Foster Parent Handbook

Arkansas Department of Human Services
Division of Children and Family Services

Our mission is to keep children safe and help families.
DCFS will respectfully engage families and youth
and use community-based services and supports
to assist parents in successfully caring for their children.
We will focus on the safety, permanency,
and well-being for all children and youth.

Care * Commit * Connect

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ABOUT THIS HANDBOOK

This handbook has been prepared to provide foster parents with information they will need to become a foster family and to maintain standing as a foster family. This handbook contains the standards that are required for a family to become approved to operate as a foster home and information about the role of a foster family. Please read this entire handbook to be familiar with the standards for which a family is responsible, and to ensure the family's continued compliance. Please contact the designated resource worker with questions about compliance or any of the licensing standards.

This handbook is only a reference guide. Contact your local DHS County Office for clarification and interpretation of any information provided in this publication.

INTRODUCTION

The Division of Children and Family Services (DCFS) is a licensed Child Welfare Agency and all of its approved foster homes must be in compliance with all licensing requirements. The Child Welfare Licensing act defines a "Foster Home" as private residence of one or more family members that receives from a child placement agency any minor child who is unattended by a parent or guardian in order to provide care, training, education, custody or supervision on a 24 hour basis, not to include adoptive homes (see PUB-04: Minimum Licensing Standards for Child Welfare Agencies). Although the licensing standards' definition of a foster home does not include adoptive homes, DCFS foster and adoptive homes must meet the same licensing standards to comply with federal funding regulations.

Foster Care is a program designed to provide a substitute family life experience in a DCFS approved foster home, provisional foster home, or licensed facility for a child who needs care for a temporary, or in some instances, for an extended period of time. During this time, the birth/legal family is either nonexistent or dysfunctional due to social, emotional, economic, and/or physical reasons. Foster care is founded on the premise that all children have a right to a safe and supportive environment in which to grow.

The purpose of foster care is to provide a healthy home and community experience for the child while the conditions which caused the placement away from the birth/legal family are being resolved. Thus, foster care is intended to be temporary. The length of a child's stay in foster care will depend a great deal on the conditions which caused the placement and the time and the resources available to resolve them. The goal of foster care is to work toward a permanent placement for the child, preferably, return to the birth/legal parents.

Foster care is a team effort involving DCFS, the foster parents, the child in foster care, and the birth/legal parents. When all those directly involved in the situation understand their own and each others' roles and cooperate as team members in a team effort, the quality of the experience for all is increased, and the effect on the child's future well-being is greatly improved.

Good communication among all team members, as well as mutual respect, understanding, and honesty is essential for achievement of foster care goals. All team members share the responsibility for ensuring that lines of communication are kept open and in use.

Because of differences in responsibilities and perspectives, conflicts may arise. How well conflicts are worked out will determine the success with which the team is able to serve the needs of the child.

TYPES OF FOSTER HOMES

There are two types of foster homes: Regular Foster Homes and Provisional Foster Homes.

Regular Foster Homes

Regular foster homes are ones in which the foster parents agree to provide 24 hour care for a particular child in foster care. There will be an agreement between the child-placing agency and the foster parents that the family can care for that child as a substitute family until such a time as a permanent plan can be developed and implemented for that child. The foster parents will be given pertinent information about the child in foster care. This includes reasons for placement, circumstances for removal from the parent's home, where siblings are placed, a copy of the case plan and visitation plan. They will be kept informed concerning plans for the child's future. In many instances it will be appropriate for foster parents to reach out to the birth/legal parents. However, this outreach will be supervised by members of the reunification services team.

Family members and the physical characteristics of the home must be evaluated to determine special qualifications of the prospective foster family. Evaluation is considered with regard to special training and expertise, experience, and preference as to the numbers, ages, sex and characteristics of children who may be placed in their home.

Provisional Foster Homes

In an effort to preserve family connections and expedite placement of children, the Division may place a child in foster care with a relative or fictive kin if one has been identified and is appropriate. Relative means a person within the fifth degree of kinship to the child by virtue of blood or adoption. Fictive kin means a person not related to the child by blood or marriage but who has a strong, positive, emotional tie to the child and plays a positive role in the child's life, such as a godparent, neighbor, or family friend. This type of placement is classified as a "Provisional Foster Home". The purpose of opening a provisional foster home is to enable DCFS to make a quick placement for the child with a relative or fictive kin with whom a bond already exists. Therefore, a provisional home may be opened before the results of the FBI Background Check are received, before the provisional foster parents have completed the pre-service training, and before a full home study is finished (however a walkthrough of the home is required before placement in a provisional home). These are the only differences in approval requirements, including minimum licensing requirements, between provisional foster homes and regular foster homes in Arkansas.

Once opened as a provisional home, DCFS staff works with the foster parents in that home to bring them into full compliance within a six month period. Provisional foster homes that are not in full compliance at the end of six months must be closed and the child(ren) removed or the relative must have been granted permanent custody by the court. If the home is opened as a regular foster home, the foster parents may then request to care for non-relative/non-fictive kin children in foster care with the understanding that additional evaluation of their home would be required to ensure that it would be an appropriate placement for non-relative/non-fictive kin children. Provisional foster homes shall not be paid a board payment until the relative meets all of the licensing requirements and DCFS standards, and is reclassified as a regular foster home.

The child is in the custody of the Department, therefore, the child shall remain in a licensed or approved foster home, shelter, or facility until the relative or fictive kin's home is opened as a provisional foster home, regular foster home, or the court grants custody to the relative or other person after a written, approved home study is presented to the court.

RESPONSIBILITIES OF THE FOSTER CARE TEAM

Children in Foster Care

Children have certain inherent rights based on their special status as children and their inability to care for themselves. Among these inherent rights are the right to live with their birth/legal family and to receive love, protection, nurturance, and support until they reach the age of majority; the right to be free from harm, neglect, and abuse; to receive an education; to have physical care and medical attention; to enjoy all facets of family life; to be disciplined and to receive religious and moral training, and to grow into well-adjusted young adults.

When a child's right to live with his or her own birth/legal family is in jeopardy, the child has a right to be represented by legal counsel and to have their legal rights protected in any judicial procedure which addresses custody or guardianship. DCFS has certain responsibilities to children who have been removed from the custody of their birth/legal parents.

Responsibilities of DCFS to children in foster care

1. Place the child in a foster home, provisional foster home, or other substitute care facility that can best serve the child's needs and is the least restrictive environment.
2. Place the child close to birth/legal parents to allow frequent contact.
3. Ensure the child has regular visits with birth/legal parents, siblings, and others with whom there is a significant relationship, unless restricted by court order.
4. Give the child honest information regarding all decisions.
5. Provide the child the basic rights inherent to all children as stated above.
6. Allow the child to participate in case planning, conferences, staffings, and court hearings, etc., whenever possible and age appropriate.
7. Keep a record for each child that includes legal documents (e.g., birth certificate, social security card, court orders).
8. Help the child return to the birth/legal parents' home at the earliest possible time or be legally freed to form new family ties with relatives or adoptive parents.
9. Prepare the child for successful transition to adulthood.

Birth/Legal Parents

Birth/legal parents are the key to long-range planning for the child in foster care. They are central members of the foster care team. The child began with them, identifies with them and, in most instances, has a longing to return to them. The return home of the child is dependent on his birth/legal parents' ability to improve their situation. Otherwise, the birth/legal parents face the possibility of long-range plans being made which may include termination of parental rights. With the exception of parents of children for whom DHS is guardian or birth/legal parents whose rights have been permanently terminated, DCFS has certain responsibilities to the birth/legal parents of children placed in the custody of DHS.

Reponsibilities of DCFS to Birth/Legal Parents

1. Offer and provide services that will help keep their family together.
2. Let them know they may seek the assistance of an attorney any time a legal action involves their child. Arkansas law requires that defendants have the opportunity to be represented by legal counsel at all stages of court proceedings. If it is determined by the court that a parent or legal guardian, based on their financial resources, is unable to pay for an attorney, the court will appoint an attorney to represent them
3. Let the family know why it was necessary to temporarily remove their child and place him or her with a foster family.

4. Do not judge or criticize the family. Acknowledge that they share in their child's life.
5. Let the family know how they can still be involved in their child's life while he or she is in foster care.
6. Let them know what they must do to have their child return home.
7. Include the family when creating the case plan.
8. Give the family every possible support and service for achieving the goals of the case plan to help their child return home.
9. Return their child home when the necessary changes or conditions required by the court have been made.

Responsibilities of birth/legal parents

1. Provide any and all important information about their child and family to DCFS.
2. Tell their FSW about any special needs their child has, including health conditions, school information, and important family customs or cultural practices.
3. Participate in staffings and court hearings.
4. Work with FSW to create a case plan.
5. Participate in the services to support the case plan goals offered to the family and work on achieving the goals of the case plan.
6. Be involved in their child's medical appointments or social or religious activities.
7. Keep in contact with FSW and keep him or her updated on progress in achieving the goals of the case plan.
8. Maintain contact and communication with their child. Keep appointments to visit with their child.
9. Let DCFS know as soon as possible if they wish to give up parental rights.

Foster Parents and Provisional Foster Parents

It is the responsibility of foster parents and provisional foster parents to provide 24 hour nurturing care to children in foster care. They also have a responsibility to help the child develop a good self image and have positive feelings about their past, present, and future.

As temporary substitute parents, foster parents are close to the child in foster care on a day-to-day basis. This closeness allows the foster parents to function as a vital member of the foster care team. As such, the foster parents are in an excellent position to evaluate the child's current needs and ensure that those identified needs are being met by the foster family or through resources in the community.

As team members with a unique perspective of the child, foster parents can contribute a special knowledge to DCFS and to the birth/legal parents including information about the child's behavior, relationships with playmates, and other members of the foster family and adjustment to school and to the neighborhood.

By observing the child's relationship with their birth/legal parents and the child's reactions to visitation, foster parents can enhance the DCFS work with the birth/legal parents. In some instances, the foster parent may also serve as a mentor to the birth/legal parents. This mentoring relationship may be the first opportunity the parent has had to observe and learn effective parenting skills.

Responsibilities of DCFS to Foster Parents

1. Provide pre-service training and continuing education.
2. Provide all available information concerning the child and the birth/legal family situation to enable them to make an informed decision about the ability or inability to provide care for the child and participate in the case.
3. Involve them as team members in pre-placement activities and case planning as well as staffings and court proceedings.
4. Ensure they have a clear understanding of their role as well as the role of other team members in achieving case goals.
5. Provide them with a board payment for food, clothing, and shelter for children in their care.
6. Allow them to continue their own family patterns and routine, as much as possible.
7. Allow them to request the removal of a child from their home, with notice.
8. Give advance notice, whenever possible, when a child is to be removed from their home.
9. Promptly inform them of any complaint against their home or of any condition or problem in the home which adversely affects their status as foster parents and provide guidance and support toward resolution of the condition or problem. (See section on Complaints Against Foster Family Other Than Child Maltreatment.)
10. Provide access to a internal review of adverse action procedure when differences arise with DCFS which have not been resolved to their satisfaction (see section on Internal Review of Adverse Action Involving Foster Parents).
11. Inform them of DCFS programs, services, and policies, which relate to foster care.

Responsibilities of foster parents to DCFS, the child, and the child's family

1. Participate in foster parent pre-service training and continuing education programs designed to enhance their ability to care for children in foster care.
2. Help develop an individualized training plan and follow the plan.
3. Follow the policies and the decisions of DCFS and accept the supervision of DCFS; Cooperate with monitoring and investigations, and provide information required to verify compliance with rules.
4. Assist the child and DCFS in planning and achieving the child's return to their parents' home or to a permanent placement.
5. Communicate with the attorney ad litem about the status and needs of the child so that the attorney can present to the court a complete and accurate picture of the client.
6. Attend and participate in case planning and case plan reviews.
7. Provide a nurturing family life experience for the child including guidance, intellectual stimulation, affection, and appropriate discipline.
8. Provide the level of supervision, care, and treatment necessary to ensure the safety and well being of each child placed into their home, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards, and risks.
9. Establish well defined rules; set expectations and limits consistent with the child's age, and clearly establish there will be consequences for inappropriate behavior; discipline with kindness and understanding; train and teach the child using positive techniques that stress praise and encouragement, rather than using negative techniques.
10. Protect the child by locking up all dangerous objects and substances.
11. Store all medications in a secure location and follow the instructions on the label when giving them to the child. Understand the possible side effects of all medications and keep a log of all medications given to the child.

