has been jointly determined that the child's best interest is to remain in the child's current school, the LDSS shall arrange for transportation and payment of transportation expenses.

Under these circumstances, funding for regular school transportation is available as a legitimate maintenance expense. These payments are made in addition to the basic maintenance payments made on behalf of the child.

Transportation costs for the child to remain in his or her current school shall be paid from:

- Title IV-E funds for eligible children, consistent with federal and state law/policies.
- State pool funds through CSA for non-Title IV-E eligible children, consistent with state law.

Reasonable and necessary transportation costs shall be paid to keep the child in the same school when jointly determined to be in the child's best interest. Reimbursement of transportation costs may be made to foster

parents, friends, relatives, neighbors, and employees of child placing agencies and residential programs. Public transportation, such as bus fare or other similar transportation, is paid at the established rate. Providers shall submit receipts for travel costs to the LDSS in order to receive reimbursement. The LDSS may reimburse the local school division's school bus transportation fund. There shall be a documented agreement or contract between the LDSS and the local education agency (LEA) or the company that manages the school bus system and a copy placed in the child's file. All travel costs require receipts and/or other documentation as determined by the LDSS. The LDSS shall maintain these receipts/documents per foster care record retention.

Reasonable and necessary transportation costs shall be defined as those costs that are equivalent to the state/federal mileage reimbursement rate. For those situations where the LDSS must negotiate a higher rate, the LDSS should have documentation to support why this is needed to meet the child's needs for school transportation. (For example: flat rates such as \$70 per day without a breakdown of the costs is unacceptable.) Federal language does not define reasonable or set maximum rates, however, monthly amounts that exceed the child's maintenance rate require justification. Approval of transporters other than foster parents is at the discretion of the LDSS utilizing the local approval standards for this practice. It is the service worker's responsibility to review and approve the transportation costs, then provide the supporting documentation (negotiated rate and justification) to the eligibility worker to determine eligibility for Title IV-E funds.

For more information on funding transportation costs, see [Section 12.10.2](#).

12.12.2.1.2 "Specialized" transportation in child's IEP

When a youth entering or in foster care has an IEP that requires "specialized" transportation to the current school, such transportation costs are paid for by the school division responsible for a free appropriate public education (FAPE). "Specialized" transportation includes individualized provisions, noted in the IEP, that are needed because of the student's disability and that are necessary to guarantee access to a FAPE. Examples include the following:

- Student requires transportation to a private school program (i.e., private day or private residential school).
- Student requires physical accommodations/modifications (e.g., car seat or security devices such as harnesses, brackets, restraints, seatbelts, vests, etc.).

- Student requires specialized equipment such as special or adapted bus, lift, or ramp.
- Student requires a bus with two-way radio, phone, or other equipment in case of emergency.
- Student requires specialized services including personnel to provide assistance or supervision (e.g., aide).
- Student requires necessary medical equipment to perform procedures on the bus.
- Student requires alteration to school or bus schedule (e.g., partial day attendance, shortened bus ride, etc.).

Neither Title IV-E nor CSA funds may be used to pay for services outlined in an IEP.

Clarifying that specialized transportation costs for youth with an IEP is the school division's responsibility, does not change any other requirements for the LDSS and local school division to work collaboratively to ensure youth receive uninterrupted education services at the school determined to be in the youth's best interest.

12.12.2.2 Enrolling child in new school

When the LDSS and the school division jointly determine the child's best interest is to immediately enroll the child in the school of residence for the child's new foster care placement, the LDSS should follow the procedures described in this section.

12.12.2.2.1 Notifying new school of need to enroll child

Within 72 hours of placing a school age child in an initial or different foster care placement, the LDSS or LCPA shall in writing:

- Notify the principal of the school in which the child is to be enrolled and the superintendent (or designee) of the relevant school division of the placement.
- Inform the principal of the status of the parental rights of the child's parents ([§ 63.2-900 D](#)).

The LDSS or LCPA should submit the [Notice of Student Receiving Foster Care Services Form](#) which provides these notices to the school.

