

Section 4 Overview

This section pertains to the policy and procedures necessary when an out-of-home placement of a child is imminent or has occurred.

Chapter 24 Overview

This chapter addresses the medical/mental health planning process and legal basis for the provision of medical and mental health services to children in the legal custody of the Children's Division. Routine medical care, life support/sustaining therapies, and HIV/AIDS issues are discussed. This chapter also establishes a protocol to be used in determining which Children's Division (CD) families involve children who have been placed in custody due solely to a need for mental health services and where no instance of parental abuse, neglect, or abandonment exists and a protocol to divert such children from the Division's custody. Also, included in this chapter are procedures for responding to the death of a child in the legal custody of the Children's Division.

Table of Contents

- 24.1 Legal Basis for the Provision of Medical/Mental Health Services
- 24.2 Medical Information to be Obtained when Child Enters Care
- 24.3 Medical Service Alternatives/Planning
 - 24.3.1 Routine Medical/Dental Care
 - 24.3.2 Human Immunodeficiency Virus (HIV) Screening
 - 24.3.3 Emergency and Extraordinary Medical/Dental Care
 - 24.3.4 Children's Treatment Services
 - 24.3.5 Missouri Medical/Dental Services Program (MM/DSP) (Also Known as Title XIX or Medicaid)
 - 24.3.5.1 Medicaid Eligibility Documentation of U.S. Citizenship and Identity
 - 24.3.6 Bureau for Children with Special Health Care Needs (BCSHCN)
 - 24.3.7 Department of Mental Health
 - 24.3.8 Residential Care Referral
 - 24.3.9 Private Psychiatric Hospital Placement
 - 24.3.10 Medical Foster Care
- 24.4 Identification of Children in the Custody of the Children's Division Solely for the Purpose of Accessing Mental Health Services
- 24.5 Custody Diversion Protocol
- 24.6 Voluntary Placement Agreement
- 24.7 Pregnancy of Child in Out-of-Home Care
- 24.8 Chemical Dependency Treatment
- 24.9 HIV/AIDS Issues
- 24.10 Life Support/Sustaining Therapies and Do Not Resuscitate Order (DNR) or Removal of Life Support for the Child in the Legal Custody of the Division.
- 24.11 Death of a Child in Out-of-Home Care
 - 24.11.1 Burial Arrangements

Title: Child Welfare Manual
Section 4: Out-of-Home Care
Chapter 24: Medical/Mental Health Planning
Effective Date: July 16, 2008
Page: 2

Memoranda History:

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#); CD08-47

24.1 Legal Basis For The Provision Of Medical/Mental Health Services

The legal basis for the provision of medical services comes from the following Missouri statutes:

207.020(17) To accept for social services and care, homeless, dependent and neglected children in all counties where legal custody being vested in the Children's Division by the juvenile court where the juvenile court has acquired jurisdiction pursuant to subdivision (1) or (2) of subsection 1 of section 211.031, RSMo;

208.204.2. Through judicial review or Family Support Team meetings, the Children's Division shall determine which cases involve children in the system due exclusively to a need for mental health services, and identify the cases where no instance of abuse, neglect, or abandonment exists.

208.204.3. Within sixty days of a child being identified pursuant to the above, an individualized treatment plan shall be developed by the applicable state agencies responsible for providing or paying for any/all appropriate services-subject to appropriation-and the Department of Social Services shall submit the plan to the appropriate judge of the child for approval. The child may be returned by the judge to the custody of the child's family.

208.204.4. When the children are returned to their family's custody and become the service responsibility of the department of mental health, the appropriate moneys to provide for the care of each child...shall be billed to the Department of Social Services by the Department of Mental Health pursuant to a comprehensive financing plan developed jointly by the two departments.

210.108.1. As used in this section, "voluntary placement agreement" means a written agreement between the department of social services and a parent, legal guardian, or custodian of a child seventeen years of age or younger solely in need of mental health treatment. A voluntary placement agreement developed under a Department of Mental Health assessment and certification of appropriateness authorizes the Department of Social Services to administer the placement and care of a child while the parent, legal guardian, or custodian of the child retains legal custody.

210.108.2. The Department of Social Services may enter into a cooperative interagency agreement with the Department of Mental Health authorizing the Department of Mental Health to administer the placement and care of a child under a voluntary placement agreement. The Department of Mental Health is defined as a child placing agency under section 210.481 solely for children placed under a voluntary placement agreement.

210.108.3 Any function delegated from the Department of Social Services to the Department of Mental Health regarding the placement and care of children shall be administered and supervised by the Department of Social Services to ensure compliance with federal and state law.

210.108.4. The Departments of Social Services and Mental Health may promulgate rules under this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall be come effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonservable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

210.720(2) In such permanency hearings the court shall consider all relevant factors including; (3) The mental and physical health of all individuals involved, including any history of abuse of any individuals involved.

210.760 In making placements in foster care the Children's Division shall: (2) Provide full and accurate medical information and medical history to the persons providing foster care at the time of placement.

210.002 Year 2000 Plan requires The Children's Division (CD) to participate in the development and implementation of coordinated social and health services which includes preventive, maintenance and long-term medical and mental health care.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History:

24.2 Medical Information to be Obtained when Child Enters Care:

1. The Children's Service Worker (CSW) will ensure that initial medical information is obtained from the parent/physician and given to the foster parent within 72 hours, if possible, but no later than 30 days following placement. This information should include:
 - a. Immunization history;
 - b. Past and current medical problems;
 - c. Allergies and adverse reactions to medications;
 - d. Hospitalizations and surgeries;
 - e. Dental records;
 - f. Current medications;
 - g. Current and past medical providers;
 - h. Developmental milestones;
 - i. Prenatal and birth history;
 - j. Current and past illnesses;
 - k. Psychological services - past and current;
 - l. Nutritional history;
 - m. Environmental issues which may pose health risk, i.e., exposure to lead;
 - n. Mother's use of alcohol/drugs during pregnancy; and
 - o. Risk factors contributing to potential exposure to HIV/AIDS.

2. The Children's Service Worker shall establish and maintain a medical record (separate and distinct section in the file or separate record) on each child in care. In order to ensure continuity of care, this record shall include copies of the initial medical examination report and ALL existing medical records on the child, including both current and past medical information.

Also included in the medical record should be a copy of the log of illnesses, medications and the amount given, visits to physician/therapist and the purpose of the visit. The medical log should be kept by the placement provider and submitted to the Children's Service Worker for inclusion in the child's record on a monthly basis.