12. Provide for enrollment and regular school attendance when age-appropriate in an accredited school and encourage the expression of the child's strengths and special talents. Provide the child regular activities to promote the physical, social, intellectual, spiritual, and emotional development of the children in their care.
13. Attend school conferences concerning a foster child, and notify DCFS of any situations that may affect the case plan or require agency involvement.
14. Notify DCFS promptly of serious illness, injury, or unusual circumstances affecting the health, safety, or welfare of the foster child.
15. Provide each child their own clothing that is clean, well-fitted, seasonal, appropriate to age and sex, and comparable to community standards.
16. Allow foster children to acquire and keep personal belongings.
17. Cooperate with DCFS in arranging for routine medical and dental care as well as making sure the child receives appropriate care during any illness. Accompany the child on all medical appointments.
18. Provide routine transportation for each child.
19. Protect the child from exposure to second-hand smoke and take every precaution to ensure his or her health and safety.
20. Maintain a record of health care and immunization records via the Medical Passport.
21. Keep a lifebook for the child that includes periodic photographs of the child; a record of the child's memberships, activities, and participation in extracurricular school or church activities; trophies, awards, ribbons, etc.
22. Speak positively of the child's birth/legal family.
23. Maintain absolute confidentiality of private information about each foster child and the birth/legal family.
24. Fully cooperate with DCFS's efforts to achieve the case plan goals for each foster child, including visitation.
25. Maintain open communication with all team members, including communication with the child's birth/legal family when contact between foster parents and the family is part of the case plan.
26. Give advance notice to DCFS of any major changes that affect the life and circumstances of the foster family, including change of residence, whenever possible.
27. Show support and help prepare the child for any move that he or she must make (back to their family, to a relative's home, another foster home, an adoptive home, or independent living).
28. Keep the terms of the Initial Foster Home Agreement and Addendum

Foster parents are prohibited from using corporal punishment on a child in foster care

Methods of discipline that are unacceptable for use by foster parents with the child include, but are not limited to:

1. Cruel, severe, or humiliating actions, such as washing mouth with soap;
2. Taping or obstructing child's mouth;
3. Placing painful or unpleasant tasting or hot substances in child's mouth;
4. Placing a child in dark areas;
5. Humiliation in public;
6. Physical punishment inflicted in any manner, such as hitting, pinching, pulling hair, slapping, kicking, twisting the arms, forced fixed body positions, spanking, etc.;
7. Denial of meals, clothing, shelter;
8. Interference with any case plan requirements, or any denial of basic rights;
9. Denial of visits, telephone, or mail contact with family members;
10. Assignment of extremely strenuous exercise or work;
11. Locked isolation of any kind; and
12. Punishment of any kind for bedwetting or poor toilet habits. If a child is experiencing problems with enuresis, a therapist should be engaged to help with this issue.

DEPARTMENT OF HUMAN SERVICES & DIVISION OF CHILDREN & FAMILY SERVICES

DHS, acting through DCFS, serves as the court-appointed legal custodian of the child and has the ultimate responsibility for ensuring that the child has the best possible foster care experience and that appropriate long-term plans are made. There is also a direct vested interest in resolution of the problems or conditions affecting the status of the birth/legal family. The cooperative efforts from the courts, other agencies, and community resources are necessary to ensure that responsibilities to the child and assistance in resolution of problems or conditions affecting the child's birth/legal parent are carried out.

Department/Division responsibilities

1. Remain legally responsible for the supervision and decision making regarding foster children. (Foster parents have daily responsibility for the care of the children.)
2. Provide the child in foster care, birth/legal parents, and foster family with the necessary support services to accomplish goals set out in the case plan.
3. Provide foster parents with the information necessary to provide adequate care to each foster child, including the child's health, reason for entering care, probably length of placement, and siblings. As additional information is obtained by the caseworker, it shall be promptly shared with the foster parents.
4. Provide foster parents with instructions for contacting agency personnel at any time.
5. Ensure a caseworker visits the child in person at least monthly while the child is in foster care.
6. Include foster parents in case planning for each child and provide them with a copy of the current case plan and visitation plan.
7. Provide for timely reimbursements to foster parents for cost of care and fees for services.
8. Approve respite care and babysitting arrangements.
9. Maintain a record for each foster family that contains all information and documentation required by licensing standards. (See PUB-04: Minimun Licensing Standards for Child Welfare Agencies.)
10. Work with birth/legal parents and foster families to see that the child's emotional needs are met.
11. Conduct regular staffings and schedule and attend statutorily required hearings.
12. Provide necessary medical and psychological services, evaluations, care or treatment needed by the child. Ensure that each child in foster care has a medical exam at least annually.
13. Ensure that the child has planned regular visitation with birth/legal parents; or, if there are barriers to visitation, provide services directed toward removal or reduction of barriers to visitation.
14. Ensure visits for the child with siblings by planned regular contact (at least every two weeks).
15. Maintain regular contact with all team members according to the case plan.
16. Keep all team members informed of significant changes in the status of the case or individual team members.
17. Provide opportunity for religious experiences with respect for the child's and birth/legal parents' religion.
18. Take the legal steps necessary to place the child in a permanent home when return to the birth/legal parents is not possible within a reasonable length of time, usually not more than one year.
19. Keep the terms of CFS-462: Initial Foster Home Agreement & CFS-462A: Foster Home Agreement Addendum.
20. Communicate with the child's school about custody and other issues that might impact the child's ability to learn.
21. Investigate the foster home if DCFS receives a complaint report of non-compliance with licensing standards. Investigation shall be completed within 60 days of receiving the report, unless good cause is documented.
22. Prepare a closing summary, including reasons, if the home closes.

APPROVAL, TRAINING, & SUPPORT OF FOSTER HOMES

Foster Home Approval Process

In order to ensure quality foster homes, DCFS will complete a thorough home assessment for each prospective foster family. The home assessment is a mutual selection process. It involves several components including, but not limited to, an in-home consultation visit, background checks, pre-service training, a home study, and ongoing consultation with the prospective foster parents to ensure that all appropriate criteria related to both compliance and quality are met. An assessment will be conducted prior to the placement of a child in one's home. Families that move to Arkansas from another state where they have been approved as a foster family must complete the entire approval procedure of the Arkansas DCFS.

The purpose of the foster home assessment is threefold: first, it is to educate candidates; second, it is to assess their character, suitability, and qualifications to open a foster home, and third, it is to see that they meet the *Standards of Approval for Foster and Adoptive Homes*, PUB-22.

Assessing the character, suitability, and qualifications of the family to operate a foster home will be done in relation to the following areas:

1) The family's capability to provide for the needs of a child who is placed in their care;
2) The family's ability to accept and encourage the child's relationship with birth/legal family;
3) The family's ability to relate to the child in a helpful way; and
4) The family's ability to work as part of a team with DCFS staff, other agencies, and community resources to reach the goals set forth in the case plan.

Standards of Approval

Age - The minimum age is 21 years. Alternative compliance must be obtained if one or both applicants are age 65 or over or when one or both spouses of a currently opened foster home reaches age 65.

Health - All household family members must pass a medical exam (within six months prior to the approval) and have a doctor's recommendation at the time the home is initially approved. Each foster parent and every family member must repeat the exam yearly to remain in compliance.

Physical Disabilities - Physical disabilities of any family member will be evaluated to determine the effect, if any, the disability has on the family's ability to provide adequate care for a child and how the disability may affect a child's adjustment to the family.

Relationship Stability: In a two-parent home, both people shall be joint applicants and actively participate in the approval process. The couple shall demonstrate a stable relationship. In assessing relationship stability, considerations may include major life changes such as:

- Death or serious illness among family members
- Marriage, separation, divorce, or other significant changes in the couple's relationship
- Addition of household members (e.g., birth, adoption, aging relative moving in)
- Loss of or change in employment

Marriages and divorces shall be verified. Prospective foster parents must provide a copy of their marriage license to verify marriage and a copy of their most recent divorce decree to verify divorce.

Single parent households are welcome particularly for those children whose need for a two-parent household is not a crucial aspect of the care required. In a single parent home, the major life changes listed above shall also be considered when assessing the person's ability to be an effective foster parent.

All foster parents should have a strong support system in order to assist them in their role as foster parents and, in turn, better serve children in foster care. Applicants with professional training, such as nurses, may be desirable for children with special needs. Other adults (grandparents, aunts, etc.) and children who are a part of the household shall be assessed regarding how they may be affected by the presence of a child in foster care and also the effect they themselves may have on the child in care.

Maximum Capacity - Foster homes shall not have more than five unrelated children in care. The foster home may care for up to eight children if they are all related to each other. A foster home shall not have more than eight children in their home, including their own children. This includes placement or respite care. Including the foster parents' biological children, the foster home may have no more than two children under the age of two and no more than three children under the age of six. The sole exception to the above limits shall be in those instances in which the placement of a sibling group in a foster home with no other children in the home would exceed the limits.

Eight related children from the same sibling group may be placed together in the same foster home. In this instance, the total number of the foster parent's children who reside in the home will determine the number of children from one sibling group that may be placed together in the home.
For example:

0 children of the foster parent and 8 children that are related (to each other)
1 child of the foster parent and 7 children that are related (to each other)
2 children of the foster parent and 6 children that are related (to each other)
3 children of the foster parent and 5 children that are related (to each other) or unrelated

Including the foster parent's own children, the foster home may have no more than two children under age two and no more than three children under age six.

Parenting Ability – Ability to provide a nurturing family life experience for the child including guidance, intellectual stimulation, affection, and appropriate discipline.

Employment - In two-parent homes where the parents are both employed outside the home or in a single-parent home where the parent is employed outside the home, careful consideration must be given to the age and characteristics of the children for whom the home wishes to provide care as well as to the family's plan for child care. Stable employment history is required of the primary wage earner in the foster home. The foster home shall not be licensed as a Child Care Family Home.

Income - Evidence of stable income sufficient to meet the needs of one's family is required for approval. The foster family shall provide documentation of sufficient financial resources to meet their needs. The family shall have sufficient, reliable income to assure stability and security, without including the board payment. Management of income shall be considered more important than amount of income. Keeping children is foster care is not a profitable venture.

Physical Standards - Location, condition, and physical layout of the home will be considered. Physical conditions of the home shall present no hazard to the safety or health of a child. The home should have at least two exterior

doors situated to provide safe exit or the home shall have a written statement from the Fire Department that the alternative escape route is approved. This approval shall be kept in the foster home case record. There shall be 50 square feet of sleeping space per child in foster care and an opening window, large enough that the child can exit through it, in each bedroom where a child in foster care sleeps. Bars, grilles, grates, or other items that block access to the window are permitted only if they can be removed from the inside without the use of a key, tool, or force greater than that required for normal operation of the window. In this event, each such bedroom must have a working smoke detector in the bedroom. The stacking of baby beds is prohibited.

Telephone - The home shall have an operational telephone. Working cell phones kept on the premises are acceptable. The phone shall be accessible to children.

Transportation - The foster parents shall maintain a mode of transportation which complies with state motor vehicle laws and shall allow children in foster care to be transported only by a licensed driver. Foster parents must have proof of current insurance and a valid vehicle safety record check. Children in foster care shall be transported only while wearing safety belts, or in child safety seats, according to Arkansas law.

Home Environment - Cleanliness of the home will be considered.

Central Registry - A Child Maltreatment Central Registry Check must be conducted prior to approval on foster parent applicants and each member of the household age 14 years or older, excluding children in foster care, including any state where either the applicant or household member work if different from their state of residence. A registry check will also be conducted in any other state where the applicant has worked or resided during the preceding five years. An Adult Maltreatment Central Registry Check must be conducted prior to approval on foster parent applicants and each member of the household age 18 and one-half years and older. The Division will repeat the Child Maltreatment and the Adult Maltreatment Central Registry Checks every two years. Successful completion is necessary before referral to pre-service training. Expedited checks will be done on provisional foster homes.

FBI Criminal Background Check – A finger-print based FBI criminal background check must be conducted prior to approval on foster parents and any other members of the household 18 and one-half years of age or older, excluding children in foster care. This check need not be repeated. Conducting a finger-print based criminal record check is not necessary to open a provisional foster home.

Criminal Record Check - An Arkansas State Police Criminal Record Check must be conducted prior to approval on the foster parents and all members of the household age 18 and one-half years and older, excluding children in foster care. The Division shall repeat the Criminal Record Check every two years. Successful completion or approval of alternative compliance is necessary before referral to pre-service training.

Motor Vehicle Safety Check - A motor vehicle safety check will be conducted on each household member who will be responsible for transporting children in foster care. Each member must have a current, valid driver's license. The foster family members must be in compliance with the Arkansas Motor Vehicle Safety program. DCFS will check the driving record (violation points) for each potential foster parent. The Arkansas State Vehicle Safety Program sets the maximum number of traffic violation points a foster parent may be allowed. It is the foster family's responsibility to report any traffic violations to their Resource Worker within 24 hours.