The mandated time frame for notification may overlap and/or dictate the time frame for determining the child's best interest for school placement, depending upon when the child is placed in the new residence.

When the timing of the LDSS' official notification of the need to enroll the child and LDSS's presentment of the child to the school for immediate enrollment coincide, the [Immediate Enrollment of Child in Foster Care Form](#) may be used for both purposes. This form meets all legal requirements for LDSS notification and minimum legal requirements for school enrollment (see [Section 12.12.2.2](#)). In such circumstance, copies of the completed immediate enrollment form shall be provided to the school for the superintendent (or designee) and the principal to comply with state legal requirements, in addition to other parties.

12.12.2.2.2 Enrolling child immediately and appropriately

The child shall be immediately and appropriately enrolled with all educational records provided to the new school ([Social Security Act, Title IV, § 475 \(1\) \(G\) \[42 USC 675\]](#)). The child shall be enrolled as soon as possible but no more than 72 hours after placement ([22 VAC40-201-50 D](#)). Delays in continuous enrollment in school are not in the best interest of the child, and both federal and state laws prohibit delaying the child's on-going education.

- "Immediate" means **no later than the beginning of the next school day** after the presentment for enrollment.
- "Presentment" means the person enrolling the child has appeared at the school and presented all required information and certifications ([§ 22.1-3.4](#)).
- "Enrollment" means the child is attending classes and participating fully in school activities.

The CPA who has custody of the child and who is presenting the child to the school for immediate enrollment should submit the completed [Immediate Enrollment of Child in Foster Care Form](#) to the school which provides all required information to immediately enroll the child. This form should be printed on yellow paper to alert the school and distinguish it from other documents.

The [Immediate Enrollment of Child in Foster Care Form](#) documents the minimum legal requirements for immediately enrolling the child. The person enrolling the student provides a written statement with the child's name and address and to the best of the person's knowledge: the child's age, and the following required certifications:

- Whether the child has or has not been expelled from attending school at a private or public school division of the Commonwealth or in another state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person.
- Whether the child has been found guilty of, or adjudicated delinquent for, any criminal acts listed in [§ 16.1-260 G](#) or any substantially similar offense under the laws of any other state, the District of Columbia, or U.S. territory. The notification shall include the nature of the offense ([§ 22.1-3.2](#)).
- That the child is in good health and is free from communicable or contagious disease ([§ 22.1-3.4](#)).

The form also provides necessary information to ensure a smooth transition and affirmation of educational continuity for the child and school.

Should the child have been involved in any offenses, the CPA should communicate with the school division and provide information regarding any rehabilitative efforts made or completed by the child to prevent the occurrence of any further offenses.

Upon presentment of the immediate enrollment form or the minimum legal requirements, the new school shall immediately enroll the child **no later than the beginning of the next school day**. If, despite all reasonable efforts, school officials are unable to enroll the child by the beginning of the next school day following presentment for enrollment, the student shall be enrolled **no later than the second school day** following presentment. In such instances, school officials document reasons for the delay and attach this information to the [Immediate Enrollment of Child in Foster Care Form](#).

The sending and receiving school division representatives shall expedite the transfer of the student's record ([§ 22.1-289](#) and the [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#), as applicable).

The CPA shall provide the following documentation required for enrollment when available, including the child's:

- Birth certificate ([§ 22.1-3.1 A](#)).
- Proof of immunization ([§ 22.1-271.2](#)).
- Pre-school physical examination ([§ 22.1-270](#)).

If these three required documents to enroll the child in school are not immediately available when the CPA assumes custody or changes placement of the child, the CPA shall obtain and produce, or otherwise ensure compliance with these requirements, **within 30 days** after enrollment of the child ([§ 63.2-900 D](#)).

For students with disabilities, the school division responsible for the child's IEP and FAPE must ensure that the child receives FAPE even if the required enrollment documents are not immediately available ([8 VAC 20-81-30.D](#)). Additionally, the school division must also ensure that any related IEP requirements are followed, including as necessary, the requirements of Prior Written Notice, and notices of IEP meetings.