Related Subject: Section 5 Chapter 1 Documentation and Record Maintenance

3. A summary of the child's medical history including any recent illnesses, and the name and dosage of medication currently taken by the child shall be passed on to the new resource, in writing, whenever a change in placement occurs.
4. The initial health examination shall occur within 24 hours of the child coming into care. If possible, this initial examination should be a complete Healthy Children and Youth (HCY) screening (physical, eye, hearing, dental examinations). If only a partial screening (physical examination) can be completed within 24 hours, eye, hearing and dental examinations shall occur within the first 30 days the child is in care.
5. Ongoing medical care should be obtained in accordance to the HCY examination/immunization schedule.
6. All information about the child's medical care while in out-of-home care shall be shared with the parent/caregiver on an ongoing basis. A copy of the complete medical history should be furnished to the parent/guardian.
7. The Children's Service Worker (CSW) shall ensure children receive sexual health education including information on sexually transmitted diseases and birth control appropriate to their individual age and physical and emotional maturity. The CSW should make extensive efforts to involve the physician in sexual health decisions and encourage the child to discuss these matters with his/her parent/s when circumstances allow.. All efforts to comply with this policy must be clearly documented in the record. Directives given by the Court to handle birth control consent or sexual health decisions contrary to this policy should be followed and documented in the record.
8. In order to prevent further spread, unnecessary avoidance, and embarrassment, resources and information shall be made available to all parties involved with children that have communicable diseases, parasites, sexually transmitted diseases or test positive for HIV exposure.
9. The Children's Service Worker shall ensure that children with serious emotional and behavior disturbances receive appropriate counseling, therapy and/or medication. Also, the Worker must ensure that the placement provider has the knowledge and skills necessary to provide appropriate care for the child.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History:

Title: Child Welfare Manual
Section 4: Out-of-Home Care
Chapter 24: Medical/Mental Health Planning
Effective Date: July 16, 2008
Page: 3

24.3 Medical Service Alternatives/Planning

Medical planning for children in out-of-home care is a necessary service to ensure that children receive the medical care they need. The following includes several medical service alternatives for which planning will be necessary:

24.3.1 Routine Medical/Dental Care

Routine medical/dental care including services available through the Healthy Children and Youth (HCY) Program, also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT):

- Children entering out-of-home care need initial medical examinations, as well as regular medical examinations throughout their out-of-home care placement.
- Plan with out-of-home care providers and other appropriate team members to ensure that all children in out-of-home care shall receive education on sexual development, appropriate to their age, life experiences, and living conditions. This information should include information on sexuality and venereal diseases.
- Children in out-of-home care are eligible for MM/DSP (MO HealthNet, Title XIX). As a result, they are also eligible for HCY services.

24.3.2 Human Immunodeficiency Virus (HIV) Screening

HIV Screening (ELISA test) is available for children entering out-of-home care who are displaying symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or at increased risk of AIDS. The Children's Service Worker may arrange for the ELISA test through the local Health Department or a private physician. The ELISA test is covered by MM/DSP.

24.3.3 Emergency and Extraordinary Medical/Dental Care (Over \$500.00)

When children are in CD custody their birth parents still have certain rights. One of these rights is to give permission for extraordinary medical/dental care. Whenever possible, the worker should seek parental permission for these medical/dental services. If this is not possible, the Children's Service Worker shall seek approval for the medical/dental services from the juvenile court. Then the Children's Service Worker shall seek approval through their Regional Office.

24.3.4 Children's Treatment Services

Children in out-of-home care are eligible for a variety of children's treatment services, medical and psychiatric services covered by a contract with CD. If a child in out-of-home care is in need of these services, the worker should consult the listing of CD approved contractual treatment providers who offer the service

and make the appropriate referral. Payment will be made at MO HealthNet or state contracted rates.

NOTE: For medical examinations, the HCY referral should be done first. CTS would be used if an HCY physician is not available.

24.3.5 Missouri Medical/Dental Services Program (MM/DSP) (Also Known as Title XIX or MO HealthNet)

Children in out-of-home care are eligible for MM/DSP if they are in the custody of CD. Guidelines established by the MO HealthNet Division determine which medical services are eligible for payment and at what rate. Staff should use this program whenever possible to provide a child with medical care. HCY services are available through this program.

Section 6036 of the Deficit Reduction Act of 2005 section 1903 of the Social Security Act requires that states obtain satisfactory documentation of citizenship in order to receive Medicaid benefits. States must obtain documents establishing identity and citizenship for new applicants and recipients for all categories of Medicaid.

For all children coming into Division custody after July 1, 2006, and for all eligibility re-determinations, the Children's Service Workers will provide the Eligibility Specialist with a copy of the court order and if available documentation of identity and citizenship, preferably a copy of the child's birth certificate. **(Original birth certificates will remain in the child's file.)**

If documentation is not available the Children's Service Worker will begin the process of collecting the appropriate documentation immediately and when obtained forward copies to the Eligibility Specialist. The Children's Service worker will presume all children coming into care as eligible for MO HealthNet, however if the worker is not able to collect the proper documentation, it will be the responsibility of the Eligibility Specialist to make that determination and put the proper coding on the SS-61. The Eligibility Specialist may request the Children's Service Worker to collect particular documentation during the certification or re-certification process.

The citizenship and identification verification process is also applicable for children eligible for MO HealthNet who were referred to the Division for adoption subsidy by outside adoption agencies.

24.3.5.1 Medicaid Eligibility Documentation of US Citizenship and Identity

Documents Used to Verify both U.S. Citizenship and Identity:

- U.S. Passport. The passport does not have to be currently valid to be accepted as long as it was originally issued without limitation;

- Certificate of Naturalization (N-550 or N-570); or
- Certificate of Citizenship (N-560 or N-561).

Documents Verifying Citizenship Only:

- U.S. Birth Certificate or IBTH.
- IBTH is available for individuals born in the State of Missouri.
- IBTH will display birth records for those born in Missouri back to 1920.
- IBTH can be viewed to verify citizenship. When using this information, document in the case record the date viewed and the information verified. **Do not print and file the IBTH in the case record.**
- A Certification of Report of Birth (DS-1350).
- Consular Report of Birth Abroad (FS-240).
- Certificate of Birth Abroad (FS-545).
- U.S. Citizen ID card (I-197 or I-179).
- American Indian Card (I-872).
- Northern Mariana Identification Card (I-873).
- Final adoption decree which shows a U.S. place of birth.
- Official Military Record of Service which shows a U.S. place of birth.
- Hospital record that meets the following criteria:
 1. **Created on hospital letterhead;**
 2. **Established at the time of the person's birth;**
 3. **Created at least five years before the initial application date; and**
 4. **Indicates a U.S. place of birth.**

NOTE: For children under 5 years of age, the document must have been created near the time of birth.