References - A minimum of three references familiar with one's child caring experiences and practices will be contacted regarding the character and ability to provide for children.

Smoking - DCFS policy is that second-hand smoke is detrimental to a child's health and the presumption will be that it is not in a child's best interest to be placed in a foster home that permits smoking in the presence of a child in foster care.

Foster parents will indicate if smokers in the home or who visit the home will be permitted to smoke while in the presence of a child in foster care. If a foster parent indicates that smoking will occur in the presence of a child in foster care, the foster home will be designated a "smoking" foster home and no child may be placed or remain in the foster home unless it is in the child's best interest to be placed in or remain in the foster home. The worker must clearly identify why it is in the child's best interest to be exposed to second-hand smoke if a request to place a child in a smoking home is made. No child in foster care shall be placed in a smoking foster home without a waiver from the Assistant Director of Community Services.

State law prohibits smoking in a vehicle if a child in the car is under the age of 14. Thus, no foster parent or DCFS employee may smoke in the vehicle when transporting a child in foster care who is under the age of 14. Per DCFS policy, foster parents are also prohibitied from smoking in a vehicle when a child 14 and older who is in foster care is present.

In accordance with A.C.A. 20-27-1804, smoking is prohibited in all vehicles and enclosed areas owned, leased, or operated by the State of Arkansas, its agencies, and authorities. Therefore, DCFS staff may not smoke in a state vehicle OR in their private vehicle when a child in foster care or receiving other services from the Division is present.

Alternative Compliance & Policy Waiver Requests

DCFS bases its standards of care and character on the Child Welfare Agency Licensing Act (CWALA). If it is believed that an applicant possesses special abilities or circumstances which would make them good foster parents in spite of their inability to meet a standard, the county office may request an approval for alternative compliance or a policy waiver.

An alternative compliance is a request for approval from the Child Welfare Agency Review Board (CWARB) to allow a licensee to deviate from the letter of a regulation, provided that the licensee has demonstrated how an alternate plan of compliance will meet or exceed the intent of the regulation. What is proposed as an alternative to compliance with policy or standards will comply with the intent, if not the actual requirement.

A policy waiver request is a request to deviate from DCFS policy, procedures, and standards. Waiver requests may be approved by the DCFS Director.

All policy waiver and alternative compliance requests will be approved or denied based on the individual circumstances of the foster parent applicant. Safety and welfare of the child(ren) involved will be paramount.

If a foster parent or applicant has questions or concerns regarding alternative compliance or waiver requests, they should consult their Resource Worker.

Training

DCFS recognizes the child's right to be placed in a home able to deal with the special problems and traumas of out-of-home care. Foster parenting is a specialized field, different from parenting one's own children, and for which special training is essential. As foster parenting is far too complex to be covered in one course, DCFS will provide opportunities for training of prospective foster parents and training related to the special needs of children in out-of-home placements. An individualized training plan will be developed taking into consideration the age and characteristics of children for whom the foster parent has expressed preferences.

Pre-Service Training

Successful completion of the assessment and, if applicable, approval of alternative compliance or policy waiver, is necessary before referral to pre-service training. Training of prospective foster parents will be done by using group processes, but may be done on an individual basis when necessary. Foster parents must complete the Division's pre-service training curriculum which includes 27 hours of Foster/Adopt PRIDE training and three hours of DCFS orientation prior to placement of a child. Foster parents shall have current CPR and First Aid Training. No child will be placed in the foster home until each foster parent has obtained CPR Certification and completed First Aid training.

First Aid and CPR training and certification will only be accepted from a certified trainer associated with the American Heart Association, the American Red Cross, the National Safety Council, the Health and Safety Institute, or EMS Safety Services.

Online CPR and First Aid training is acceptable provided the online course is offered through American Heart Association, American Red Cross, the National Safety Council, the Health and Safety Institute, or EMS Safety Services. In addition, the online curriculum must also require hands-on, skill-based instruction as well as written and practical testing. As such, participants shall demonstrate the skills learned through the online portion of the curriculum in the presence of a certified trainer in order to complete certification (i.e., training and certification that is provided solely online will not be accepted).

Prospective foster parents must obtain a certification card from the trainer representing the certifying national organization. DCFS staff will coordinate the CPR and First Aid training with the national organization.

Continuing Education

DCFS will require participation in local educational and training opportunities. Each foster parent shall annually participate in a minimum of 15 hours of approved training. This additional 15 hours becomes due at the end of the second year that a foster home is in operation. The same training classes cannot be repeated yearly. Training classes may cover a wide range of topics related to parenting, child development, behavior problems, medical needs, etc., and may be offered by educational systems (college, university, local school system), Health Department, Community Mental Health Centers, the Foster Parent Association and others. Special TV programs related to child abuse, parenting adolescents, etc. may also be considered training. However, videos, TV programs, online courses and books are only accepted on a limited basis. No more than five hours of videos, books, or online courses or TV programs for each foster parent will be accepted per year and must have prior approval by the Area Director or designee. To be considered as training these programs must be discussed with the Resource Worker assigned to the foster parents and receive prior approval before the program is viewed. Participation shall then be documented in the foster home case record. The DCFS County Office will inform all foster parents of any training and educational opportunities known to them.

CPR training is not allowed to be counted toward the required 15 hours. Online CPR and First Aid training is acceptable provided the online course is offered through American Heart Association, the National Safety Council, American Red Cross, the Health and Safety Institute, or EMS Safety Services. In addition, the online curriculum must also require hands-on, skill-based instruction as well as written and practical testing. As such, participants shall demonstrate the skills learned through the online portion of the curriculum in the presence of a certified trainer in order to complete certification (i.e., training and certification that is provided solely online will not be accepted).

A statewide foster parent training conference and area conferences are held yearly, if funds are available, to give foster families the opportunity to obtain the required hours. Both in-state and out-of-state conferences may be considered training. Funds may be available to defray expenses for these educational opportunities. Prior approval is required for reimbursement. Contact a Resource Worker.

The appropriate DCFS County Office will maintain the training record, both DCFS and non-DCFS sponsored. Foster parents are responsible for reporting to their Resource Worker participation in non-DCFS sponsored training. Evidence of attendance (training certificate, etc.) will be needed to document participation.

Both travel and baby-sitting expenses incurred when attending mandatory local and DCFS sponsored training are reimbursable. A Resource Worker must be contacted prior to the training for approval of such expenses.

Reevaluation of Foster Homes

The Resource Worker will monitor the foster home at least quarterly for continued compliance with the minimum licensing standards and policy requirements and complete CFS-475(F): Checklist for Compliance.

Foster homes must be reevaluated annually (i.e., no later than the anniversary month of the foster home's approval), to assure that they continue to meet all standards and policy requirements. Any foster home that does not continue to meet standards will be closed. The Resource Worker or designee will formally review each foster home and complete CFS-475 (A-C): Checklist for Ongoing Monitoring and CFS-451: Foster Parent Reevaluation. The review will be filed in the foster home record.

This reevaluation is necessary to ensure that changes in the family, either physical changes or changes in attitudes, do not adversely affect children placed in that home. After having actually experienced children in foster care in the home, one may have very different feelings about foster parenting and the ability to work with different types of children. The opportunity will be provided to express any changes in feelings subsequent to the last approval, evaluation, or reevaluation. Also, a Resource Worker may assess the family's ability as shown by past experiences with children in foster care. This information will be recorded in the foster home record to be used by any Resource Worker placing or supervising a child in that home.

The foster parent reevaluation packet will be mailed or hand-delivered to be completed prior to the home visit by the resource worker. The resource worker will make an appointment to conduct the reevaluation, review the completed packet, and interview the family. The foster parent reevaluation form will be filed in the foster home record and a narrative entry will also be made in the record that reflects the resource worker's assessment of the following items:

- Continued compliance with Minimum Licensing Standards
- Continuing education compliance
- Maintenance of current CPR Certification and First Aid training
- How the family has met the needs of the children placed, including physical, emotional, educational and recreational needs

- Identification of persons in the home at the time of the reevaluation
- Attitudes toward birth/legal parents
- Impressions and Evaluation
- Objective evaluation of present and future capacity as a foster home
- Strong points of the foster home
- Weak points of the foster home
- How the family has met the needs of the children placed in the home
- Health and Financial Status
- Declaration on status of other applicable requirements, such as physician's exam, criminal record checks, motor vehicle check, and telephone
- Recommendations
- Age, sex, and special characteristics of children who should be placed in the home
- Problems which can and cannot be handled
- Recommended length of placement desirable

(For reference, see CFS-451: Foster Parent Reevaluation)

The Resource Worker will notify the family of the disposition of the reevaluation in writing within 10 days. When re-approved, the family will receive a reevaluation letter.

Support to Foster Families

As an integral part of DCFS delivery system, one can expect support from DCFS in the form of training, in-home contacts, case consultation, board payments, special services to children in one's care, and recognition and acknowledgment of these efforts.

When a foster parent requests that a child in foster care be removed from their home, excluding an emergency that places the child or a family member at risk of harm, the foster parent will be expected to attend a staffing to discuss what services or assistance may be needed to stabilize the placement. The staffing will be held within 48 hours of notification by the foster parent to remove the child from their home. The age-appropriate child in foster care, the child's attorney ad litem and a CASA, if appointed to the case, the parents, or guardian, and all parties' attorneys shall be notified so that they can attend and participate in the staffing and planning for the child's placement. If the placement cannot be stabilized, the foster parent will continue to provide for the child in foster care until an appropriate alternative placement is located, but this shall not be longer than five business days.

Foster parents work primarily with two different DCFS staff positions. These are the Family Service Worker and the Foster Parent Resource Worker. The Volunteer Foster Parent Liaison may also be another source of support to other foster parents. To better understand how these individuals work as a team and interact with the goal of providing the best overall experience for children in foster care, the following job descriptions are offered.

Family Service Worker

The Family Service Worker (FSW) is primarily responsible for working with the child in foster care and his or her biological or legal family. They work to correct problems in the home of the birth/legal parent with the goal of preventing the need for removal and, if removal is necessary, then working to reunify the child and family.

In the course of serving the needs of children in foster care, the FSW will frequently visit the foster home. When he or she visits the home, the main objective is to discuss the case plan, any changes in the plan, or specific problems with the placement. Neither foster parents nor the FSW are expected to have answers to all problems. Foster parents have the child-raising experience. The FSW has the objective knowledge about children in foster

care. Together, solutions are found. The Family Service Worker is expected to be neither a formal guest in the home nor a casual acquaintance or a "best friend." The relationship is most positive when it is pleasantly professional. Problems with the FSW visiting occur when foster parents, and/or child in foster care, do not know the purpose of the visit. Problems also arise when the FSW is seen as a negative authority figure. For example, threatening the child with "if you're not good I'll call the worker", or perceiving the FSW as someone who will solve all the problems, i.e., "We'll call the worker; she'll take care of everything," is not productive. This does not support the team approach and it undermines the foster family's authority. Foster parents and the Family Service Worker are partners working together. This partnership works best when each person presents the other to the child as a positive influence in that child's life, each one bringing his or her contribution to the effort taking place on behalf of the child.

The following are some of the responsibilities of the Family Service Worker:

- Providing protective services, foster care, and supportive services for abused and/or neglected children;
- Providing assistance in investigating suspected child abuse and neglect complaints to determine if allegations can be substantiated by making on-site visits, securing background information, and interviewing parties involved;
- Documenting all casework activities for children in foster care whose cases they are assigned;
- Providing assistance in developing case plans to establish goals, objectives, tasks, and time frames for all parties involved;
- Recruiting families, providing assistance in conducting home studies and family assessments to determine appropriate child placements;
- Visiting clients and/or foster parents to monitor progress toward case objectives;
- Performing any other related responsibilities as required to further the goal of a therapeutic experience for children in protective services and foster care; and,
- Maintaining regular contact with clients, law enforcement officials, medical personnel, teachers, child care personnel, foster parents, agency and private attorneys, and the general public.

Foster Parent Resource Worker

The Foster Parent Resource Worker is responsible for overseeing the operation of all foster homes. Each DCFS service area has an assigned Foster Parent Resource Worker who serves as an advocate for the foster parent. The Resource Worker is responsible for recruiting foster families, facilitating orientations and training sessions, and other licensing and education requirements, both new and on-going. They monitor compliance, provide case management to promote foster home retention, provide support, facilitate corrective action, develop resources, and assess homes that are not in compliance as well as work with those homes and families, and provide other types of general support to care providers within their area.