The LDSS shall retain a copy of the [Immediate Enrollment of Child in Foster Care Form](#) for the child's foster care paper case record. Copies should be provided to the birth parents, prior custodians, and/or the foster, adoptive, or resource parent(s), as appropriate. The school retains the form in the student's cumulative record.

12.12.3 Resolving school placement disputes

It is the responsibility of the LDSS and the school division to collaborate in the child's best interest in determining school placement and to resolve any conflict concerning the school placement determination.

If the school division representative/foster care liaison and the LDSS service worker do not agree on the child's best interest for school placement, the child **remains** in the school in which the child was enrolled at the time of the foster care placement until the school placement issue is resolved. For responsibilities on arranging transportation and payment of transportation expenses for the child to remain in the current school, see [Section 12.12.2.1](#).

The LDSS and the school should use the procedure delineated below for resolving school placement disputes.

- **Within five (5) business days** of the best interest determination meeting, the LDSS supervisor and the school division administrator work together, review the best interest determination documentation, and resolve the dispute.
- If the school division administrator and LDSS supervisor do not agree on the child's best interest for school placement, a written request is submitted **within the same five (5) business days** to the school division superintendent (or designee) and the LDSS director (or designee) for a review of the best interest determination documentation. The written request includes the completed [Best Interest Determination for Foster Care School Placement Form](#) which documents:

- The factors that were considered in determining the school placement that is the child's best interests.
- The team's determination for school placement.
- The participants involved.
- Whether each participant agreed or disagreed with the team's determination.
- The reasons for agreement or disagreement.
- Any additional information pertinent to the dispute.
- Efforts made to resolve the dispute.
- **Within ten (10) business days** following the submission of a written request, the LDSS director (or designee) and the school division superintendent (or designee) review the request, the best interest determination documentation, and any additional information pertinent to the dispute. They work together to resolve the dispute.
 - If the LDSS director (or designee) and the school division superintendent (or designee) reach consensus regarding the child's best interest for school placement, the LDSS service worker and school division representative are informed of the decision.
 - If the two parties cannot agree, they should seek guidance and consultation from their respective state agencies. This request is submitted **within the ten (10) day timeframe**. The LDSS submits this request to the Regional Permanency Consultants. Local school division representatives submit their requests to the Virginia Department of Education, Office of Student Services.
- After the Virginia Departments of Education and Social Services work together to provide guidance and technical assistance to the involved local agencies, the school division superintendent (or designee) and LDSS director (or designee), in consultation with the team, should resolve the dispute. The LDSS and school make a determination as to whether the child:
 - Remains in the current school; or
 - Changes schools and enrolls in the school of residence for the child's new placement, if remaining in the same school is not in the child's best interests. The service worker, school division representative and the child's new school shall ensure the child is enrolled appropriately and immediately, with all educational records provided to the new school.

- All written documentation is placed in the child's foster care paper case record and the student's cumulative record to be available for any required federal reviews.

Note: For students with disabilities, the determination regarding the ability of a student to receive FAPE is the exclusive decision of the student's IEP team. Such a determination may only be challenged through the established dispute resolution mechanisms of special education law (i.e., a state complaint, mediation, or due process hearing). The IEP team determination, or the determination reached through the special education dispute resolution process is final, and the child must be enrolled in the school that can provide FAPE.

12.12.4 Communicating with school on child's education

The CPA, in collaboration with the birth parent(s) or prior custodians as appropriate, and the resource parent or current placement provider, should:

- Refer the child for an evaluation for determination of eligibility for special education services if he or she is suspected of having a disability.
- Communicate any other special needs or issues the child may have related to school.
- Inform school personnel of foster care requirements, such as regular court dates, the child's permanency plan, and the child's service plan, as appropriate.
- Monitor the child's educational progress through attending conferences with school personnel, report cards, performance evidence, and IEP meetings as appropriate, and through maintaining contact with the foster care placement and birth parent(s) or prior custodians.
- Inform the school at any time the child is a subject of a petition alleging the child committed, or was adjudicated delinquent for, any criminal acts listed in [§ 16.1-260 G](#) and provide the nature of the offense.