- Life or health insurance record, created at least five years before the initial application date, showing a U.S. place of birth.
- U.S. State Vital Statistics official notification of birth registration.
- Statement signed by the physician or midwife who was in attendance at time of birth.
- Institutional admission papers from a nursing home, skilled nursing care facility, or other institution that were created at least five years prior to the initial application date and indicates a U.S. place of birth.
- Medical (clinic, doctor, or hospital) record that was created at least five years before the initial application date and indicates a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing citizenship.
- For children under 5 years of age, the document must have been created near the time of birth.

Note: When using a document from the above to verify citizenship, a second document must be obtained from the following list to verify identity.

Evidence of Identity

Section 1903(x) provides that identity must be established. When documents verifying both citizenship and identity are not available, a document may be used to verify citizenship accompanied by a second document that verifies identity. **Sources of documentation of identity for children under age 16 are as follows:**

- School record that shows the date and place of birth and parent(s) name. School records may include nursery or child care records.
- Clinic, doctor, or hospital record showing date of birth.
- Court orders identifying individual.
- Identity may be verified through our database if child received coverage as a Newborn.

- If none of the above documents are available, an affidavit by the parent or guardian may be used.

Verification of Citizenship and Identity for Newborns

Citizenship and identity are not required to be verified to add children as newborns as these children are deemed to have applied for and been found eligible to receive MO HealthNet benefits as a result of their mothers being active recipients at the time of birth.

Obtaining Records from the Bureau of Vital Records

The Bureau of Vital Records, within the Missouri Department of Health and Senior Services, has certificates of Missouri births, deaths and fetal death reports. BVR screens frequently utilized by staff include IBTH and IDTH. In Missouri these records are not open to the public and each screen includes the wording: “**Information on this screen is confidential and shall be used for official state purposes only**”. This information is for inquiry only and should not be printed, faxed or copied.

Certified copies of Missouri records of birth, death and fetal death reports can be obtained by submitting a written request to:

Missouri Department of Health and Senior Services
Bureau of Vital Records
P.O. Box 570
Jefferson City, MO 65102

See “Policy and Procedure For Release of Vital Records Information” at:
<http://www.dhss.mo.gov/DataAndStatisticalReports/VRProtocols.pdf>

24.3.6 Bureau for Children with Special Health Care Needs (BCSHCN)

This bureau provides some medical services not covered by MO HealthNet. To make a referral for a child, the Children's Service Worker should make sure that the needed medical services are not covered by MO HealthNet. When it has been determined that the needed medical services are not covered by MO HealthNet, the Children's Service Worker may make a referral to the appropriate regional bureau office.

24.3.7 Department of Mental Health

The Department of Mental Health (DMH) provides mental health services to children who are determined to be eligible for the services. Children in out-of-home care and who are in need of mental health services may be

referred to the appropriate DMH facility determined to meet the needs of the child. Three separate DMH divisions deal with the following:

- Comprehensive psychiatric services;
- Mental retardation and developmental disabilities; and
- Alcohol and drug abuse.

It is important to make the referral to the Division that deals with the specific mental health need. For more information on referral procedures, contact the DMH facility in the catchment area serving the geographical area in which the child lives. See Section 24.4.

24.3.8 Residential Care Referral

Children in out-of-home care and in need of residential treatment should be referred to their area RCST Coordinator via the CS-9.

24.3.9 Private Psychiatric Hospital Placement

Children in out-of-home care who are eligible for private psychiatric hospital care. These facilities provide services including medical treatment, psychiatric/psychological counseling and testing, nursing care, educational services, social work services, recreation services and occupational therapy. The Children's Service Worker should contact the hospital directly to arrange for the child's admission. Cost for the child's care is paid by MO HealthNet for a number of days as prescribed by the Professional Activity Study (PAS).

Payment for days beyond the PAS days may be paid with Regional Office approval. The psychiatric facility should request prior approval of the extension through the MO HealthNet Division (MHD) for extended MO HealthNet payment of the service. If MHD denies, the psychiatric facility should submit the request for payment to the County Office. Such a request is forwarded through normal supervisory channels to the Program Development System Unit (PDSU). The worker should consult the listing of CD contracted services and use these facilities, if treatment is anticipated to exceed the number of PAS days.

24.3.10 Medical Foster Care

Children in out-of-home care who require special care directly attributable to a medical/physical/developmental disability may be eligible to receive medical foster care. If a child is in need of such special care, refer the child through supervisory lines for the Regional Director's approval. The referral must include form CS-10 and written documentation of the child's

Title: Child Welfare Manual
Section 4: Out-of-Home Care
Chapter 24: Medical/Mental Health Planning
Effective Date: August 29, 2006
Page: 7

problems and the involvement of the foster parents in caring for the child, if applicable.

Related Subject: Section 4, Chapter 15 Medical Foster Care
--

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History:

24.4 Identification Of Children In The Custody Of The Children's Division Solely For The Purpose Of Accessing Mental Health Services

Parents should not have to relinquish custody of their child due solely to a need to access clinically indicated mental health services. Children in custody for that reason and absent a probable cause or preponderance of evidence CA/N finding may be eligible for return to the custody of their parents through a protocol established by the passage of Senate Bill 1003 (SB 1003) during the 2004 legislative session:

1. Supervisory Review Of Children Who Are In Division Custody Solely For Mental Health Services Per Section 208.204.2 And 208.204.3 RSMo.

Children who have entered Children's Division custody, absent a probable cause or preponderance of evidence CA/N finding, should be carefully reviewed to determine if they meet the criteria that were contained in SB 1003 signed into law in 2004.

The review of a child in CD custody and determination of meeting SB 1003 criteria must include the following:

- Is the child in the custody of the Division solely because the parents were unable to access or afford mental health needs of the child?
- Is the parent verbalizing a desire for the child's return to his/her custody if the child could receive the necessary mental health services?
- Would the child's safety or the safety of others in the home be compromised by such a return of custody?

Should the parent of a child not previously identified as potentially meeting the eligibility criteria contact the CD expressing a belief that his/her child indeed meets these criteria, CD staff will respond to the request and inform the parent that an FST meeting will be convened within two weeks of the parent's request.

2. Convening The Family Support Team

Once the review is completed and it appears that the reason for the initial placement may be due *solely* to a need to access clinically indicated mental health services, a Family Support Team (FST) meeting is to be convened by the CD case manager upon agreement with the child's parents. This FST meeting should be scheduled and held within 2 weeks in order to begin the process for further assessment and planning. Current policy for FST meetings is to be observed in keeping with the requirements of Section 4, Chapter 7 of the Child Welfare Manual. It is crucial that the child's family be actively involved in the FST and planning process. The case record should clearly document if the family states they are not yet ready to regain custody.