The Foster Family Resource Worker's assistance to the foster care family includes, but is not limited to the following:

- Conducting interviews for the purpose of gathering social histories or other needed information to assess for eligilbity or appropriateness of referral;
- Administering background checks;
- Responding to adoption inquiries and referring, when appropriate, to adoption staff;
- Conducting quarterly foster home visits for monitoring continued compliance, appropriateness, and suitability;
- Completing annual evaluations of each foster home;
- Checking for licensing compliance;
- Following up with corrective actions for homes that are out of compliance;

- Responding to requests from foster parents as they need required logs and/or on-call lists, etc;
- Creating Family Development Plans for continued inservice training and conducting make-up training as needed;
- Conducting health and safety assessments as needed (only in regard to licensing complaints-non maltreatment) and other licensing standard compliance;
- Assisting in the development of foster parent support groups/associations and participating in the annual foster parent conference;
- Visiting the foster home;
- Providing training information;
- Providing information regarding available resources; and,
- Performing any other duties identified by the Area Director that will promote the success of the foster home.

The Resource Worker will work with the foster parents to improve the overall working relations between DCFS and the Foster Parent Association.

Volunteer Foster Parent Liaison

The Volunteer Foster Parent Liaison is an experienced foster parent who serves on a voluntary basis as a statewide advocate for other foster parents when they have specific needs or questions about resources. Some of the Volunteer Foster Parent Liaison duties include:

- serving as a statewide contact to identify resources needed by foster parents and children in care;
- developing a list of resources for foster parents;
- assisting foster parents in navigating the child welfare system;
- advocating for children's educational needs;
- tracking trends /issues/concerns and sharing those with the DCFS Foster Care Manager;
- maintaining the foster parent website;
- assisting with recruitment and retention activities.

The Volunteer Foster Parent Liaison may be contacted if the foster parent has a complaint; however, the Volunteer Foster Parent Liaison is not part of the official Internal Review of Adverse Action procedure (see the section on Foster Parents Internal Review of Adverse Action for further clarification). In addition, this is not a position that will respond to or mediate specific case issues or personnel issues. Those issues will continue to be handled through the Division chain of command.

To obtain the current Volunteer Foster Parent Liaison name and contact information, please ask your Resource Worker.

Visits to the Foster Home

The Family Service Worker overseeing the care of individual children in the foster home will make at least weekly visits in the home during the first month of placement. After the first month, the FSW must make weekly contact with the child at school, or during sibling or parental visits, but must continue to visit the home at least monthly. More frequent visitation may be made to the home to help solve any problems that arise.

The visits will be used to relay necessary information to the child and to allow the foster parents to voice their feelings about the placement and subsequent adjustment jointly, as well as, privately, and to ascertain if the needs of

that particular child are being met. Each visit will include a private conversation with the child away from the foster parent. Visits may be scheduled or unannounced.

The Resource Worker will visit the home at least quarterly to monitor continued compliance with licensing standards and to check in with you to make sure you are receiving the support you need as a foster parent.
You may also have a visit from a Licensing Specialist from the Placement and Residential Licensing Unit (PRLU) of the DHS Division of Child Care and Early Childhood Education. The role of the Licensing Specialist is to ensure that DCFS is meeting its requirements as a child welfare placement agency rather than evaluating you as an individual foster home.

Availability of Family Service Worker & Resource Worker to Foster Families
For foster parenting to be a successful experience, one must have access to the Family Service Worker and Foster Family Resource Worker. If either of these staff members is absent from the office when telephoned, calls will be returned promptly. If a visit is necessary, it will be scheduled.

Telephone numbers of the Resource Worker who may be contacted after hours will be furnished (See section on DCFS County Office contact persons in the back of this Handbook). After-hours contact should be used for emergencies only. Also, information will be provided which may be needed for the child in the home in an emergency situation, such as the child's Medicaid number and Medical Passport. At the time of placement all information known about the child will be provided, such as: expected length of stay, information regarding illnesses, chronic health problems, medication, habits, etc.

Crisis and After Hours Response
Foster parents will have access to a Family Service Worker in their county 24 hours a day, seven days a week. A list of after hours numbers (on-call pager/cell phone numbers) where the local on-call FSW can be reached will be provided. If the after hours call requires a direct contact with the child's FSW, the on-call worker will provide the assigned Family Service Worker's home phone number or will contact the assigned worker and have that worker make contact.

Child Care for Children in Foster Care
Child care may be authorized and routinely provided for a child in foster care if both parents work outside of the home or if it is determined to be appropriate as part of the case plan or if court-ordered. Appropriate reasons include: 1) socialization, kindergarten readiness, and/or therapeutic benefits for the child; or, 2) to ensure the child may be placed in a foster home in his/her county or in close proximity to his home. The service may be authorized for up to three months at a time and only be provided by DCFS when resources are available.

Child care providers must be on the voucher system and licensed by The Division of Child Care and Early Childhood Education (DCCECE) or on the Voluntary Child Care Registry. If the child was enrolled in child care prior to coming into care, the child should remain in that particular child care facility (provided it is licensed by DCCECE or on the Voluntary Child Care Registry) if at all possible. This in an effort to provide the child with consistency in his/her daily caregivers and reduce the amount of trauma a child experiences when coming into foster care.

If a child was not enrolled in child care prior to coming into care or if a new child care facility must be used, the Division and foster parents shall make every effort to place the child in a high quality child care center. For more information on high quality child care centers, visit the Better Beginnings website at http://www.arbetterbeginnings.com/.

Enrollment in overnight daycares is not allowed. Likewise, late night pick ups (i.e., after 8:00 p.m.) from child care centers that have extended hours are also unacceptable.

Child care may also be provided as a part of an out-of-home placement case to provide assistance to foster parents for non-routine circumstances that relate to the retention and/or support of the foster home such as foster parent training. Child care provided for such purposes may be reimbursed by the Division when funding is available.

ALTERNATE CARE

Alternate care for children in out-of-home placement may be used to provide assistance to foster parents when circumstances requiring supervision by an appropriate adult other than the foster parents exist, e.g., if both foster parents work, during foster parent training, transporting a child in foster care for medical purposes, need for short-term, temporary care to provide relief to the foster parent from the on-going responsibility of care, etc. Alternate care is as follows:

Normal Age-Appropriate Activities – Children in foster homes should be encouraged to participate in normal age-appropriate activities such as overnight visits with friends, extra-curricular activities, church activities, and short-term summer camps. Foster parents shall exercise careful consideration when determining whether a child may participate in any normal age-appropriate activity. Foster parents shall notify the FSW if the child will spend more than 24 continuous hours outside the foster home when participating in said activities.

Babysitting – Babysitters may be used to provide occasional care for children in the foster home for no more than six continuous hours at one time. Foster parents shall exercise careful consideration when evaluating the character and competence of any individual asked to babysit. Foster parents may reimburse the baby-sitter if they choose to do so. The Division will not reimburse for baby-sitting services. Babysitters shall not transport children. Background checks are not required.

Foster Family Support System – The Foster Family Support System (FFSS) may be comprised of up to three other households identified by the foster family. FFSS members may provide care for children when the foster parent is unable to do so on the occasion of anticipated or unanticipated events.

Foster parents shall exercise careful consideration when evaluating the character and competence of any household asked to serve as an FFSS member. FFSS members must be at least 21 years of age. There is not a standard maximum age limit for FFSS members, but FFSS members must be physically, mentally, and emotionally capable of caring for children for up to 72 hours. Foster parents may reimburse an FFSS member if they choose to do so. The Division will not reimburse FFSS members.

Members of a Foster Family Support System may transport children and care for children in the foster home or in the home of the FFSS member. However, an FFSS member shall not provide care for more than 72 continuous hours at one time regardless of the location in which care is provided and/or regardless of which FFSS member is providing care. No extensions may be granted for FFSS care of a child. The FSW shall be notified when an FFSS member will provide care for more than 24 continuous hours. FFSS members taking children out-of-state for overnight trips are prohibited.

The Foster Family Support System shall not be used in place of respite care or as an out-of-home placement. The number of children placed in an FFSS member household must meet all Minimum Licensing and DCFS Policy requirements.

All prospective FFSS members must be cleared through the Child Maltreatment Central Registry and a State Police Criminal Record Check. The Division will request any other state where the prospective FFSS member has resided in the preceding five years to check its child abuse and neglect registry. The Division will provide documentation in the case record that the Child Maltreatment Central Registry and State Criminal Record Checks were conducted on the prospective FFSS member.

Documentation of at least one visual inspection of the home for evaluation purposes is required of all prospective FFSS members.

The Division will check the driving record (violation points) for each potential FFSS member. The Arkansas State Vehicle Safety Program sets the maximum number of traffic violation points an FFSS member foster parent may be allowed.

Respite Care – When a Foster Family Support System member is not available to provide needed care on a short-term basis, respite care may be utilized in order to temporarily relieve the foster family of the ongoing responsibilities and stresses of care. There are two types of respite care:

Informal Respite Home – An approved DCFS foster home that can provide temporary care when the Foster Family Support System is unable to assist or for situations in which children will be outside of the foster home for more than 72 continuous hours. An Informal Respite Home may provide care for no more than 7 continuous days at one time. Periods of respite care in an Informal Respite Home lasting longer than seven consecutive days require approval from the Area Director or designee.

If an Area Director approved extension exceeds 14 continuous days, the regular foster parents' board payment will be affected. If the child has stayed in any combination of FFSS or informal respite homes (i.e., outside of the regular foster home placement, the total amount of days within those alternate care types cannot exceed 14 consecutive days as board payment may be affected.)

Foster parents may reimburse an informal respite provider if they choose to do so. The Division will not reimburse an informal respite provider. The number of children placed in an Informal Respite Home must meet all Minimum Licensing and DCFS Policy requirements.

Formal Respite Care – A DCFS contract provider who supplies short-term respite care particularly when a child's current placement is at risk of disruption and/or respite is needed to prevent a residential, acute psychiatric, or similar placement. Formal Respite Care should be provided in accordance with a family-driven, youth-guided respite plan and in coordination with a child's behavioral health treatment plan (if applicable).

Formal Respite Care shall be provided for no more than 7 days per 3 month period. Longer periods of Formal Respite Care require approval from the Prevention and Supports Manager. If an approved extension exceeds 14 consecutive days, the regular foster parents' board payment will be affected. If the child has stayed in any combination of FFSS or informal respite homes before a formal respite stay, the

total amount of days within those alternate care types (i.e., outside the regular foster home placement) cannot exceed 14 consecutive days as board payment may be affected.

Counseling

Where there is a need for counseling services for the foster home to prevent disruption and to promote stabilization, counseling shall be provided. Requests for counseling are made to the Family Service Worker, who is responsible for making that referral to the appropriate Community Mental Health Center.

Transportation

Foster families should have their own transportation available to transport the child to appointments/activities. Transportation costs such as attending staffings, court, visits with parents or siblings, and all medical appointments will be reimbursed. (Other extraordinary costs may be approved on a case by case basis).

Room and board payments include routine travel expenses. As such, transportation will not be reimbursed for shopping for clothes or groceries, taking a child to school, school activities or church (unless prior approval has been obtained based on special circumstances), or child care (unless it is a Medicaid allowable expense).

Extraordinary circumstances might include situations in which a child may wish to attend a church other than that of a foster parent and travelling to his church would require a significant deviation from the route taken to the church attended by a foster parent. The Assistant Director of Community Services will consider for approval all written requests. Approval will be made based on individual situations and will be given only for specified time periods.

Transportation costs are reimbursed to foster parents at a rate determined by the Department. The foster parent completes a travel reimbursement form (TR-1) and submits it to the County Travel Supervisor for approval and processing. When determining miles driven from city to city for mileage reimbursement, please use the Rand McNally online services at http://www.randmcnally.com/.

Requests for travel reimbursement must be submitted on a monthly basis. Requests for reimbursement for medical and independent living transportation must be submitted on separate TR-1 forms.

Medical Transportation

The foster family will complete a TR-1 for regular travel and a separate TR-1 for Medicaid travel, e.g., when a child is taken to receive services from a medical provider. When the foster parent needs assistance with transportation, the foster parent should contact the Family Service Worker as soon as possible. The FSW, Program Assistant, or a volunteer transporter may be assigned to assist with travel.

Community Resources

The DHS County Office will inform all foster parents about available resources in the community as well as resources in other areas which may be relevant to a particular child. This information will be updated as new services become available.

It will be the responsibility of DCFS to pursue any resource needed for a child which is mutually agreed upon. Foster parent's assistance may be enlisted for this purpose.

Foster Parent Associations

The formation of active and independent foster parent associations is encouraged. DCFS will provide support by the appointment of a Resource Worker to the association. A DCFS representative will also be available when called upon to provide information about the Foster Care Program and allow foster parents to voice any concerns they may have with DCFS policies.

Income Tax Information

Board payments paid to foster parents are not considered taxable income by the Internal Revenue Services. Current tax laws may allow special treatment for foster parents. Because IRS laws are complex and subject to change from year to year, for specific tax advice foster parents should consult with an accountant or tax specialist.

Internal Review of Adverse Action Involving Foster Parents

Foster parents have the right to appeal decisions affecting them and the operation of their home. Most problems can be solved at the local level if the foster parents and FSW keep each other informed about matters of interest and importance pertaining to the child. It is important for foster parents and Family Service Workers to discuss and work out issues and problems as they occur.

All complaints may not be appropriate for an internal review, and while the county office will make every effort to reconcile disagreements or other issues, some situations may not be reconcilable such as those decisions made by the county office based on current policy and procedure.

Examples of issues to take through an Internal Review are:

- Closure of a foster home due to any circumstance;
- Removal of a child from the foster home without appropriate cause and/or without appropriate notice;
- Failure by DCFS to share appropriate information;
- Failure by DCFS to provide necessary support (failure to return phone calls or habitually being unavailable when needed, failure to help with initial clothing or problems with the child, medical/Medicaid coverage and/or providers); or
- Failure by DCFS to keep the terms of the initial written agreement with the foster home (CFS-462: Initial Foster Home Agreement and CFS-462A: Foster Home Agreement Addendum).

Prior to requesting an internal review at the Central Office level, foster parents should request an informal discussion of the problem with the FSW and the FSW's immediate supervisor. If, after the foster parents have discussed their issue(s) related to the adverse action with the FSW and the FSW's supervisor, and believe that DCFS failed to uphold its policies and/or philosophies, then, the foster parents must submit in writing their request for the Area Director of the area where the fosters live to review their case as it relates to the adverse action. This request must be submitted to the Area Director 30 calendar days from the date the adverse action occurred. The Area Director will schedule a meeting with the foster parents within 10 business days of the receipt of the written request and attempt to resolve the problem.

If the foster parents are not satisfied with the results of the meeting with the Area Director, the foster parents may request an internal review from the Foster Care Manager or designee in Central Office to present their case. A copy of the request and written reports of the previous two meetings will be forwarded to the Foster Care Manager or designee. The Foster Care Manager or designee will review the request and forward it with a recommendation to the Assistant Director of Community Services or designee within 10 business days of receipt of the request and written reports.

The Assistant Director of Community Services or designee will notify the foster parents in writing of the decision of the review within 10 business days of receiving the recommendation and other materials from the Foster Care Manager or designee.

If the decision is unfavorable to the foster parents, the Assistant Director of Community Services or designee will inform the foster parents that they have 15 business days in which to submit a written appeal to the DCFS Director. The DCFS Director will review the request as well as the previous reports and dispositions. The DCFS Director will then notify the individual within 10 business days of the appeal decision. This is a final action and is not appealable to any other person or entity.

REPORTS OF CHILD MALTREATMENT INVOLVING MEMBERS OF FOSTER HOMES

All child maltreatment allegations concerning any person in a foster home shall be investigated in accordance with the Child Maltreatment Act § 12-18-602.

If any child in foster care is the subject (alleged offender or alleged victim) of an allegation of child maltreatment, the Division shall notify the child's family, the OPLS attorney, Child Abuse Hotline, the CASA and the attorney ad litem. The attorneys ad litem for all other children placed in the home shall be notified as well.

The safety and welfare of any children in foster care shall be paramount.

COMPLAINTS AGAINST FOSTER FAMILY OTHER THAN CHILD MALTREATMENT

Any complaint against the foster parent will immediately be brought to the attention of the DCFS County Office Supervisor or Area Director.

After the investigation has determined the validity of the complaint, the foster parent will be advised, in writing, of the complaint, the outcome of the investigation, any corrective action needed to be made, and any other action that will be taken. An agreement will be made between the foster parents and their Resource Worker for corrective action. The foster parents must submit in writing the steps necessary to correct the deficiency within 10 days after notification from the appropriate decision-making personnel, or submit application applying for alternative compliance (see section on alternative compliance). This corrective action plan must receive the approval of the DCFS County Office Supervisor. Foster parents will notify their local DCFS County Office and Central Office within 30 days of the original findings being received, and that all corrective steps have been completed. In the absence of said notification from the foster parents, it will be presumed that they have elected not to comply with the findings of the appropriate decision-making personnel.

DCFS will offer any assistance available to correct the problem. If, after working with the foster parents, the problem still exists, another meeting will be held to discuss closing the home.

Any complaint, regardless of nature, must be recorded in detail in foster homes record. The report will include the following information:

1. Date and nature of complaint;
2. Source of complaint;
3. Reaction of the foster family;
4. Services offered to the family;
5. Conclusion of investigation; and
6. Corrective action.

CLOSING A FOSTER HOME

Division's Decision

If it is deemed necessary by the county office to close a foster home, a written summary will be prepared documenting past and present reasons for closure as well as all efforts by the county office to rectify the problem. The final assessment and determination of closure will be made by the Resource Worker in collaboration with designated county staff, the Area Director and Central Office staff, as appropriate. The closure process will include a mandatory face-to-face conference with the foster parents at which time reasons for the closure will be explained. The county office will provide written notification of the closure including the reasons for the closure and the foster parents' right to request an internal review of the adverse action (for additional information, see section on Internal Review of Adverse Action Involving Foster Parents).

By Request of Foster Family

If the foster family requests that their home be closed as a foster home, the Resource Worker will discuss the reasons for closure with the foster parents. The request for closure by the foster parents will be confirmed in writing by the Resource Worker and sent to the foster parents.

After a home has been closed at the request of the foster family, if the family wishes to reopen their home, the family and home must be reevaluated to ensure that all areas of compliance are still met and all background checks must be repeated. Additional requirements vary depending on how the foster home has been closed.

FOSTER CARE PLACEMENT

Legal Factors Pertaining to Foster Care

All children entering foster care do so under authorization by the Court.

Legal custody constitutes authorization by the court for DCFS to assume physical control of a child. A child will never be placed in foster care without legal custody.

A.C.A. § 9-27-313 authorizes the Division to take emergency 72 hour legal custody of any child who is in immediate danger when there is not sufficient time to petition for and obtain a court order.

Termination of parental rights with the power to consent to adoption is primarily granted in cases where the child cannot return home. Adoption may then occur without further notice to the birth/legal parents.

Selection of a Foster Home

Based on information from the family assessment the Family Service Worker will select the foster home that best meets the child's needs.

The law requires that a child be placed in the least restrictive, most family-like environment possible. A child will also be placed as close to his birth/legal parents as possible. Placement should be in the same county, unless the child needs special services not available in the originating county. This is to help facilitate visits with parents, siblings, relatives, or other people with whom the child has established bonds and supportive relationships. Factors taken into consideration in selecting a foster home include the child's age, sex, religion, disabilities, interests, problems, existence as part of a sibling group, case plan, proximity to family (within a 50 mile radius), maintaining enrollment in the child's school, developmental needs of the child and, training and skills of foster parents.

Consideration will be given to the foster parent's preferences as to children approved for their home. There will be no violation of the limitations of these preferences.

A foster home offers a less restrictive environment than other types of out-of-home placement and is particularly adapted to meet the developmental needs of a child.

A foster home is suitable for any child who can accept family life, attend community schools, and live in the community without posing a danger to self or others. This includes children with special needs.

Preparing the Foster Parents for Placement of a Child

The Family Service Worker will realistically describe the child in foster care to the foster parent when asking a family to accept a child. However, sometimes in emergency situations, all information may not be known.

The following will be included in the child's description:

- Age;
- Probable length of placement;
- Education and school information;
- Health of child, special health needs;
- Disabilities, special equipment, facilities, or help needed;
- Behavior, both positive and negative, that can be expected;
- Siblings and where they live;
- Reasons the child is in foster care;
- A general indication of the case plan including the plan for visitation of both parents and any siblings; and,
- Interests.

This information is confidential and should be treated as such.

The Family Service Worker will arrange pre-placement visits between the child and the foster family. Several visits are preferred, but a minimum of one pre-placement visit is required, except in emergencies.

The Family Service Worker will know or at least meet the foster parents before taking a child for pre-placement or placement visits in a provider's home.

The Family Service Worker will discuss these pre-placement issues:

- General requirements regarding the number of children that reside in the foster home,
- Where the child will be in school, how the child will get to school, arrangement for the transfer of school records, who will have a conference with the teacher or principal;
- Activities, toys, etc. the child enjoys, the child's likes, and any fears the child may have;
- Financial arrangements;
- The foster parent's feelings on the impending placement;
- The foster parent's perception of the child;
- Maintaining the child's records; and,
- Medical needs and issues.

Foster parents shall maintain records in accordance with DCFS' policy and procedures for the children placed with the family. The records shall include:

1. Health Records:

a) Name, address, and telephone number of a person to contact in case of emergency and those persons authorized to give medical consent;
b) A record of the child's medical and dental appointments, illnesses and health problems, prescribed medications, immunization record and hospitalizations (Medical Passport).

2. Progress Records:
   a) The dates of arrival and departure of the child in the foster home;
   b) Progress notes on those areas of the child's case plan as indicated in the written agreement in which foster parents are involved;
   c) Journal of the child regarding significant events;
   d) School reports;
   e) Significant photographs of the child taken periodically; and,
   f) A record of the child's memberships, and participation in extracurricular activities.

Role of Resource Worker

The Resource Worker will help foster parents understand that the child is going through a series of changes. Among these are: separation from the birth/legal parents and interacting with DCFS personnel, a new family, and new surroundings. The child in care can experience anxiety as a result of these changes. The Resource Worker will suggest to the foster parents ways to help the child move through these changes. The Family Service Worker will also assist the foster family through difficulties which occur, emphasizing that there will be good times and bad times during the placement, and that the bad times are no reflection on their parenting ability. In part, the goal of support from the Resource Worker is to help assure continuity for children who are placed in their home. In supporting the foster parents, the Resource Worker will work with them to help prevent the potential harm that can come to a child due to several moves.

Placement of Children by a Sheriff or Chief of Police

In an emergency situation, a Sheriff or Chief of Police may place children in a DCFS foster home. The foster parent must be well known to the Sheriff or Chief of Police, and they must determine that the foster home is safe and provides adequate accommodations for the child. The foster parent must notify DCFS county staff on the next business day after the placement of the child.

FINANCES

Board Payment

DCFS makes a monthly board payment to foster parents. This monthly board payment includes payment for room and board, clothing, ongoing school and personal supplies, and a small allowance for the child. The amount listed below is included in the monthly board payment and must be used for the child. If a child in foster care is eligible for Medicaid, foster parents are required to use a Medicaid provider for meeting the medical needs of the child. Medicaid should be the primary payment source for medical and dental services, including hospitalization. If Medicaid cannot cover such expenses, state funds may be a secondary payment option.

Generally, foster parents receive the board payment in the fourth week of each month. The monthly board payment is for the period starting on the 27th of the month and ending the 26th of the following month. For example, October's board payment is for the 30 days that begin September 27th and end on October 26th.

Other services or supplies needed by the child must be authorized and approved per DCFS policy. (See section on additional expenses.)

DCFS shall pay foster parents a monthly board rate according to the following chart; these rates are effective for board payments of November 2009 and after:

Birth through 5 years	**$410.00 Monthly**
Board and Care	350.00
Clothing	45.00
Personal Needs	15.00
6 through 11 years	**$440.00 Monthly**
Board and Care	365.00
Clothing	50.00
School and Personal Needs	25.00
12 through 14 years	**$470.00 Monthly**
Board and Care	380.00
Clothing	60.00
School and Personal Needs	30.00
15 through 17* years	**$500.00 Monthly**
Board and Care	395.00
Clothing	70.00
School and Personal Needs	35.00

*Refer to Policy VIII-B for requirements to continue board payments for youth age 18-20 (board payments must end the day the youth elects to leave foster care or the end of the month of his 21st birthday).

Board rates are established as part of policy, and any exception must receive prior approval. (For more information, see section on Special Board Rates)

If a child is absent from the foster home for hospitalization or a trial placement for 10 days or less and is to return to that home, no change of status is necessary. However, the child's Family Service Worker must always be advised of an absence from the home.

The agency pays according to the number of nights a child is in the foster home. Payment for stays of less than 24 hours will be based upon a daily rate determined by the Division. If a child is in the home for part of a month, a partial board payment will be made.

Clothing

When a child first enters foster care, the Division may issue an initial clothing order for the purchase of new clothing. Initial clothing orders will be issued on case-by-case basis. Not all children will need to purchase new clothing as they may come into care with ample clothing. The FSW will assess what clothing items are needed and issue the authorized amount of clothing allowance. Purchases will be made using the DHS-1914 process, which requires submission to and approval by the Financial Support Unit. Upon approval, a typical scenario might involve the foster parent selecting clothing and leaving it with appropriate customer service staff of the store, where the FSW may present and pay for the merchandise.

Foster parents should use the following guidelines:

1. Foster parents shall provide, with the assistance of the Division, each child with their own clean, well fitting, attractive, seasonal clothing appropriate to age, sex, individual needs, and comparable to the community standards.
2. Foster parents shall include the child in the choosing of their own clothing whenever possible and age appropriate.
3. Foster parents shall allow the child to bring and acquire personal belongings. The foster parent should establish and maintain a personal property inventory.
4. Money for clothing and personal needs paid monthly to foster parents is based on the age of the child. The foster parents are to spend that amount of money for the child. Money may be spent monthly or may be saved and used for a larger purchase at a later time
5. Foster parents shall send all personal clothing and belongings with the child when the child leaves the foster home. To facilitate this, the foster parent should maintain a clothing inventory.

Personal Allowance for a Child in Foster Care

The foster parent will give an allowance to the child from the board payment. The amount of the child's allowance is decided by the foster parent, based on the child's age.

Special Board Rates

There are occasions when the regular board rate is inadequate when caring for a child with special needs. Foster parents may identify and document those needs so that the Family Service Worker can request authorization from the Area Director for a special board rate.

Overpayments to Foster Parents

From time to time, foster parents may be overpaid on a board payment. If this happens, during the next month, the computer system may automatically generate a correction. The amount of the overpayment will become an accounts receivable due from the foster parent if restitution is not made prior to the next payment cycle. Per funding source, each subsequent board payment will be offset until the amount of the overpayment is recovered. The funding source of the board payment (federal or state funds) will determine whether the overpayment is deducted from the next board payment. If funds are from the same funding source, it will be deducted from the next board payment. If it is not deducted, the Office of Finance and Administrative Services will send a notice of overpayment. Account reviews are processed monthly and overpayment statements are normally sent monthly.

A foster parent may contact the Foster Care Technical Assistance Unit at 501-682-8345 for help with any overpayment statement. The unit will research the overpayment and provide an explanation.

Reduced Board Rates

A child's board rate may sometimes need to be reduced rather than increased. This applies to those children who are residents of a state institution; e.g., School for the Deaf or Blind/Rehabilitation Training Facility, Human Development Center, or who are attending college and for whom the case plan includes visits in the foster home on weekends, holidays, or summer vacation. Board Payments will only be made for a child visiting in a foster home for the actual time the child is there.

Foster Care Payment and Eligibility for Assistance

Board payments, made by DCFS for the care of children in homes of public assistance recipients, are not considered as a resource in determining eligibility for assistance or the amount of the grant. This payment is designated for certain purposes and is not available to the foster parents. For any foster parent applying for the

Supplemental Nutrition Assistance Program (SNAP; formerly food stamps), a re-evaluation of stable income will take place. This may impact the approval status of the foster home.

School Lunches

Children in foster care are eligible for free meals in all schools which participate in the National School Lunch/Breakfast Programs and in the Commodity-only schools.

WIC Programs

The Women, Infants and Children Food Program, WIC, is administered by the Health Department. The program provides, on a monthly basis, nutritious foods for pregnant and nursing women and infants and children up to age five years. Eligibility is determined by a medical assessment of nutrition risks such as iron-poor blood and improper growth, etc. Foods provided by WIC are supplemental and are not intended to fulfill all nutritional needs for a month. Children in foster care may be eligible for WIC.

Replacement and/or Supplemental Clothing

A monthly allowance for clothing replacement is included in the board payment. During the months when there are no replacements, the clothing allowance must be saved for the months when more than usual amounts of clothing are needed. All receipts from the purchase of clothes must be retained and turned in to the Resource Worker at the quarterly visit.

With the approval of the County Office Supervisor and Area Director, it is permissible to obtain another clothing order. This should happen only in an exceptional circumstance. The foster parent may request a "Replacement/Supplemental Clothing Order." These requests may not exceed $400.00 in one quarter. The foster parent should contact the Family Service Worker in the event that this need should arise.

Payment for Medical Services

Medicaid is the primary source of medical payment for children in foster care. If a child in the home does not receive a Medicaid card, contact the Family Service Worker. (A card should be received within a week for a new child and by the third of the month thereafter.) Although the FSW may provide a copy of the Medicaid Card for the foster parent to keep in the Medical Passport, and so that they may obtain medical services for the child, the actual Medicaid Card will be kept in the child's case record in the county office. When there are no Medicaid providers available in cases of emergency, the Family Services Worker (with the approval of the County Supervisor) will authorize and bill medical services via DHS-1914 or contract. In the event medical services are denied by Medicaid, the child's medical needs will be met with Foster Care funds. A child shall not be denied medical services because the child is not Medicaid eligible.

Additional Expenses

In addition to the items already listed, the following items are allowable with the approval of the County Office Supervisor:

- Required School Materials and School Fees, including athletic wear**.** Foster parents must have prior approval for such purchases.

- Graduation Expenses - The Division recognizes and values the importance of education and youth in foster care completing their education. There are certain expenses that can be purchased and/or reimbursed for senior year graduation. All these expenses whether purchased by the Division or reimbursed to the foster parent require prior approval. High School Graduation expenses will be authorized for the following items:

- Senior Ring: Maximum amount the Division will commit is 250.00
- Prom: Maximum total cost the Division will commit is $350.00. This cost shall include prom dress, alterations, tux, shoes, undergarments and tickets to prom (if there is a cost).
- The Division will reimburse a maximum amount of $500.00 for cap/gown, invitations, thank you notes, and senior pictures.

- Cell Phones - The Division generally does not provide cell phones. If a foster family chooses to allow a child in care to purchase or use a cell phone, the Division will not be responsible for any expenses related to the purchase, use or abuse of the phone.

- Holiday Allowance - Children will be provided additional funds so they may participate in Holiday giving. The amount will be based on the age of the child. Consult the Family Service Worker with regard to the amount provided. The money is included in the November check and is to be used by the child for purchasing gifts for biological family members and friends.

- Emergency medical services and drugs not purchasable by Medicaid

- Non-Medical transportation provided by the foster parent or public carriers when directly related to the case plan for the child. (See Transportation section).

- Child care or Baby-sitting fees, when required to attend training or for one's own children when transporting a child to services, are also reimbursable. This does not include child care for a foster parent's employment.

Any other expenses must receive prior approval from the Area Director. This can be requested by the Family Service Worker.

Trust Funds

When a child in foster care has income from child support or Social Security benefits, DCFS will apply to become payee. The child's funds will be deposited into a trust account for the child if payee status is awarded to the Division. Separate accounts are maintained for each individual child in foster care, including those from the same sibling group. The funds in the account should be utilized solely for the individual child for whom the account was established, and no funds should be spent for any other child.

Foster care trust accounts are delineated into two distinct types: Dedicated and Regular. Each account type has different rules for how the funds may be spent.

Dedicated Trust Account

A Dedicated Account is usually funded from the Supplemental Security Income (SSI) Program administered by the Social Security Administration (SSA). SSA deposits funds in this type of account if the child is owed six or more months of retroactive payments. DCFS must obtain permission from the SSA to spend money from a Dedicated Account. With prior approval from the SSA, income in a Dedicated Account may be used for the following:

1. Medical Treatment; and
2. If pertaining to an impairment-
   a) Personal needs assistance
   b) Housing modifications
   c) Special Equipment

d) Therapy or rehabilitation, or
e) Other items or services if approved by the SSA.

Regular Trust Account

Money in a Regular Account is usually income from child support or Social Security Survivor's (Title II) benefits. Although these funds have fewer restrictions than a Dedicated Account, spending must be appropriately prioritized according to the child's needs:

1. Medical needs.
2. Reimbursement of board/contract payments.
3. Clothing purchases:
   a) Initial clothing is limited to $150.00 upon entry into foster care.
   b) Supplemental clothing is limited to a maximum of $400.00 per calendar quarter.
4. Education related expenses-including fees for extracurricular activities-excluding school supplies which are covered in the monthly board payment.
5. Miscellaneous expenses-damaged/destroyed property, legal fees, restitution for stolen goods etc.-Excluding clothing, toys and electronic equipment.
6. Electronic equipment purchases—must have prior approval from the Area Director.
7. Exceptional purchases, toys or video games purchases outside of Christmas purchases must not exceed 20% or $500.00 of the child's available trust account balance and be appropriate for the child's age and/or disability. Expenditures exceeding 20% must have prior approval of the supervisor and Area Director.

After basic needs are met, purchases may be made for items or services that will enrich the child's life. Examples of this include, but are not limited to items such as tutoring, music lessons, and dance lessons.

Purchases utilizing the funds of trust accounts must be approved by the child's FSW. In some instances approvals must also be approved by the FSW's Supervisor, Area Director, and/or DCFS Executive Staff. Only DCFS staff is permitted to make purchases from the accounts. To maintain a child's eligibility for some Medicaid Programs, the balances in Regular Accounts must remain within limits set by the State and Federal Governments. For example, if a child is receiving SSI then the countable value of the Regular Trust Account must be under $2,000 at the end of each month. A report is available to DCFS staff that lists children in foster care with Regular Account balances of $1,000 or more.

Foster parents are encouraged to assist DCFS in identifying children's needs that can be met using foster care trust funds. Recommendations for purchases that meet the criteria discussed in this document should be made to the FSW so DCFS may decide if money is available for the purchase from a trust account and so that DCFS may secure the necessary approvals to make the purchase.

Incidental Expenses

An Incidental Expense Fund is established for the purpose of providing items and activities which serve to normalize a child's life experience while in care. For example, camp fees, music lessons, field trips, school uniforms and other items not specifically covered by other means can be met by this fund. The Incidental Expense Fund is intended for items or activities which cost $25.00 or more and use of the funds does not require prior approval. Items covered by the board payment are not eligible for reimbursement from this fund. In addition, these funds shall not be used for Holiday gifts. The Family Service Worker will assist the foster parent in accessing these funds when the money is needed for a situation that meets the policy guidelines.

MEDICAL SERVICES

Medical Passport

In order to comply with health care standards in the interest of good clinical practice and effective service to children in foster care, an abbreviated health record ("Medical Passport") shall be completed by the Family Service Worker or Health Services Specialist for each child. The Medical Passport will include initial health screening, timely comprehensive health assessments and a descriptive health plan for each child.

The Family Service Worker or Health Service Unit shall request medical records on the child for the time prior to entry in foster care. The medical history information gathered shall be given to the physician who will do the comprehensive health assessment. The medical history is used to supplement and correct the child's Medical Passport. Requests for medical records are documented on the Requested Medical Records Log, CFS-353.

The Medical Passport forms are to be completed during initial placement into foster care. The Family Service Worker shall complete CFS-362: Medi-Alert to Foster Care Provider and CFS-6007: Placement Plan – Placement Provider Information. The Family Service Worker and the foster parent are to complete CFS-365: Receipt for Medical Passport, optional together. The CFS-352 is used for Initial Dental Exam, Medical, Vision, Hearing, & Psychological Episodic. The CFS-366 is used for the Initial Physical.

After each health care visit, the Family Service Worker, Health Service Unit, or Health Care Specialist shall collect records of the child's health care, keep the child's Medical Passport up to date, and shall provide the revised Passport to the child's foster parent.

Initial Health Screening

A child who enters the custody of DHS shall receive an initial health screening:

- Not more than 24 hours after removal from home, if the reason for removal is an allegation of severe maltreatment or there is evidence of acute illness or injury; and
- Not more than 72 hours after removal from the home for all other children.

The foster parent should accompany the child to the initial screening, and to any appointments for on-going health or mental health services. If this is not possible, the foster parent shall be available by telephone to the person conducting the screening. The Family Service Worker or Health Service Unit shall inform the foster parent of the results of the screening, and any instructions for the child's care and treatment, and shall give the foster parent the name of the person who performed the screening, and the names of the child's prior health care providers, if known.

The initial health screening should include a head-to-toe physical. If possible, the physical should be conducted by the child's Primary Care Physician (PCP). Within the first 30 days the following tests will be conducted:

- Complete blood count;
- Check for anemia and infection;
- Abnormalities in the urine (urinalysis);
- HIV, sickle cell, tuberculosis, and other communicable diseases, shall be considered for children in high risk groups.
- Immunizations, and lead poisoning levels are usually completed at the local County Health Office.

Upon completion of the initial health screening, the Family Service Worker or Health Service Unit shall complete the CFS-362: Medi-Alert and give a copy to the child's foster parent.

All health screening requirements conform to the Child Welfare League of America's 2004 Standards for Health Care Services for Children in Out-of-Home Care.

Assessing Health Needs

If the initial health screening indicates that treatment or further evaluation is needed within 30 days, the Family Service Worker or Health Service Unit shall ensure that the need is promptly met.

The foster parent should accompany the child to receive treatment, and shall consult with the health care provider about the child's health care needs. DCFS shall provide assistance with transportation, child care for other children in the foster home, and other necessary support to enable the foster parent to accompany the child to this and any subsequent health care visits. This assistance may either be provided through the use of DCFS staff, including paid or volunteer aides, or through agreements to reimburse the foster parent for such supportive services.

If a foster parent cannot accompany the child, the Family Service Worker or Health Service Unit shall accompany the child, and convey the health care provider's diagnosis and instructions to the foster parent. The Medical Passport shall be revised and this revision provided to the foster parent.

Comprehensive Health Assessment

A comprehensive health assessment should be completed within 60 days of placement. The comprehensive health assessment includes assessments of cognition/achievement, speech/language development, hearing, vision, medical, emotional and behavioral development. The University of Arkansas for Medical Sciences Project for Adolescent and Child Evaluation (UAMS PACE) Program is responsible for conducting the comprehensive health assessments. Medications should be provided as necessary.

Within the first 60 days, a dental examination should be completed for signs of infection, gross abnormalities, malocclusion, painful areas, inflammation of the gums, plaque deposits, decayed or missing teeth, and an assessment of the continuing dental hygiene practices for the child. All follow-up dental work that is recommended by the provider shall be completed in 30 days.

Birth/legal parents or relevant members of the extended family should be encouraged, when appropriate, to participate in the Comprehensive Health Assessment.

After the Comprehensive Health Assessment, there will be a written summary of the medical, mental health, educational, dental and social status and needs of the child. The Child's Health Services Plan should be completed at the Comprehensive Assessment. The Family Service Worker or Health Service Unit shall provide copies of the health plan and updates to the child's birth/legal parents, foster parents, and the child, if age 10 or older within seven days.

Continuing Health Services

After the initial physical, dental, visual, and hearing examinations are completed during the Comprehensive Health Assessment, all subsequent examinations shall be accomplished as part of the ongoing Early Periodic Screening Diagnosis Treatment (EPSDT) screening program, based on the respective periodicity schedules. The medical provider will complete CFS-352 at each examination. A physical examination control schedule shall be maintained so that examinations are conducted according to the Division of Medical Services' EPSDT periodicity schedule. The Family Service Worker or Health Service Unit shall update the CFS-362, CFS-6007, CFS-368 as necessary, after each physical examination.

The initial screening can be received at any age. The Family Service Worker shall schedule all subsequent screenings according to the 2005 American Academy of Pediatrics periodicity schedule on the next page. If a child needs a screening outside the periodicity schedule, the Family Service Worker may issue an EMS-694 marked, "Child in foster care - Unscheduled EPSDT Screening authorized by the Division of Children and Family Services", 30 days before the appointment.

Mandatory Immunizations

State law requires that certain immunizations are obtained before a child enters school. Foster parents should assist in maintaining current immunizations. See Recommended Immunizations Timetable.

Physicians' Guide to Preventive Health Screening

KEY:
✔ = to be performed
R = to be performed for patients at risk
O = objective, by a standard testing method
S = subjective, by history
←●→ the range during which a service may be provided, with the dot indicating the preferred age

TYPE OF EXAMINATION	AGE OF PATIENT																												
	Prenatal	Newborn	2-4 days	By 1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	3 years	4 years	5 years	6 years	8 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years	20 years	21 years
HISTORY																													
Initial/Interval	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
MEASUREMENTS																													
Height & Weight		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Blood Pressure													✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Head Circumference		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔																	
SENSORY SCREENING																													
Vision		S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
Hearing		O	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
PHYSICAL EXAMINATION		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
PROCEDURES—GENERAL																													
Hereditary/Metabolic Screening		←●→																											
Immunization		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Hematocrit or Hemoglobin								●→		R	R	R	R	R	R				←●→										
Urinalysis															✔				←						●✔				→
PROCEDURES—PATIENT AT RISK																													
Lead Screening								●→				✔			✔*														
Tuberculin Test									R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Cholesterol Screening												R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening																			R	R	R	R	R	R	R	R	R	R	R
Pelvic Exam																			R	R	R	R	R	R	R	R	R	R	R
ANTICIPATORY GUIDANCE																													
Injury Prevention	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Violence Prevention	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Sleep Positioning Counseling	✔	✔	✔	✔	✔	✔	✔																						
Nutritional Counseling	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
DENTAL REFERRAL									←				●																

**If not performed at 12 or 24 months.*

Based on AAP recommendations, as of 2005.

This material was prepared by Arkansas Foundation for Medical Care (AFMC) under contracts with the Arkansas Department of Human Services, Division of Medical Services. The contents presented do not necessarily reflect their policies. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. MP2-PGPHS.PSTI, 1-2/06

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Foundation for Medical Care
www.afmc.org/mmcs

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		see footnote 1	HepB						
Rotavirus[2]			RV	RV	*RV*[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR		see footnote 7			MMR
Varicella[8]						Varicella		see footnote 8			Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). ***(Minimum age: birth)***

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:

- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). ***(Minimum age: 6 weeks)***

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). ***(Minimum age: 6 weeks)***

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). ***(Minimum age: 6 weeks)***

- If PRP-OMP (PedvaxHIB® or Comvax® [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TriHiBit® (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.

5. Pneumococcal vaccine. ***(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])***

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant.

6. Influenza vaccine. ***(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])***

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

7. Measles, mumps, and rubella vaccine (MMR). ***(Minimum age: 12 months)***

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. ***(Minimum age: 12 months)***

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). ***(Minimum age: 12 months)***

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Meningococcal vaccine. ***(Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [MPSV])***

- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2009

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ Age ▶	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]	*see footnote 1*	Tdap	Tdap
Human Papillomavirus[2]	*see footnote 2*	HPV (3 doses)	HPV Series
Meningococcal[3]	MCV	MCV	MCV
Influenza[4]	Influenza (Yearly)		
Pneumococcal[5]	PPSV		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	HepB Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		
Varicella[10]	Varicella Series		

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 7 through 18 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). ***(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL®)***
- Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
- Persons aged 13 through 18 years who have not received Tdap should receive a dose.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. Human papillomavirus vaccine (HPV). ***(Minimum age: 9 years)***
- Administer the first dose to females at age 11 or 12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.

3. Meningococcal conjugate vaccine (MCV).
- Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
- Administer to previously unvaccinated college freshmen living in a dormitory.
- MCV is recommended for children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other groups at high risk. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 5 or more years previously and remain at increased risk for meningococcal disease should be revaccinated with MCV.

4. Influenza vaccine.
- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

5. Pneumococcal polysaccharide vaccine (PPSV).
- Administer to children with certain underlying medical conditions (see *MMWR* 1997;46[No. RR-8]), including a cochlear implant. A single revaccination should be administered to children with functional or anatomic asplenia or other immunocompromising condition after 5 years.

6. Hepatitis A vaccine (HepA).
- Administer 2 doses at least 6 months apart.
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

7. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
- If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. Varicella vaccine.
- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if they have received only 1 dose.
- For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2009

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Hepatitis B[1]	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Rotavirus[2]	6 wks	4 weeks	4 weeks[2]		
Diphtheria, Tetanus, Pertussis[3]	6 wks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 wks	4 weeks If first dose administered at younger than age 12 months 8 weeks (as final dose) If first dose administered at age 12-14 months No further doses needed If first dose administered at age 15 months or older	4 weeks[4] If current age is younger than 12 months 8 weeks (as final dose)[4] If current age is 12 months or older and second dose administered at younger than age 15 months No further doses needed If previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	4 weeks If first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) If first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks If current age is younger than 12 months 8 weeks (as final dose for healthy children) If current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months			
Hepatitis A[9]	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	4 weeks	4 weeks If first dose administered at younger than age 12 months 6 months If first dose administered at age 12 months or older	6 months If first dose administered at younger than age 12 months	
Human Papillomavirus[11]	9 yrs	Routine dosing intervals are recommended[11]			
Hepatitis A[9]	12 mos	6 months			
Hepatitis B[1]	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months If the person is younger than age 13 years 4 weeks If the person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).
- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).
- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).
- Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy; administering 1 dose of Hib vaccine to these persons is not contraindicated.
- If the first 2 doses were PRP-OMP (PedvaxHIB® or Comvax®), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer 2 doses separated by 4 weeks and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.
- Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
- For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if 3 doses were received previously or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses were received previously.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49(No. RR-9)), including a cochlear implant, at least 8 weeks after the last dose of PCV.

6. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR).
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
- If not previously vaccinated, administer 2 doses with at least 28 days between doses.

8. Varicella vaccine.
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For persons aged 12 months through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

9. Hepatitis A vaccine (HepA).
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
- Doses of DTaP are counted as part of the Td/Tdap series
- Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 2 and 6 months after the first dose). However, the minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be given at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at http://www.vaers.hhs.gov or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at http://www.cdc.gov/vaccines or telephone, 800-CDC-INFO (800-232-4636).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

The immunization schedules shown above should serve as a guideline only; acceptable alternate schedules do exist, and consultation may be required in some cases.

Hospitalization

- When a child in foster care is hospitalized, the Family Service Worker working with the child must provide the hospital with the child's Medicaid number, if applicable, vital statistics, previous medical history, and other identifying information as indicated.

- The Family Service Worker signs both the admission forms and the required consent for surgery if indicated. A second opinion by a medical specialist will be obtained before major surgery whenever possible.

- The Family Service Worker completing admission forms must leave with the hospital the name and telephone number of the Worker to be contacted regarding the child.

- Foster parents shall not sign a child in foster care into the hospital or sign other medical or surgical consent. Physicians and hospitals may determine that an emergency exists and waive the usual required consent, or they may take consents on the telephone with a second party at the hospital listening and verifying the consent. The Foster Parents should notify the FSW immediately when a child in foster care is hospitalized. As soon as possible, the FSW shall visit the hospital and sign the required consents.

Prescription Drugs

Children in foster care are eligible for prescription drugs through the State Prescription Drug Program.

When there are no Medicaid providers available in cases of emergency, the FSW (with the approval of the County Supervisor) will authorize and bill for medication and medical services using a DHS-1914.

ADDITIONAL INFORMATION

Educational Services

It is the responsibility of DCFS to provide educational opportunities to help each child meet their full potential. To ensure that children in the custody of DHS receive a quality education, it is the Division's policy to enroll children in foster care only in schools accredited by the Arkansas Department of Education.

Children in foster care shall attend public schools. However, the DCFS Director may grant an educational waiver allowing a child to be placed in a non-public school, including a private, parochial, or home school if it is the best interest of the child. No state or federal funding may be used for such placement. For a child in foster care to be enrolled in a non-public school or be home schooled, a certified mental health professional must present documentation stating that the non-public schooling is in the child's best interests.

Tutoring can be purchased for a child in need of additional educational assistance. Consult the Family Service Worker regarding tutoring. Educational testing and counseling should be available to a child in foster care when they begin to make career/curriculum decisions. If a child desires to pursue college or vocational training after high school, the Family Service Worker will assist the child in the exploration of resources to pursue this plan.

Foster Care Staffings

A staffing is a meeting of key persons who are responsible directly or indirectly for problem solving and decision-making in regard to a child's case plan.

An initial staffing for the child is held within the first 30 days of the child's stay in foster care. Another staffing is held two months after the first staffing and every three months thereafter.

Foster parents will be invited to all staffings on children currently in their care in accordance with the Foster Home Agreement Addendum, CFS-462A. However, it may not be necessary for them to attend the entire staffing.

The Family Service Worker will inform the foster parent in advance of the purpose of the staffing, and what information, if any, that one may be called upon to present. Information presented may include the following:

- Observations about the child;
- If visits have occurred between the birth/legal family and the child, the child's reactions as perceived by the foster parent;
- The child's adjustment in one's home and community;
- Any problems the child is currently experiencing and difficulties this may be causing the family; and,
- Input regarding development of the case plan and the foster parent's assessment of progress in those areas.

Visits between the Child and Birth/Legal Parents/Siblings/Relatives

In order to achieve reunification of families, DCFS shall strive to ensure visitation be made available within the first five days of placement. Visits will be based on the families' needs and reasons for the home placement.

The foster parent plays a very important role in the visitation of the child with parents and siblings. This role includes acceptance of the visits, emotional preparation of the child and supportive follow up with both the child and the child's worker. The foster parent can help the child by preparing the child for changes in the family circumstances or anything that might be unexpected and difficult for the child to accept. The same supportive attitude is needed after the visit.

The foster parent's help is vital to the success of the child's visitation with family members. However, a foster parent may find visitation difficult in some situations. For example, a child may be returned upset, with lost clothing, uncombed hair, etc. These issues may cause the foster parent to question the value of the visits. At such times, it will help to discuss these feelings with the FSW to be reminded of the reasons for visitation. Frequently, with supportive understanding, such problems can be worked out satisfactorily for all concerned.

In any case, the foster parent should always report to the child's FSW the reaction of the child to the visit and the foster parent's perceived observation.

Parent/Child Visits

1. Children in foster care shall have at least weekly visits with their parents. However, in the exercise of professional judgment, if such visits are contrary to the health and welfare of the child, an exception may be made to omit the visits. This provision shall not be construed to compel a child to visit with his/her parents over the child's objection. Visits shall be subject to the orders of the presiding court.
2. A visitation schedule shall be established within three days of initial placement. Visits shall begin no later than five days from the date DHS assumes custody of the child unless, in the exercise of professional judgment, such visits are contrary to the health and welfare of the child or are impossible due to circumstances outside DCFS' control. Visitation shall be subject to the orders of the presiding court.

3. Visits shall, if possible, take place in the parents' home or in the most homelike setting available or in some appropriate educational or recreational setting. The DHS office is the most restrictive setting for visits and should be avoided if possible.
4. For those children in foster care whose parents or legal guardians are incarcerated, the Arkansas Department of Correction (ADC) social worker will be contacted to arrange visitation between the child placed in an out-of-home setting and his incarcerated parent(s) unless such visitation is prohibited by the court, not recommended by a physician, etc.
5. Visits are to increase in frequency and duration. This will include weekend visits leading up to the child's return home, unless specific documented harm is caused by the visits.
6. Children in foster care shall have reasonable opportunities to communicate in writing or by telephone with their parents unless prohibited by court order.

Siblings Visits

1. If a child has a sibling, the Family Service Worker shall arrange sibling visits. Sibling visits shall take place at least once every two weeks unless, in the exercise of professional judgment, the children's best interests require less frequent visitation.
2. If it is in the child's best interest, visits between siblings and with relatives may continue after Termination of Parental Rights (TPR), if visitation was established prior to TPR. Visitation after TPR will continue until an adoption placement is made or the out-of-home placement case is closed. Continuation of visits with parents who have had their parental rights terminated does not continue. Relative visits after TPR must have court approval and cannot continue without the court's approval.
3. Sibling visits shall, if possible, take place in the parents' home, in the home of one of the siblings, in the most homelike setting available or in some appropriate setting such as an educational or recreational setting.

Relative Visits- Children shall have an opportunity to visit with grandparents, great grandparents, or others as determined by the Family Service Worker. Relatives should be allowed supervised visitation. These visits can help explore alternate placement options.

Publication of Information about Children in Foster Care

There are occasions when questions may be asked or pictures requested for purposes of newspaper, television, or radio publicity. All publicity must be approved through the FSW and the County Office Supervisor. Some situations may require the involvement of the DHS Director of Communication.

Youth in Foster Care Application for an Arkansas Driver's License and Insurance Reimbursement Programs

The Director of DCFS may authorize an employee or any foster parent to sign an application for a youth in foster care to obtain an Arkansas Learner's Permit or Intermediate Driver's License. The youth in foster care must meet requirements set by the Division and the State of Arkansas, and be approved by the Director. The foster parent may apply for reimbursement for the additional cost to add the child to their automobile insurance. Participation in both of these programs is voluntary. For more information, the foster parent should consult with their FSW.

Runaways

If a child runs away from the foster home, the foster parent should immediately notify the child's Family Service Worker, On-Call Worker, and/or County Office Supervisor. The Foster Parent should be able to provide information regarding clothes the child was wearing, etc., to aid the worker in making a report to the police.

When a Youth in Foster Care is Arrested

When a youth in foster care is arrested, a foster parent should notify the FSW or On-Call Worker (if after hours). The FSW will talk to law enforcement officials to find out where the youth is being held, the alleged offense, times of the hearings, and possible repercussions. The FSW will also determine if the youth understands his or her legal rights and has not unknowingly waived the rights to silence and to presence of an attorney during any questioning.

The FSW will attempt to have the youth released into the custody of the foster parent if they are willing to sign a statement that the youth will be returned on the day of the detention hearing and/or the adjudication hearing. The youth's birth/legal parents will be notified. The DHS Attorney will be notified, and will contact the Prosecuting Attorney to assure that both the rights of DCFS and the youth are protected and that the youth has an attorney. The DHS Attorney will represent DHS, when appropriate, in the court hearing. The FSW will attend court with the youth.

Foster Parent Adoption

Once parental rights have been terminated, children may be adopted. A foster parent may apply to DCFS to adopt a child. A distinction is made between foster parents who apply through the regular adoption program and foster parents who apply to adopt a particular child.

Foster parents applying through the regular adoption program must meet the same requirements as all other adoption applicants. The FSW will refer any interested foster parent to an Adoption Specialist.

When foster parents are interested in adopting a child in foster care in their home, DCFS will consider the benefits provided by them for that child and other certain conditions. The child's desires will be especially considered. The FSW will speak with the child alone regarding this major decision in his or her life and help the child consider all the facts.

If a foster parent wishes to adopt a child in their home, the foster parent should make the request known by requesting and completing CFS-489: Foster Parent Request for Consideration to Adopt if the foster parent meets the basic qualifications outlined on the form. Discuss the desire to adopt with the FSW to determine eligibility.

ANOTHER PLANNED PERMANENT LIVING ARRANGEMENT (APPLA)

This goal addresses the quality of services the youth will receive, including tranistional services, and a plan for supervision and nurturing. APPLA can only be selected if the youth cannot be reunited with his or her family, another permanent plan is not available, and:

- a compelling reason exists why termination of parental rights (TPR) is not in the youth's best interest; or
- the youth is being cared for by a relative and TPR is not in the best interests of the youth.

This category applies only to those youth who are secure in their setting, who have been with a foster home for a number of years, and for whom this is the most suitable plan that can be made. The following criteria must be met:

- The youth is secure and has demonstrated good adjustment in the foster home and is firm in the decision, after consideration, that he or she does not wish to be adopted;
- The foster parents have revealed their love and affection for the youth but cannot adopt;
- The youth has resided in the foster home sufficiently long to develop close ties;
- It is apparent that the youth should not be placed with birth/legal parents, relatives or adopted; and
- The youth is 14 years old or older.

Transitional Youth Services (TYS)

Transitional Youth Services assists youth age 14-21 who are interested in furthering their educational/vocational goals and who voluntarily participate in the program's services. The program coordinates and provides life-skills training and educational assistance to current and former youth in foster care in preparation for the transition into adulthood and mainstream society. Training is provided in various formats and in accordance with case plans. All training is coordinated through the Family Service Workers and TYS Coordinators. Each County Office can provide more information about this program. The foster family may be reimbursed for transporting youth to life skills training classes and other TYS activities.

Be Your Own Advocate!

Be Your Own Advocate!, DCFS PUB-50, is a resource for youth in foster care age 14-21 and was developed along with the Youth Advisory Board to provide youth with information they will need while in foster care. This book is only a reference guide. The youth may contact their FSW or TYS Coordinator for any questions or further explanations.

Extended Foster Care

Youth may choose to remain in foster care past the age of 18 as determined appropriate by the youth and his/her Transitional Team and if:

- The child is completing secondary education or a program leading to an equivalent credential; or,
- The child is enrolled in an institution which provides post-secondary or vocational education; or,
- The child is participating in a program or activity designed to promote, or remove barriers to, employment; or,
- The child is employed for at least 80 hours per month; or,
- The child is incapable of doing any of the above described activities due to a medical condition.

Liability of Foster Parents

Foster parents must carry homeowner's or renter's insurance and general liability insurance, which may be included in the homeowners policy.

Any claims for damages or destruction to a foster parent's personal property, not covered by homeowner's insurance, car insurance, or to the property of others due to the actions of a child placed in a foster home should be filed with the Arkansas Claims Commission. Foster parents or the individual may request the appropriate application to submit their claim by contacting the Arkansas Claims Commission, 101 East Capitol Ave., Suite 410, Little Rock, AR 72201-3823, Telephone: 501-682-1619, www.claimscommission.ar.gov.

The foster parents or the individual should contact their County Office and provide information needed to complete an incident report. (This is a different document from the claim form mentioned above.) This incident report will be submitted to Central Office and will be used to assist the Claims Commission in processing the claim.

Foster parents approved by the Division shall not be liable for damages caused by children in foster care, nor shall they be liable to the children in foster care or to the parents or guardians of the children in foster care for injuries to the children in foster care caused by acts or omissions of the family foster parents unless the acts or omissions constitute malicious, willful, wanton, or grossly negligent conduct. (Act 941 of 1989)

The information contained within this handbook is a guideline for the DCFS Foster Care Program. If any information contained herein should be in disagreement with official DCFS policy as written in the DCFS Family Services Policy and Procedure Manual or with state/federal law; then the policy or law shall take precedence. DCFS urges discussion of any concerns related to children in foster care in one's home with a Family Service Worker.

In the event one needs to contact the Division of Children and Family Services for any reason, please call the persons listed below in the order they are listed. For example, if one cannot reach the Family Service Worker or feel they need to speak to a supervisor, then one should call the second name listed.

DCFS CONTACT INFORMATION

CHILD'S NAME_____

FAMILY SERVICE WORKER_____

Work Phone_____

Emergency Phone_____

FAMILY SERVICE WORKER'S SUPERVISOR_____

Work Phone_____

Emergency Phone_____

DCFS COUNTY OFFICE SUPERVISOR_____

Work Phone_____

Emergency Phone_____

FOSTER PARENT RESOURCE WORKER _____

Work Phone_____

Emergency Phone_____

DCFS AREA DIRECTOR_____

Work Phone_____

Emergency Phone_____

CHILD MEDICATION FLOW SHEET

Patient Name	Age	Allergies

Date Start / Stop	Medication Dosage/Direction/Amount	Refills Date/Amount/Initials			

NATIONAL FOSTER PARENT ASSOCIATION CODE OF ETHICS FOR FOSTER PARENTS

Preamble

Foster family care for children is based on the theory that no unit in our society, other than the family, has ever been able to provide the special qualities needed to nurture children to their fullest mental, emotional and spiritual development. If, for a certain period, a family ceases to provide these special qualities, substitute care must be used. It is recognized that ideally, foster care is temporary in nature. Persons who provide foster family care must have commitment, compassion and faith in the dignity and worth of children, recognize and respect the rights of natural parents, and be willing to work with the child-placing agency to develop and carry out a plan of care for the child.

Foster care is a public trust that requires that the practitioners be dedicated to service for the welfare of children, that they utilize a recognized body of knowledge about human beings and their interactions, that they be committed to gaining knowledge about human beings and their interactions, and that they be committed to gaining knowledge of community resources which promote the well-being of all without discrimination.

Each foster parent has an obligation to maintain and improve the practice of fostering, constantly to examine, use and increase the knowledge upon which fostering is based, and to perform the service of fostering with integrity and competence.

Principles

In order to provide quality foster care services, foster parents subscribe to the following principles:

I regard as my primary obligation the welfare of the child deserved.

I shall work objectively with the agency in effecting the permanent plan for the child in my care.

I hold myself responsible for the quality and extent of the services I perform.

I accept the reluctance of the child to discuss his past.

I shall keep confidential from unauthorized persons information pertaining to any child placed in my home.

I shall treat with respect the findings, views and actions of fellow foster parents, and use appropriate channels, such as a foster parent organization, to express my opinions.

I shall take advantage of available opportunities for education and training designed to upgrade my performance as a foster parent.

I respect the worth of all individuals regardless of race, religion, sex or national ancestry in my capacity as a foster parent.

I accept the responsibility to work toward assuring that ethical standards are adhered to by any individual or organization providing foster care services.

I shall distinguish clearly in public between my statements and actions as an individual, and as a representative of a foster parent organization.

I accept responsibility for working toward the creation and maintenance of conditions within the field of foster family care which enable foster parents to uphold the principles of this code.