LDSS may contact the [School Division Foster Care Liaison](#). The Virginia Department of Education's [Superintendent's Memo #306](#) dated December 10, 2010 recommended that each school division designate a point of contact for students in foster care.

12.12.5 School nutrition programs

The Healthy, Hunger Free Kids Act of 2010 provides categorical eligibility for free meals, without further application for foster care children. The school division should obtain documentation indicating the status of the child as a child in foster care in the

placement and care responsibility of the state or that the child in foster care has been placed with a caretaker household by a court.

Prior to the Act, a separate application for free and reduced lunch price meals was submitted for a foster child who was considered a household of one. Now, a foster care child is categorically eligible and may be certified without an application with the appropriate documentation.

Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes the non-foster care children. Information should be relayed to the foster family that the presence of a foster child in the home does not convey eligibility for free meals to all children in the household in the same manner as Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF).

When the LEA is processing a household application, the foster care child will be certified for free meals and then an eligibility determination will be made on the remainder of the household based on the household's income (including personal income earned by the foster child).

Foster payments received by the family from the placing agency are not considered income and do not need to be reported.

12.12.6 Regular education services

The local school division shall provide free textbooks required for courses of instruction for children attending public schools ([§ 22.1-243](#)). Other educational services needed by the child and not provided by local school divisions may be purchased using state pool funds. Some educational services may be purchased from independent living funds for youth ages 14 and over.

12.12.6.1 When regular education services may be purchased

- To achieve an educational goal;
- They are not the responsibility of state and/or local education agencies;
- Services are not available without cost; or
- Charges for services are the same to all residents regardless of income.

12.12.6.2 Educational services that may be purchased

- Normal school expenses such as school trips, summer school, gym suits, fees for labs, art classes, etc., and school supplies.

- Tutoring.
- Training for employment if no other resource exists.
- Tuition and fees, school supplies, textbooks required for college degree or vocational education.
- Tuition and fees, etc., for placement in a private school for the child who is not eligible for special education. In this instance, the child's foster care paper case record shall document that:
 - All other resources to meet the child's specific need have been explored.
 - These resources have been determined to be inadequate to meet the child's needs.

12.12.6.3 Other school-related expenditures

Expenses related to school activities that are not necessary to meet an educational goal such as class rings, club dues, and prom fees may be purchased from Chafee Independent Living Funds for youth ages 14 years and older, private donations, and local only funds. After all other funding sources are pursued and determined not available, state pool funds may be used based on CPMT procedures.

12.12.7 Special education services

- School divisions are mandated by law to provide, without cost, instruction specifically designed to meet the unique needs of children with disabilities, ages 2 through 21 ([§ 22.1-214](#)).
- A child is determined eligible for special education and related services by an eligibility team at the school. This team uses data gathered through a comprehensive evaluation. The school division may use data provided by the LDSS or other source (e.g., psychological, medical, hearing or vision screenings/evaluation, and sociocultural evaluations). This team makes its decision for such services no later than 65 business days after the referral for the evaluation is received by the division.
- The school division shall develop an individualized education program (IEP) **within 30 calendar days** after eligibility has been determined.

If the child's parent cannot be found or parental rights have been terminated, school divisions are required by law to train and appoint surrogate parents to represent the educational interests of the children, which may include those in the custody of the LDSS. When a surrogate parent is appointed, that

individual holds the same rights and responsibilities relative to the child's education as are afforded to parents. Local school divisions may appoint the foster parent as the surrogate parent under certain circumstances. The school division may recognize the foster parent as parent when the child is in permanent foster care. Additionally, the permanent foster care parent shall have an ongoing, long-term relationship with the child, is willing to make the educational decisions required of the parent under the regulations governing special education, and has no interest that would conflict with the child's interests.