Additional and crucial FST participants shall include:

- The local representatives of the Department of Mental Health's (DMH) Administrative Agents and/or DMH Regional Center staff; and
- Representatives of current placement and treatment providers.

If the child has developmental issues that can best be served by MR/DD within DMH, this agency should be actively involved in the planning process.

The focus of the FST meeting is to jointly determine if the child's placement in CD was due *solely* to a need for mental health services **and** was unrelated to parental abuse, neglect, or abandonment. In addition, the team should determine if the child can be returned safely to the custody of the parent even if he/she continues to need out-of-home care.

If consensus is **not** reached by the FST on whether the child meets the eligibility criteria, the child shall be considered inappropriate for the Senate Bill 1003 protocol. This, however, should not exclude other efforts toward reunification or further steps to obtain clinically indicated services or supports through DMH.

3. Development Of An Individualized Plan To Return The Child To The Custody Of The Parent And Request For A Court Hearing

If the FST agrees that the family meets the criteria for SB 1003 and the parent desires to have the child returned to his/her custody, an individualized plan shall be developed which outlines all services and supports needed by the child and family and identifies who shall be financially responsible for each.

The child, if appropriate and the family shall actively participate in the plan's design. Identified services shall be provided in the least restrictive and most normalized environment. Treatment services and supports shall include but not be limited to those which are home and community based.

This plan shall be submitted to the court within sixty (60) days of the child having been identified through consensus of the FST. The judge may then return custody of the child to the parent.

4. Payment For Services Provided To The Child And Family Once Custody Has Been Returned To The Parent

208.204.4: When children are returned to their family's custody and become the service responsibility of the Department of Mental Health, the appropriate moneys to provide for the care of each child in each particular situation shall be billed to the Department of Social Services by the Department of Mental Health pursuant to a comprehensive financing plan developed by the two departments.

The Children's Division is committed to assuring that the child and family continue to have access to those services that help them meet the needs of the child. If the Division previously paid for such services, it will continue to do so. It is not necessary for the child to be returned to the home of the parent in order for custody to be transferred. To that end, the Division will continue to fund residential treatment if the child continues to need that service as identified through the individualized treatment plan.

Staff should contact the payment unit in Central Office (573-751-8946) for assistance in payment to placement providers for any youth in need of continued residential placement but no longer in the Division's legal custody.

5. Ongoing Implementation of Sections 208.204

For youth who meet criteria under statute cited above and are not otherwise diverted from CD custody, staff should implement the above protocol as quickly as possible to help expedite the youth's return to the custody of his/her parents. The issues relating to the child's placement should be addressed as early as the initial 72-hour FST meeting. The representation of DMH and the current placement provider(s) should be brought into the FST process as soon as possible to assist in the service planning.

Within sixty (60) days of a child being identified as appropriate for the provisions of Section 208.204.2-3 RSMo. an individualized treatment plan shall be developed by the FST, and the Children's Division shall submit the plan to the juvenile/family court judge for approval. The child may be returned by the judge to the custody of his/her family.

The instructions for Form CS-1 have been revised to better document the needs of the child and family, see CS-1 in [E-Forms Index](#). Issues relating to the child's mental health needs and the services and supports that may be needed for his/her parents should be addressed in the ongoing FST meetings. Special emphasis should be placed on determining if the child can be safely returned to his/her parents custody if the necessary mental health services and supports were in place.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History:

24.5 Custody Diversion Protocol

The Custody Diversion Protocol is only to be used when a parent is verbalizing the intent to surrender legal custody of his/her child solely to access needed mental health services, or the parent sees relinquishment of custody as the only option available to obtain such services. This protocol is predicated upon the belief that no parent should **voluntarily** have to relinquish custody of his/her child in order to access mental health services if clinically appropriate services and supports, either within or outside the home setting, can be provided to the youth and family.

Families may feel compelled to relinquish custody due to conflicting information about obtaining appropriate treatment for their children, including information from facilities which may be unaware of community-based alternatives to residential care that may be available to families. Staff must recognize the family's need for help and provide them with both objective information and realistic treatment options.

Custody Diversion Protocol Steps:

Entry

A parent/legal guardian or hospital/residential treatment center contacts a representative of a Juvenile Court, Children's Division (CD) or Department of Mental Health (DMH), reporting that the parent may not allow the child to remain/return home at this time, opting to give up custody instead:

1. If the child is currently in an out-of-home placement and a representative of the Juvenile Office (JO) or CD is contacted, staff should ask if the legal guardian has made a recent referral to the appropriate Community Mental Health Center/ Administrative Agent, hereafter referred to as CMHC/AA, of the DMH. If this has not been done and the legal guardian is willing to do so and maintain custody at this time, the JO or CD staff should provide contact information for the CMHC/AA to the parent/legal guardian. A referral in order to access mental health services through the protocol would **not** be necessary at this time.
2. If a recent referral had been made to the CMHC/AA and the legal guardian continues to express a desire to voluntarily relinquish custody, the JO or CD staff should tell the caller that the legal guardian should call the designated representative of the CMHC/AA, which serves the home area of the child (where the legal guardian/custodian resides). The DMH has designated CMHC/AA staff specifically to serve as contacts for the Custody Diversion Protocol. Likewise, specific contact persons have been identified by the CD and JO in each judicial circuit. Additionally, CD, JO, or CMHC/AA staff should explain that custody will not be accepted at this time and that an assessment process must first occur. The hospital/residential center where the child is currently admitted should be informed that no decisions on alternative placement will likely occur for 3-7 days.

NOTE: Local staff should collaborate with DMH and JO to inform private providers, hospitals, and residential treatment agencies of the protocol and encourage proactive discharge planning.

3. If the child is currently living at home and the parent/legal guardian contacts any of the agencies, the same process noted above should be used.
4. If the parent/legal guardian comes in person to the local CD or JO with the child and safety is not a concern at this time, the process should be explained and the parent encouraged to contact the CMHC/AA with the child returning home at this time. If the parent/legal guardian refuses to take the child home, the agency initially contacted should immediately call an emergency meeting (in person or by phone) with the contacts of the other two agencies and develop an emergency plan for placement. The assessment process outlined below should then continue.
5. It is the responsibility of the agency receiving the initial call to ensure that utilization of the Custody Diversion Protocol is appropriate. The agency receiving the initial call should complete and forward to the CMHC/AA screening information after obtaining witnessed oral permission from the legal guardian. The screening information ensures that the protocol is being applied under appropriate circumstances. (See attached Screening and Feedback Form.)

DMH Contact:

1. If it appears upon notification that a parent intends to give up custody to access mental health treatment services, the CMHC/AA will arrange with the parent/guardian of the child to conduct a level of care assessment as soon as possible or within no later than 2 business days.
2. If there is information that the youth is a client of a DMH Regional Center and/or has a diagnosis of mental retardation or a significant developmental disorder, the Regional Center will be contacted by the CMHC/AA to participate in the assessment process.
3. If the child is placed out of the home, the DMH assessment will likely occur at the hospital or residential treatment center.
4. The DMH assessment shall examine the child/youth's current mental health needs along with the family's perceptions of the child's needs and identify any risk factors through conducting a clinical interview with the child, obtaining a history of past needs and services, and obtaining information from past and current caretakers to establish the level of care needed for the child related to mental health issues.
5. If, in the course of the assessment, abuse and neglect is suspected, the CA/N Hotline should be contacted as required by law (210.115 RSMo.).

6. Upon completion of the assessment and/or if there is a significant delay in arranging the assessment, the CMHC/AA and/or Regional Center should complete the lower half of the received Screening and Feedback Form and forward it to the appropriate referring party. This is to notify the referring party if there is a significant delay in completing the assessment and identify any interim safety concerns and/or to notify the referring party of the outcome of the assessment.
7. A meeting should be conducted with the parent/guardian, outlining the results of the level of care assessment, service options, and fiscal resources necessary to implement the plan. If the parent/guardian is in agreement with the assessment and services offered, such services, including out-of-home placement, may then be accepted by the parent and implemented by the CMHC/AA and/or Regional Center **with no need for a change in custody or a VPA**. Such a scenario constitutes “business as usual” and represents the customary manner by which families are served by the CMHC/AA and/or Regional Center.
8. If, through the assessment, it appears that a temporary placement outside of the family home would be clinically appropriate yet is otherwise unavailable from the CMHC/AA and/or Regional Center **and** the child remains at risk of entering CD custody, a Voluntary Placement Agreement (VPA) through the CD may be explored. The CMHC/AA and/or Regional Center should provide a brief explanation of a VPA to the parent/guardian and explain that a referral could be made to the CD to access this agreement. If the parent is agreeable, the CMHC/AA and/or Regional Center should contact the CD, requesting a meeting be scheduled with the parents, CD, and CMHC/AA and/or Regional Center to review the assessment and the possibility of utilizing a VPA.
9. If the parent/guardian rejects the services outlined through the level of care assessment after an attempt to obtain consensus on a plan and continues to request out of home placement and/or plans to give up custody of his/her child to CD, then the local CD representative should be contacted.
10. The CMHC/AA and/or Regional Center staff should attempt to obtain voluntary authorization from the parent/guardian to share information with CD and contact the CD designee in that county to initiate a screening by CD. If the parent refuses to have information shared and continues to choose to give up custody, it should be explained to the parent that a CA/N hotline call will be placed.
11. If a child is currently in a placement outside of his/her county of residence, the CMHC/AA and/or Regional Center may elect to contact the CMHC/AA and/or Regional Center that serves the county in which the treatment center operates and request a courtesy assessment. However, it is the responsibility of the CMHC/AA and/or Regional Center in the county of residence of the parent/guardian for making final determination and developing, implementing, and coordinating the service plan unless specifically agreed to otherwise.

CD Contact:

1. CD, upon notification from the CMHC/AA and/or Regional Center representative, with appropriate consents for information release or via the Child Abuse/Neglect Hotline, will initiate a screening to be completed as soon as possible or than within no later than 2 business days. In addition, staff should document that the Division responded, and the disposition of our involvement in participating in the custody diversion protocol. No formal information system is required in this instance, but this information should be provided to the Circuit Managers. If the case is brought to the Division's attention through a non-CA/N referral such as a mandated (M) or preventive services (P) referral, staff should document all activity in the record as currently required. Those calls from the Hotline which are classified as CA/N reports should generally be addressed as Family Assessments and documented per current policy.

NOTE: Regardless of how the case was brought to the division's attention, the screening described in #2 below shall apply and shall be completed within two business days of CD notification.

2. This screening will determine child safety and risk, any indicators of abuse/neglect, and the family's perception of the mental health needs of the child. CD policy and statute shall be followed relating to the observation of the child. This screening will determine whether there is a need for services through the CD and identify any community-based services that CD can add to the plan, OR, if there is evidence of abuse or neglect, whether CD should remain involved and if any court action is required.
3. Upon completion of the CD screening, the CD designee and CMHC/AA and/or Regional Center designee will confer to develop a plan and determine which agency will take the lead in contacting the parent/guardian to arrange a meeting.
4. CD and CMHC/AA and/or Regional Center staff will meet with the parent/guardian to review the DMH assessment and CD screening to identify service options and to develop a plan. Next, one of the following steps will be pursued:
 - If the parent accepts the services offered, CD, CMHC/AA, and/or Regional Center should implement the plan through the Family Support Team (FST) process.
 - If the parents are insisting on an out-of-home placement and DMH has endorsed such a temporary out-of-home placement, the CD may approve the use of a Voluntary Placement Agreement and enter into an agreement with the parent/guardian so as to support the child remaining in the parent's custody. See Section 24.6
 - If the parent/guardian rejects all the services offered and refuses to take the child home or find alternative means to care for the child, CD will

initiate a referral to the court based on 211.031.1(1)d RSMo. In such instances the CD is prohibited from entering a finding of abuse or neglect in the Central Registry.

Court Involvement/Early Reunification:

1. CD will notify the JO of the need to obtain temporary custody of the child based on the CD assessment and/or meeting outcome cited above.
2. CD, JO, CMHC/AA and/or Regional Center will develop a temporary plan for placement and services that best meet the child's needs.
3. Within 72 hours of the child placed in the temporary custody of CD, CD shall convene a meeting with all involved/interested parties, including the parent/guardian, to examine the child's and family's needs and identify service options. Staff should follow the processes introduced in [Memo CD04-83](#) and Child Welfare Manual Addition: Section 4, Chapter 24, Medical/Mental Health Planning, 24.4 – Identification of Children in the Custody of the Children's Division Solely for the Purpose of Accessing Mental Health Services to address youth who have entered CD custody solely for the purpose of accessing mental health services.
4. If the court has ordered custody placed with CD pursuant to 211.181.1(5) RSMo., this team will develop a plan and submit it to the court within 30 days. The court may then return the child to the custody of the parent or further adjudicate.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History:

24.6 Voluntary Placement Agreement

With the 2004 passage of House Bill 1453, the Voluntary Placement Agreement was introduced and established in statute (210.122 RSMo). The Voluntary Placement Agreement is predicated upon the belief that no parent should have to relinquish custody of a child solely in order to access clinically indicated mental health services.