- A surrogate parent is not required for a child in a non-custodial placement. The parent or guardian is responsible for requesting services and signing IEPs. The federal Individuals with Disabilities Education Act (P.L. 108-446) prohibits LDSS staff from serving as parents (or surrogate parents) for children in custody.
- If the child's parents (which includes birth parents, adoptive parents, permanent foster parents in the situation described above, or surrogate parent) disagree with the evaluation conducted by the school division, they may request an independent evaluation at public expense.
- If the LDSS or foster parents have any concerns or disagreements about a foster care child's special education program or implementation of the special education procedures, the service workers should first contact the director of special education in the local school division for resolution. If resolution is not achieved at the local level, the LDSS may contact the Virginia Department of Education's Dispute Resolution and Administrative Services unit in the [Division of Special Education and Related Services](#) for more information about mediation, complaints, and due process hearings.

12.12.7.1 Local school responsibility

Local school divisions are responsible for paying for special education services identified on the child's Individual Education Program (IEP) when the child is placed within the school system or regional special education program.

When a child is placed in another jurisdiction, the receiving local school division should seek reimbursement for education costs from the Virginia Department of Education for any children receiving foster care services. (§§ [22.1-101.1](#) and [22.1-215](#)).

12.12.7.2 Length of time child is eligible for special education services

A child is eligible for special education services until he or she:

- Is found to be no longer eligible by an eligibility team;

- Graduates with a regular or advanced diploma; or
- Reaches age 22 by September 30 of the year.

The local school division where the LDSS is located that has custody of the child is responsible for the child's special education services. In the event that a child is placed in foster care in a different jurisdiction and the child can be educated in the public school or a regional program that includes that jurisdiction, the school division where the child is placed is responsible for the child's education.

12.12.7.3 Use of state pool funds for special education services

- State pool funds are to be used to purchase special education and related services for a child placed in a residential facility approved for special education or private special education day school in accordance with the child's IEP. Related services include such services as developmental day programs, infant/child stimulation, training to maximize independence, and sheltered workshops. Procedures to access state pool funds for these placements will be based upon CPMT policies. Maintenance for Title IV-E eligible children would be paid from Title IV-E funds and from state pool funds for non-Title IV-E children.
- In addition, the [CSA Manual](#) (Section 4.3.3a) specifies how state pool funds may be used to keep a child in a less restrictive special education environment, when the FAPT makes such a determination and includes it on the IFSP.
- If a child is placed in a facility for special education and is subsequently determined ineligible for special education, removal of the child from the facility or continued funding of services for that child in the facility will be based on local CPMT procedures. The LDSS, in coordination with the FAPT, is responsible for ensuring that an appropriate placement is provided for the child.

12.12.7.4 Cross-jurisdictional placements

The cost of purchasing special education and related services, where applicable, for children in cross-jurisdictional placements will be covered by the placing agency's school division through the policies of the CPMT. This also applies to children in permanent foster care placements or adoptive placements prior to the final order. If a child is served in a public school, the receiving school division pays for the services. All special education needs shall be included on the IEP in accordance with federal law.

12.13 CSA services

The Comprehensive Services Act (CSA) establishes a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the needs of troubled and at risk youth and their families. One of the targeted populations is children and youth for whom foster care services, as defined by [§ 63.2-905](#), are being provided.

12.13.1 CSA foster care services

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 or youth who has been abused or neglected, or in need of services, or a family who a child or youth has been identified as needing services to prevent or eliminate the need for foster care placement, a youth or child who has been placed through an agreement between the LDSS or the public agency designated by the CPMT and where legal custody remains with the parents or guardians, or has been committed or entrusted to an LDSS or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not reached the age of 21 years who is in the process of transitioning from foster care to self-sufficiency.

Access to CSA 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.

12.13.2 Role of LDSS when collaborating with FAPT

The LDSS shall refer the child and family to the *Family Assessment and Planning Team* (FAPT) or approved multi-disciplinary team, consistent with CPMT 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 5.9.1](#) 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.