Definition

The Voluntary Placement Agreement (VPA) is a written agreement between the Department of Social Services (DSS)/Children's Division (CD) and a parent, legal guardian, or custodian of a child under the age of eighteen (18) in need of mental health treatment. The agreement is only used when an out-of-home placement is recommended by DMH and the Custody Diversion Protocol cannot otherwise divert the need for such placement. DMH determines the need for mental health services and administers the placement and care of a child while the parent, legal guardian, or custodian of the child retains legal custody.

Practice

The VPA will only be made available to a parent in conjunction with, and only after staff has utilized the Custody Diversion Protocol which serves to link parents with DMH services for their child. The Custody Diversion Protocol reflects the mutual commitment of CD, DMH and its Community Mental Health Centers/Administrative Agents (CMHC/AA), Regional Centers, and/or Adolescent CSTAR providers, and the local Juvenile/Family Courts to assist parents in accessing needed mental health services for their children without a needless transfer of legal custody. The VPA requires the commitment of a parent to be an active participant in his/her child's treatment. **A VPA may not exceed 180 days in duration.**

Local Custody Diversion Protocol designees are responsible to approve the VPA on behalf of the division and monitor the family's progress through the duration of the VPA. A Family Support Team (FST) meeting must be held within 72 hours of placement to develop permanency and treatment plans. The local Custody Diversion Protocol designee will ensure FSTs are scheduled as necessary. Designated staff from CD, community mental health centers, DMH Regional Office, and/or Adolescent CSTAR provider, the child's family, and children who are able to effectively participate in meetings must be invited to attend all FSTs.

FSTs need to be scheduled to occur around but not later than 100 and 150 days of the date the child is placed. The child and family's progress will be reviewed to ensure appropriate transition planning occurs prior to the maximum 180 day VPA closure. If the child is unable to return home a determination must be made as to continuous care being provided by other available resources or CD petitioning the court for custody. The local Custody Diversion Protocol designees will be required to attend any hearings and testify in support of the plan to petition the court for custody.

DMH may arrange for a staffing for a youth served through a VPA. The DMH provider will notify the local Custody Diversion Protocol designee of meetings held on the child's behalf. The local Custody Diversion Protocol designee should maintain consistent communication with the DMH provider on each child served through a VPA.

Children placed in Voluntary Placements are subject to the Adoption and Safe Families Act (ASFA) requirements. Within sixty (60) days of the date the child is removed from the home, a case plan must be developed. To meet the requirements of Section 472 (a)(1) of the Social Security Act a removal from the home must occur pursuant to:

- a. A VPA entered into by a parent or guardian which leads to removal (i.e. a non-physical or paper removal of custody) of the child from the home; or
- b. A judicial order for removal of the child from a parent or specified relative.

Financing

Funding for treatment services under a VPA will be provided by DMH or the CMHC/AA, Regional Center, and/or Adolescent CSTAR provider up front with Department of Social Services appropriation accessed through an interdepartmental funds transfer. Local CD staff will **not** authorize payment for residential treatment or any other services for children placed through a VPA. Youth active in a VPA will be eligible for MoHealth Net coverage through the Family Support Division. The youth's SSI benefits and/or private insurance, as well as other means of financial support, must be explored prior to VPA approval. If the family receives SSI benefits for the youth, it is the family's responsibility to contact the Social Security Administration and inform them of an out-of-home placement.

Procedure

1. DMH must conduct an assessment and certify the appropriateness of the placement. When temporary placement outside of the family home is clinically appropriate and there are no other means of financial support for an out-of-home placement, the local Custody Diversion Protocol designee can explore a VPA.
2. If it is determined that a VPA is to be requested, the agreement must be signed by the parent(s) and the CD Custody Diversion Protocol designee. At the time a VPA is presented to a parent, CD staff shall, in conjunction with the parent, complete the Children's Severity of Psychiatric Illness (CSPI) and enter the scores on the SS-61. The CSPI is included as part of the CS-9. Staff do not have to complete the entire CS-9, only the CSPI.
3. The signed agreement must then be sent to the CD Central Office designee responsible for the oversight of the VPA program for final approval. Voluntary Placement Agreements must be signed by the CD Central Office designee before it will be considered officially approved, and a placement made.

4. If the VPA is approved, the CD Custody Diversion Protocol designee will then send a copy of the agreement to the local DMH Administrative Agent, Regional Office, or Adolescent CSTAR provider responsible for placement.
5. The local DMH Administrative Agent, Regional Office or Adolescent CSTAR provider should send a copy of the signed agreement with the identified placement date back to the local Custody Diversion Protocol designee. This should be completed within 5 days of placement. If the identified placement provider is requesting rates which exceed the standard contract rate for the Division of Psychiatric Services, CD Central Office review and prior approval is required.
6. If the approved agreement is not returned with a placement date within five (5) days the CD Custody Diversion Protocol designee should contact the DMH Administrative Agent, Regional Office or Adolescent CSTAR provider to request the begin date. A copy of the signed agreement will then be sent to the RCST Coordinator and Central Office designee responsible for the oversight of the VPA program within 10 days from receipt of the signed agreement with the placement date added. The VPA begin date is the date the child is placed in an out-of-home setting for treatment. The RCST Coordinator shall be responsible for entering the VPA begin date and the CSPI score in FACES. For additional instructions see CD09-103.
7. VPAs may not exceed one hundred eighty (180) days in duration. In the event the child is in placement less than 180 days, subsequent agreements can only be approved with the authorization of the CD Director. Total period of placement under one or multiple VPAs shall not exceed 180 consecutive days from the first day the child is placed in out-of-home care.
8. The DMH provider is to notify the local Custody Diversion Protocol designee any time a child is returned home. It is the local Custody Diversion Protocol designee's responsibility to then notify the RCST Coordinator and the CD Central Office designee. It is the RCST Coordinator's responsibility to update FACES once a child is returned home. The duration of the VPA may be for as short a period as the parties agree is in the best interests of the child.
9. The FACES system will automatically close a youth in (legal status V) the day the length of a VPA reaches 180 days in duration and the day before the child reaches his/her eighteenth (18th) birthday. However, if a youth is returned home prior to the 180 day maximum, the FACES system should be updated with a close date one day following the date the youth returned home.

Title: Child Welfare Manual
Section 4: Out-of-Home Care
Chapter 24: Medical/Mental Health Planning
Effective Date: December 17, 2009
Page: 4

NOTE: Although the FACES system will automatically close the SS-61 upon the youth's eighteenth birthday a VPA may extend beyond such. The RCST Coordinator must update the FACES system to reflect one day following the actual date the youth returned home or the day the length of the VPA reaches 180 days in duration.

Chapter Memoranda History:

CD04-83, CD05-05, CD05-48, CD05-50, CD05-51, CD06-76, CD09-97 (Rescinded),
CD09-103, CD-09-133

24.7 Pregnancy of Child in Out-Of-Home Care

Should a child become pregnant while in foster care, all efforts should be made to ensure complete prenatal care is received. In addition, the court of jurisdiction should be notified of the youth's pregnancy. The Children's Service Worker should refer the youth to appropriate persons for information and resources needed to explore her options. The child should make an informed decision without undue influence and/or coercion by the Division, placement provider or parents. If the child elects to give birth and care for the infant, every effort must be made to keep the child and infant together. The Worker must refer the child and infant to the Eligibility Specialist, utilizing form CS-IV-E/FFP1. The Worker shall carefully document the child's progress and any contact regarding the health of the child and infant in the case record.

Related Subject: Section 4, Chapter 11, Attachment F: Children of Youth in Alternative Care

24.8 Chemical Dependency Treatment

Adolescents often experiment with the use of drugs and/or alcohol and should be provided with education regarding the consequences of such behavior and support in stopping the behavior, particularly if the child comes from an alcohol/drug addicted family environment.

Chemical dependency treatment will be explored when a child is motivated and demonstrates a willingness to participate in treatment. The value of chemical dependency treatment must be carefully assessed when the child has a history of repeated failures in treatment, and there is no substantial change in their circumstances or behavior since their dismissal from the previous program. Under these circumstances, the appropriateness of a specific treatment program should be questioned if the program does not offer aftercare services.

To the extent possible, the best possible treatment must be provided in the child's community of residence, i.e., community C-Star program operated by the Department of Mental Health.

24.9 HIV/AIDS Issues

Screening for HIV/AIDS shall occur for children in the following high risk groups:

- Infants born to mothers known to be HIV antibodies positive or who are known to be HIV carriers.
- Hemophiliac youths who received blood or blood products before May 1985.
- Children who have had sexual contact with or who have shared IV needles with persons who are known to be HIV antibodies positive or who are known to be HIV carriers.

- Children whose medical symptoms or sexual histories indicate the possibility of exposure to HIV carriers.

NOTE: Screening results are reliable only for "a moment in time" and do not establish whether a child has been exposed to HIV/AIDS.

The request for HIV/AIDS screening and the results of the screening should be handled in a discreet, confidential manner. The child's Children's Service Worker and placement resource should be advised when there is a positive screening result. In order to assure that confidentiality and the child's right to privacy is protected, other persons involved (Guardian ad Litem, juvenile court, biological parents) will be notified on case-by-case and need-to-know basis. As few people as possible should be notified, depending on the circumstances of the case.

Children who are known to be HIV antibodies positive or HIV carriers and their placement provider should receive specialized counseling services and support to help them deal with the ramifications of the disease and to make plans for the possible deterioration in health.

24.10 Life Support/Sustaining Therapies

This section includes guidelines for Life sustaining therapies and Do Not Resuscitate Orders (DNR) or Removal of Life Support for Children in the legal custody of the Division. This decision will be made in consultation with the child (if mentally and physically capable of making the decision), biological parent, guardian, guardian ad litem, juvenile court, the child's physician, the child's Children's Service Worker, care provider, and at least two physicians who have access to the child and the child's records. The final decision regarding the use of life support and DNR orders or removal of life support for children in the legal custody of the Division shall rest with the court or the family if the court agrees. Children's Division and the Department of Social Services will not take a partisan position on Life Support/Sustaining Therapies in those cases in which the doctors are recommending a DNR or removal of life support. We will provide unbiased, objective facts to the court, but we will not make any recommendations as to the final outcome. The Department's position in these situation is that the decision must be made by the court after reasonable notice and an opportunity for a hearing is given to the child's parents, the Guardian ad litem (GAL), the Juvenile Officer (JO) and any other interested parties to provide input into the case as appropriate. The department will not take the position that the responsibility for making DNR or Removal of Life Support decisions should be vested in a foster parent or (former foster parent) or other third party unless ordered by the court.

The wishes of a child with a life threatening illness may be taken into consideration when making major decisions regarding medical care for the child, especially a DNR decision as to what weight to give to the child's wishes is a judgment that must be based on the individual facts of each case considering factors such as the ability of the child to understand his/her condition, to make decisions; the maturity of the child, the wishes of the parents and other parties.

NOTE: Life sustaining therapies are defined as tube feeding, respirator, physical therapies to sustain life, intravenous fluids (IV), etc.

When circuit office staff is confronted with situations which require the continued use of life support systems or the removal of life sustaining therapies and those cases in which the doctors are recommending a DNR or removal of Life Support for children within the care and custody of the Children's Division, staff shall:

1. Immediately gather appropriate identifying and medical information including:
 - a. Condition and prognosis of the child;
 - b. Other pertinent information regarding the child, i.e., age, birth date and location;
 - c. Parent(s) name and address; if there is no parent(s), then the nearest relative
 - d. Most recent court order; and
 - e. Other appropriate medical and identifying information.
2. Notify immediately, via telephone, and provide an explanation of the child's situation and appropriate information based on Step 1.
3. Refer such situations to the office of the Children's Division Director for review.
4. CD shall not be the agency to file a motion with the court asking for the court to make a DNR or removal of Life Support decisions. The motion should be filed by the JO or the GAL or parent(s) whose parental rights has not been terminated:
 - A. If the JO and/or GAL or parent(s) refuses to file such a motion, then Division of Legal Services may file a motion notifying the court that:
 - The child is seriously ill and the doctors are recommending DNR or removal of Life Supports. The best practice would include a written statement from the doctor attached to the motion;
 - CD does not make DNR or Removal of Life Support decisions and does not have a specific recommendation to make regarding the child; and
 - CD requests that the court take evidence on the child's condition and enter an appropriate order.
5. Notify the birth parent(s)/kinship of the hearing. Notice of hearing must be in writing. It is preferable to deliver the notice personally, but if this is not possible

then it should be sent by certified mail so there is documentation to show the efforts to notify interested parties. If CD does not know the location of a parent or guardian CD/Division of Legal Services needs to take all reasonable steps to locate that individual and provide them reasonable notice so that they have an opportunity to present information to the court. The steps taken to locate, the absent parent or guardian needs to be documented in the file.

6. Notify the juvenile office and/or juvenile court immediately if the medical facility does not provide all appropriate information or there is a concern for the child's health while a review is being conducted.
7. Immediately submit a written report containing the information outlined above to the Regional Director.
8. Before, during, and after the decision has been made to begin or discontinue life support systems, establish open communications with the birth parent(s), foster parent(s) and sibling(s) of the child.
9. County office staff will update Regional Director, as necessary, on any changes in the child's condition during the review process.
10. Assist the family by providing or arranging contact with support groups, counseling or any other service necessary to aid the family in the event of the child's death.

Upon notification the Regional Director will:

1. Call and advise the Children's Division Director of this medical emergency, relaying the information concerning the child as provided in the required staff report.
2. Forward immediately, upon receipt, a copy of the written report containing the information outlined above to the Children's Division Director.

24.11 Death of a Child in Out-Of-Home Care

The following are special procedures the Family Centered Out of Home (FCOOH) Case Manager will follow whenever a child who is in the care and custody of the Children's Division residing in an out of home placement has died:

Notify the Supervisor immediately that a Child in CD custody has died. This will include any sudden or unexpected death, as well as a foreseeable death due to illness.

NOTE: The Supervisor shall immediately notify the Regional Director, through supervisory channels, of the circumstances of the death; The Regional Director shall then assure the Children's Division Director has been made aware of the death pursuant to the Fatality/ Critical Event Reporting and Review Protocol as outlined in Section 2, Chapter 4.3.9.1.

If the child died under suspicious circumstances, or if there is reason to believe the child died from child abuse or neglect, the Children's Service Worker shall:

- File a report with CANHU right away;
- Assure that no other children are at risk of immediate harm. Assure the safety of other children by:
 - Contacting Law Enforcement at once if there is reason to believe any other children are at risk of immediate harm;
 - Immediately contacting the Case Manager and/or the Supervisor regarding any other children who are in the home to notify them of any concerns; and
 - Advising the Licensing Worker and/or Supervisor of the situation.

Immediately notify the **juvenile office and/or family**/juvenile court of jurisdiction and the Guardian Ad Litem and/or CASA of the child's death.

Make **personal contact** with the biological parents to notify them of their child's death. This notification is to occur **immediately**. If the biological parents reside in another county or out of state, the Children's Service Worker shall request assistance from the worker in the other county or state to make personal notification. **Do Not** notify the family of the child's death by phone or by mail. The CSW should coordinate efforts with other persons involved who may be communicating with the family or coordinating services, such as another CSW, Contracted Case Manager, OHI Investigator, Law Enforcement Officer, or Juvenile Officer, so that the primary or extended family does not experience multiple or unnecessary contacts which may only add to their grief or despair. Provide supportive services and referrals as necessary to assist the family with grieving or other issues.

NOTE: The child's death will have a profound impact on the parent and placement provider. The Children's Service Worker (CSW) should be particularly sensitive to their loss and offer appropriate support.

Consult with the Supervisor for the need to schedule a Family Support Team meeting to modify the **Family's case plan** as a result of the child's death. Allow ample time for the family to grieve and for funeral proceedings when scheduling the FST. Continue to work with the family as directed by the Supervisor.

Cooperate with the Children's Division CA/N Investigator assigned to the investigation, including an Investigator from the Out of Home Investigations Unit, if a report was received:

- Provide any information available that may assist in the investigation, including access to the case record.
- Inform your supervisor that the fatality is being investigated.

If the child was less than 18 years of age, the Children's Service Worker will need to determine if the coroner or medical examiner has been notified under the provisions of Missouri Revised Statutes chapters 58.452 and 58.772. If notification has not been made, the worker will need to notify the coroner or medical examiner of the child's death. Additionally, notify the coroner when there is reasonable ground to believe that the child died as a result of:

- Violence by homicide, suicide or accident;
- Criminal abortions, including those self-induced;
- Some unforeseen sudden occurrence and the deceased had not been attended by a physician during the 36 hour period proceeding the death;
- Any injury or illness while in the custody of the law or while an inmate in a public institution.
- In any unusual or suspicious manner;

The coroner or medical examiner will, if appropriate, contact the chairman of the Child Fatality Review Panel.

Contact all other persons who have knowledge of the circumstances of the death. This may include physicians, police, placement providers, school personnel, witnesses, etc.

The family Children's Service Worker shall gather and document in the case record, all pertinent facts regarding the child's death including:

- Cause of death;
- Time of death;
- Location of death; and
- Circumstances surrounding the child's death and any witnesses.

Update the SS-63, close the SS-61, and assure that the information in the Computer Information System is updated as soon as possible.

Complete and submit a Fatality/Critical Event Summary to the Circuit Manager, or designee to allow enough time for review so that summary can be forwarded to central

office within 72 hours of knowledge of the child's death. The completed summary should be factual and thorough, and should include:

- The cause of the death, if known;
- Current case status information (date case was opened and reason, summary of court activity, Name, address and phone number of GAL, past and current services received by family);
- List of other children remaining in the household with the alleged perpetrator and how their safety has been assured (attach a safety re-assessment form);
- A summary of progress or lack of progress made recently (attach most recent treatment plan);
- Date(s) of most recent contact(s) made with the family;
- CD history with the family (CA/N, Alternative Care/Adoption; prior FCS history);
- List of other agencies involved; and
- Other pertinent facts of case

NOTE: The Circuit Manager/designee will review the Fatality/Critical Event Summary and forward by E-mail within 72 hours of CD notification of the death to: Regional administration **and** to: [DSS.CD.CriticalEventReport](#) to update central office administration on the case, including a detailed summary of the history of the family with the Children's Division as indicated in Section 2, Chapter 4.3.9.1

Related Subject: Fatality/Critical Event Summary [Forms and Instructions](#).

Provide the coroner/medical examiner and funeral home information for completion of the death certificate.

Advise any agency the child was receiving benefits from such as SSI, VA, insurance companies, etc. A copy of the child's death certificate may be provided upon request.

Inform the eligibility specialist that the child's KIDS account can be closed.

24.11.1 Burial Arrangements

When the death occurs of a child in CD care and custody, placed in out-of-home care, the family's Children's Service Worker (CSW) will work with the biological family regarding burial arrangements and expenses. If the biological family is willing and able to assume responsibility for the burial, they should be encouraged to do so. The family worker shall explore resources such as insurance policies, Social Security and other benefits.

If the biological family is not able to assume responsibility, the CSW shall contact a local funeral home to provide a dignified burial within the acceptable standards of the community. To the extent possible, consider the wishes of the biological and foster family in making arrangements for the child's burial. Payment, not to exceed \$1,500.00, will be made from state office foster care special expense funds using the CS-65. An itemized list of expenses will need to be attached to the CS-65.

Chapter Memoranda History: (prior to 01-31-07)

[CD04-83](#), [CD05-05](#), [CD05-48](#), [CD05-50](#), [CD05-51](#), [CD06-76](#)

Memoranda History: