

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 5 Overview

This chapter will discuss policy and procedure for placing children with resource families and/or in a residential treatment facility.

- 5.1 Placement in a Resource Family
- 5.2 Placement in a Residential Treatment Facility
 - 5.2.1 Indicators of Treatment Needs in Children Age 0-6
 - 5.2.2 Residential Treatment Referral
- 5.3 Private Psychiatric Hospital Placements

Memoranda History:

[CD05-22](#), [CD06-55](#), CD07-52

Attachments:

- Attachment A: Summary Chart of Out-Of-Home Care Placement Resources Characteristics
- Attachment B: Contracted Private Psychiatric Hospitals
- Attachment C: Guidelines For The Placement Of Additional Children In Resource Homes Where A Child Has Been Placed In Residential Care
- Attachment D: Belongings of Foster Child

5.1 Placement in a Resource Family

When a child needs placement with a resource family, the Children's Service Worker will obtain a court order for placement or an authorization to detain the child and then prepare the resource provider for placement, providing all available information about the child. The Children's Service Worker shall provide to resource providers and potential adoptive parents prior to placement, all pertinent information including but not limited to, full disclosure of all medical, psychological, and psychiatric conditions of the child, as well as information from previous placements that would indicate that the child or children may have a propensity to cause violence to any member of the resource family home. The resource providers shall be provided with any information regarding the child or child's family, including but not limited to the case plan, any family history of mental or physical illness, sexual abuse of the child or sexual abuse perpetrated by the child, criminal background of the child or the child's family, fire-setting or other destructive behavior by the child, substance abuse by the child or child's family, or any other information which is pertinent to the care and needs of the child and to protect the resource or adoptive family. Knowingly providing false or misleading information to resource providers in order to secure placement shall be denoted in the worker's personnel file and shall be kept on record by the division.

When a child is to be in care for less than two weeks prior to an adoptive placement, obtain a completed Emergency Waiver of Two Week Notice, CS-44, from the resource family.

Related Subject: Section 4 Chapter 5 Attachment C [Guidelines for the Placement of Additional Children in Resource Homes Where a Child Has Been Placed in Residential Care](#), Section 1 Chapter 3 Attachment A [Foster Parent Bill of Rights and Responsibilities](#), Section 4 Chapter 27 [Permanency Through Adoption](#)

To prepare the child for placement, the Children's Service Worker will provide the child with information about the resource family. The worker will help with the trauma of separation, reinforcing the belief that the child is not the cause of the family breakdown. The child will also need help to understand the reasons the parents/caretakers cannot care for him/her. For youth, ages 14 – 21, assure the child they will be directly involved in long-term planning and will be expected to maintain personal responsibility for their actions.

- Youth, ages 14-21, shall receive a copy of "What's It All About?" A Guidebook for Teens in Out-of-Home Care, and shall be referred to the Older Youth Program for Chafee Foster Care Independence Program (CFCIP) services.

The Children's Service Worker shall arrange pre-placement visits, except in emergencies, per Section 210.566 RSMo, and arrange to obtain a medical examination and medical history.

Any pre-placement visit must be discussed and pre-approved by the Family Support Team and the pre-placement provider. The Family Support Team should review the

Foster Family Profiles of potential resource providers in determining and selecting the most appropriate placement for the child. Decisions regarding the pre-placement visit plan are on a case-by-case basis and are unique to the needs of the child. Discussion and decisions regarding the pre-placement visit should include at a minimum:

1. Does the foster youth require a pre-placement visit to facilitate a successful placement?
2. Does the resource home require a pre-placement visit to facilitate a successful placement?
3. What are the time frames for pre-placement visit(s); minimum number of visits, maximum number of visits, length of the visits, etc.?

The licensed resource home of the pre-placement visit is not eligible for any payment for the child while on the visit, except allowable mileage reimbursement if applicable. Any exception must be pre-approved through supervisory channels with final approval by Central Office.

The medical examination should include an HIV screening (ELISA test) for children displaying symptoms of AIDS or AIDS Related Complex (ARC) or at high risk of HIV exposure.

Children at risk of HIV infection include:

- Hemophiliacs or those children who received blood transfusions prior to 1985;
- Intravenous (IV) drug users;
- Infants born to a mother who tests HIV positive;
- Children with one or both parents who have tested HIV positive, have ARC, AIDS, or is at high risk for AIDS;
- Sexually active youth who have had a sexual contact with a high-risk individual or an HIV infected individual; and
- Subjects of sexual abuse where the perpetrator is at high risk of AIDS or is an HIV infected individual.

If the Children's Service Worker is unable to obtain the initial medical exam prior to placement, the initial medical examination shall occur, if possible, within 24 hours of the child coming into care. This initial health examination does not need to be a full Healthy Children and Youth (HCY) assessment. The purpose of the initial health examination is to identify the need for immediate medical or mental health care and assess for infectious and communicable diseases. When possible, this initial health examination should be completed by the child's current primary care physician as they know the child and have knowledge of the child's medical history.

If a provider is not readily accessible, this exam must occur within 72 hours of the initial placement.

A full HCY examination including eye, hearing, and dental examinations should be completed no later than 30 days after the child is placed in Children's Division (CD) custody. In addition, children should receive a developmental, mental health, and drug and alcohol screening within 30 days of the child's entry into care. If needs are identified, these needs must be treated as soon as possible.

Per Section [210.110 RSMo](#), children from birth to age 10 in CD custody should also receive a physical, developmental, and mental health screening every six (6) months following the initial examination as long as the child remains in care. Prior to all Permanency Planning Review Team (PPRT) meetings, a full HCY assessment should be completed, thus staff should schedule appointments in a timely manner to ensure the appointment occurs prior to the PPRT meeting.

Children, 10 years and older, who enter CD custody should have continued follow up as needed following the initial examination. It is the Children's Service Worker's responsibility to ensure that children in CD custody receive the appropriate screening, assessment, and follow-up services as necessary.

The needs of the child should always be foremost in deciding how soon the exam must take place. If the child has obvious medical needs, or is coming from an environment where a physical exam is indicated, the exam must take place as soon as possible.

The Children's Service Worker shall also arrange to meet the cost of care expenses.

The worker will utilize the team approach to determine the most appropriate resource family for a child who tests HIV positive. Team members should include:

- The child's physician;
- Public health personnel;
- The child's parent or caretaker;
- Case manager;
- The potential resource family provider, i.e., foster parent, adoptive parent, residential care provider;
- The child (age 13 or older); and,
- Residential licensing representative, if appropriate.

- The team may need to meet at regular intervals to assess the child's health status and the appropriateness of the placement setting.
- A child placed in an out-of-home care setting has a right to privacy. This right is necessary to protect the child. Only those persons directly responsible for the child's care or defined as a person with the need to know (see RSMo 191.650 - 191.695 and 210.566) should be informed of his/her condition.

Related Subject: Section 4 Chapter 11 [Financial Support Planning](#)

- Report immediately any accidental injuries to a child in Children's Division's custody, and who is a MO HealthNet recipient, using procedures in the Income Maintenance Manual, Chapter VII.

After transporting the child to the resource family, the Children's Service Worker will confirm or clarify any information previously shared. The worker will also provide full and accurate medical information (current condition and history) to the resource provider at the time of placement. Some of this information may be found on the Child/Family Health and Developmental Assessment (CW-103) and attachments A and B. If none or only part of the above is known, share what is available and continue obtaining needed medical history and updating the CW-103. The updated CW-103 should be shared with the resource provider as information about the child's care and treatment becomes available. If the child has tested HIV positive, provide complete information for caring for the child's special medical needs and infection control.

If the resource family is a relative or kinship provider, the Children's Service Worker should provide them with the following information at the time of placement:

1. A copy of the [Authorization to Provide Alternative Care form](#), CS-33;
2. A Medicaid form and instructions for obtaining a complete health examination;
3. Procedures for obtaining clothing for the child;
4. The name and phone number of the child's current school and instructions to enroll the child in a new school, if needed; and
5. The name and 24-hour contact telephone numbers of the worker and supervisor.

The Children's Service Worker will assist the resource family or other resource provider with the initial adjustment of the child. Follow the placement with a visit to the resource family home, the next business day to do an assessment of the initial adjustment. Determine if any assistance is needed.

The Children's Service Worker must contact the parents to continue formulating a treatment plan. Set up a visit between the birth parent(s) and child within the first week of placement. Visitation shall not take place in a home where a known or suspected methamphetamine laboratory exists or has existed unless it has been professionally treated or decontaminated by a hazardous waste cleanup agency according to the guidelines of the Environmental Protection Agency (EPA). An alternate location for the visit must be decided upon.

The Children's Service Worker will complete the necessary placement forms: AC Client Information screen in FACES (within two (2) business days of case opening), Placement Report for Resource Home Record, CD-104, Placement Report for Child's Record, CD-105, and set up a section of the record for the child, separate from parent's section of the record. Using information from Section 4 Chapter 11, the worker will also complete and submit all cost of care forms.

For youth age fourteen (14) and older, assessment for referral to the Chafee Foster Care Independence Program will begin. The Adolescent Family Support Team Guide and Individualized Action Plan, CD-94, will begin in the first thirty (30) days and be completed within 120 days of the youth coming into care. The Life Skills Strengths/Needs Reporting Form, CD-97, and the Ansell-Casey Life Skills Assessment will be completed within the first sixty days of a youth coming into care. All youth fourteen and older will be referred for Chafee Foster Care Independence Program Services within the first 120 days of coming into care.

All placement activities must be entered into FACES as soon as possible but no later than 24 hours after the change occurs. The progress of the placement and treatment plan will be recorded every 30 days thereafter. The worker will also provide a written report to the court which will include the identification of the resource family or other resource provider and information regarding placement activities. Furthermore, the worker will participate in any court hearings.

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[CD07-52](#), [CD09-05](#), [CD09-80](#), [CD10-41](#), [CD10-72](#), [CD12-18](#), CD12-26

5.2 Placement In A Residential Treatment Facility

This placement resource should be considered for children who need structured and therapeutic intervention provided in a residential treatment setting.

Related Subject: Section 4, Chapter 18.2, Residential Treatment Referral

Related Subject: Section 4, Chapter 4.4.9, Residential Treatment

5.2.1 Indicators Of Treatment Needs In Children Age 0-6

Residential treatment services for a child(ren) under the age of seven (7) years are not usually recommended or utilized. However, certain behavior conditions can exist which would indicate need for a structured treatment setting for such a child. In most instances, it is preferable that foster family care be selected. Referrals using these indicators can be made for behavioral (where available) or medical foster care. These indicators must be used as guidelines in assessing whether a referral for such services is to be made to the RCST:

1. Physical Handicaps/Medical Problems - Acute or chronic physical/medical problems which require nursing or specialized caregiving skills on a frequent and regular basis in order to maintain, control, or remediate problem(s) such as:
 - A. Infants:
 1. Failure to thrive: difficulties in feeding, slow weight gain, discrepancy in height/weight, malnourishment.
 2. Feeding difficulties: may be seen as resistance to food, does not eat effectively or remains fussy after adequate amount of feeding - no pleasurable relief.
 3. Fetal alcohol syndrome: withdrawal symptoms, physiological and neurological disturbances.
 4. Premature birth: may result in serious respiratory problems, seizures, etc.
 - B. Other conditions for any 0-6 year old child:
 1. Physical trauma: fractures, subdural hematomas;
 2. Cerebral palsy necessitating use of "range of motion" exercises, physical therapy, etc.;

3. Seizure disorders; and
 4. Casts, wheelchairs.
2. Developmental Level -Delayed development in one or more areas of basic skills essential to readiness for the tasks required in normal daily living such as:
 - A. Motor skills (gross and fine) - Specific skills vary according to age but observation can detect a disturbance in progressive mastery of tasks requiring muscle tone and control (sitting, crawling, standing, jumping, etc.) and coordination.
 - B. Cognitive skills - Specific skills vary according to age but observation and testing can detect a disturbance in object relatedness, perception and response to environmental stimuli (internal and external, task readiness).
 - C. Self-help skills - Specific skills vary according to age but are characterized by difficulties in caring for self (dressing, eating) and interacting with others (play, separation).
 3. Speech/Language - Delays in the development of speech or language, or a problem (physical/emotional) which impairs the ability to use or respond to verbal communication such as:
 - A. Expressive:
 1. No babbling by six (6) or seven (7) months of age;
 2. No attempts at simple words by 12 months;
 3. No attempts at simple sentences by 24 months; and
 4. Speech difficult to understand after three (3) years of age.
 - B. Receptive:
 1. Not localizing to sound of voice by six (6) months;
 2. Not responding to simple requests (say "bye-bye") by 12 months;
 3. Not recognizing common objects by name (i.e., "show me the ball") by 24 months; and

4. Not understanding long and complex sentences or unable to carry out two (2) to three (3) commands by three (3) years.
- C. Any significant disparity between expressive and receptive language skills.
4. Emotional Adjustment – Difficulties:
- A. 0 to 1 year:
 1. Poor sucking - no medical reason;
 2. Poor and infrequent eye contact, not molding to body of parent or substitutes after six (6) months;
 3. Not exploring environment;
 4. Does not look to one person to be special/primary to them (i.e., bonding); and
 5. No sign of separation trauma/stranger anxiety.
 - B. 1 to 3 years: Not seeking some autonomy/independence from adults
 - C. 2 to 3 years:
 1. Having long temper tantrums;
 2. Showing aggression towards peers and adults;
 3. Not following simple clear instructions (i.e., being defiant, ignoring); and
 4. Regular night terrors, nightmares.
 - D. 3 to 6 years:
 1. Inability to occupy self for short period of time;
 2. Not curious or experimental;
 3. No role model assumed;
 4. Not engaging in social play;
 5. Not toilet trained;

6. No imaginary play;
 7. Manipulative behaviors - lying, hoarding, overeating;
 8. Excessive fears, phobias;
 9. Possessions more important than people;
 10. Clinging/dependency;
 11. Role-reversals with adults;
 12. Consistent questioning "Do you like me?" "Are you my friend?";
 13. Repeated rigid body movements;
 14. Not talking;
 15. No risk taking; and
 16. Rocking.
5. Sexual Adjustment - Inappropriate sexual behavior which may result from sexual abuse or be symptomatic of emotional/psychological problems such as:
- Frequent masturbation;
 - Fear of going to sleep;
 - Frequent exposure of genitals;
 - Seeking genital contact with others;
 - Cross-sex dressing; and
 - Provocative sexual behavior.
6. Relationship within Family Setting: Cannot accept close familial relationships or cannot function in a family setting.
7. Aggression as a Problem: Random purposeless aggression, poor impulse control, attention-getting aggression, purposeful (aimed at serious hurting) such as aggression, biting or scratching, aggression against peers, adults - aggression against self.

8. Background Factors: A social history reflecting prolonged sexual abuse or malnourishment/failure to thrive, though these may not be the presenting problem; and experience with several placements, separation, or loss of caregivers, or experience with a non-bonding relationship.

5.2.2 Residential Treatment Referral

Related Subject: Section 4, Chapter 18.2 Residential Treatment Referral

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[CD05-22](#), [CD06-55](#)

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5.3 Private Psychiatric Hospital Placements

Occasionally, it may be necessary to place a child who is in the custody of the Children's Division (CD) into a private psychiatric hospital or a general hospital which offers inpatient psychiatric services. Such a placement should be limited to situations where a child needs the diagnostic and treatment services that only a psychiatric hospital can provide. Staff is encouraged to use facilities which are contracted with CD. This is especially important if it is anticipated that the child's stay will exceed the Medicaid Professional Activity Study (PAS).

Medicaid provides payment for these placements based on a PAS determination. The number of days for which Medicaid will pay depends on the specific diagnosis. Each hospital should have a listing of the PAS for each distinct diagnosis or combination of diagnoses. The actual number of days paid by Medicaid will be determined by the discharge diagnosis. The hospital should be able to complete a preliminary diagnosis and estimate the number of days of stay within the first week.

The Regional Director must be notified as soon as it appears a stay beyond the approved PAS will be necessary. It is the responsibility of the Regional Director or RCST Coordinator to approve extra days.

The Children's Service Worker monitors the number of days a child is in a psychiatric facility. Near the end of the allowed length of stay, the worker contacts the facility to discuss the child's discharge plan. When a Medicaid eligible child is in need of a psychiatric inpatient extension that is medically necessary (versus no other placement available), the worker should request, with Regional Office approval, that the facility seek prior approval of the extension through the Division of Medical Services (DMS) for DMS payment of the service. If DMS denies the extension, the facility should submit the invoice for payment to the CD county office. Such an invoice is forwarded through normal supervisory channels to the Program Development Systems Unit (PDSU). PDSU completes and enters form CS-65 in the Children's Services Integrated Payment System (CSIPS) to generate payment. A copy of the CS-65 form will be returned to the case manager county and the Regional Director who approved the extension. Psychiatric hospital placement beyond what is covered through Medicaid will be charged to the residential treatment appropriation.

NOTE: Some psychiatric hospital facilities also have residential treatment units which permit transition from the one unit to the other. RCST staff shall approve and authorize any such placement into the residential treatment unit.

It is necessary to monitor and evaluate the placement of children in a private psychiatric hospital. To do so effectively, the following procedures have been developed:

- A. Prior to or upon placement of a child in a private psychiatric hospital, county staff shall:

1. Attempt to utilize a hospital which has a contract with the Children's Division;
 2. Request that the hospital provide, in writing, a treatment plan, diagnosis, and the expected length of stay within seven (7) calendar days of admittance;
 3. Notify the Regional Director, in writing, of the placement, including the reasons for this type of placement and expected length of stay;
 4. Notify the hospital that the maximum length of stay shall be that of the PAS for this diagnosis unless approval is received from the Regional Director; and
 5. Refer to the Regional Office, any child(ren) placed in a private psychiatric hospital, where placement beyond the PAS limits is anticipated.
- B. During the child's stay in the hospital, county staff shall:
1. Develop a control system to indicate the maximum stay approved by the PAS;
 2. Make plans to move the child no later than the PAS deadline, unless the Regional Director approves an extension; and
 3. Notify the Regional Director, via a report requesting an extension, as soon as the length of stay is expected to exceed the PAS. Approval for extension shall only be authorized by the Regional Director. The following information should be included in the report:
 - a. A description of the efforts made to secure an alternate placement;
 - b. A copy of the hospital's diagnosis and recommended treatment;
 - c. An explanation of the continued need for care at the psychiatric facility; and
 - d. An indication, if appropriate, that a referral has been made to the area office for residential treatment services (RTS) or Department of Mental Health, or if transfer of custody is planned.
 4. Request the hospital seek prior approval of the extension through DMS for extended Medicaid payment of the service. The hospital should request DMS to notify the CD county office of the decision.

5. If DMS approved the extension, request the hospital invoice DMS to determine the amount to be paid through Medicaid.
6. If DMS denied the extension, request the hospital to invoice the county office. Send the invoice, through normal supervisory channels, to PDSU.
7. As soon as possible, forward to the area office the hospital diagnosis indicating continued need for psychiatric care. The area office will utilize this material in attempting to obtain an appropriate alternate placement.
8. For children whose diagnosis indicates a need for long-term treatment in a psychiatric or other facility, assess whether continued CD custody is appropriate.

Related Subject: Section 4, Chapter 13, Replacement of the Child With Another Provider

Related Subject: Section 7, Chapter 12, Developmental and Psychological Problems; and Section 7, Chapter 15, Department of Mental Health

- C. If a child is approved for continued treatment in a psychiatric facility, the Regional Director shall:
1. Notify the county of the decision regarding approval for child to remain in the facility prior to expiration of the PAS days; and
 2. Notify Children's Division Director of children approved for inpatient psychiatric hospitalization past the PAS end date. This notification will include:
 - a. Child's DCN number;
 - b. Current location of child; and
 - c. An explanation of the continued need for treatment at the psychiatric facility.

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

[CD05-22](#), [CD06-55](#)

Memoranda History:

Attachment A: Summary Chart Of Out-Of-Home Care Placement Resources Characteristics

PLACEMENT RESOURCES	Vendor/Facility Requirements				Payment/Services Categories				
	CD Licensed	Contract/Adoption Subsidy Agreement	Facility in which a child may be placed	Open as a vendor in ACTS Vendor System (SS-60)	Medicaid Allowed	Maintenance Allowed	Infant Allowance Allowed	Special Expenses Allowed (CS-65)	Residential Treatment Services Allowed (Authorized on CS-67-A)
CD Foster Family	X	X	X	X	X	X	X	X	
DMH Foster Family/ Foster Family Group Home		X	X	X	X	X	X	X	
Private Agency Foster Family	X	X	X	X	X	X	X	X	
Kinship Family CD Supervision only (Child not in CD Custody)			X	X					
Grandparent **	X	X	X	X	X	X	X	X	
Unlicensed Relative/Kinship			X	X	X		X	X	
*Licensed Relative/Kinship**	X	X	X	X	X	X	X	X	
Foster Family Group Home	X	X	X	X	X	X	X	X	

* Must complete foster parent training and meet the same licensing requirements

** Persons who elect to attend STARS and meet all of the competencies also receive the \$100 PPMN

PLACEMENT RESOURCES	Vendor/Facility Requirements			Payment/Services Categories					
	CD Licensed	Contract/Adoption Subsidy Agreement	Facility in which a child may be placed	Open as a vendor in ACTS Vendor System (SS-60)	Medicaid Allowed	Maintenance Allowed	Infant Allowance Allowed	Special Expenses Allowed (CS-65)	Residential Treatment Services Allowed (Authorized on CS-67-A)
Residential Treatment Facility	X	X	X	X	X	*X		X	X
Private Psychiatric Facility			X	X	X			X	
Public Residential Facility (which accommodates more than 25 children)	X	X	X	X	X	*		X	X
Juvenile Court Home/CD Custody			X	X	X			X	
Medical Facility			X	X	X			X	
DMH Psychiatric or MRDD Facility			X	X	X			X	

*Maintenance is allowed if a facility has a contract for alternative care services only or if a facility has a contract for residential treatment services, but agrees to accept a child on a maintenance only basis until residential treatment services can be authorized.

PLACEMENT RESOURCES	Vendor/Facility Requirements				Payment/Services Categories				
	CD Licensed	Contract/Adoption Subsidy Agreement	Facility in which a child may be placed	Open as a vendor in ACTS Vendor System (SS-60)	Medicaid Allowed	Maintenance Allowed	Infant Allowance Allowed	Special Expenses Allowed (CS-65)	Residential Treatment Services Allowed (Authorized on CS-67-A)
Independent Living			X		X	X	X	X	
Runaway					X				
Detention			X		X			X	
School for the Deaf			X	*X	X			X	
School for the Blind		X	X	*X	X			X	
Non-licensed Court-Ordered Placement			X	X	X		**	**	

*Open as a vendor if special expenses must be paid directly to the school.
 **Only if child is in CD custody.

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[CD05-80](#)

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Title: Child Welfare Manual
Section 4: Out-Of-Home Care
Chapter 5: Placement/Replacement Of The Child
Attachment B: Contracted Private Psychiatric Hospitals
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Attachment B: Contracted Private Psychiatric Hospitals

- ❖ Arthur Center
704 E. Monroe
Mexico, MO 65265
(314) 581-1785 (DVN 000145444)

- ❖ Crittenton Center
10918 Elm Avenue
Kansas City, MO 64134-4199
(816) 765-6600 (DVN 000042608)

- ❖ Heartland Hospital
1500 West Ashland
Nevada, MO 64772
(417) 667-2666 (DVN 000076966)

- ❖ Oakwood Hospital, Inc.
307 N. Main
Windsor, MO 65360
(816) 647-1785 (DVN 000294720)

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Section 4: Out-Of-Home Care
Chapter 5: Placement/Replacement Of The Child
Attachment C: Guidelines for Placement of Additional Children in Resource Homes Where a Child Has Been Placed in Residential Care
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Attachment C: Guidelines for Placement of Additional Children in Resource Homes Where a Child Has Been Placed in Residential Care

This attachment will assist Children's Service Workers with guidelines to consider for the placement of additional children in a resource home where a child has been placed in residential care. **No** additional children will be placed in the home without the approval of the Circuit Manager or designee. The Circuit Manager/designee will take into consideration the following issues when making their decisions. This information will be presented to the Circuit Manager by the foster/adopt licensing worker and/or supervisor and documented in the case record:

1. The length of time the child has been placed in residential care; the level of involvement of the resource provider toward the child in residential care;
2. A detailed report from the Residential Facility therapist that has provided treatment/family therapy for the resource parents and the child-outlining the information requested in number 1-4 of this list;
3. The plan for reunification for the child in residential care with the resource family; assess all aspects of the plan, including the identified supports in place;
4. The resource providers desire to work with Children's Division (CD) and other involved agencies;
5. Has the resource parent participated in all staffing and treatment planning meetings regarding the child in residential care, and the other children placed in their home;
6. The family's strengths and needs in accepting additional children into the home as it relates to the children requiring placement;
7. How the resource parent would continue to meet the needs of the child in residential care as well as the additional children placed in their home;
8. Review the number of children currently in the foster home and or the number of children desired in the future;
9. The above information should be provided at Family Support Team meetings regarding any additional children that would be placed in the home by licensing worker and/or/supervisor.

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Section 4: Out-Of-Home Care
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NOTE: Pursuant to [Section 210.117 RSMo.](#); [Section 210.710 RSMo.](#); [Section 210.720 RSMo.](#); and [Section 211.038 RSMo.](#) restrictions on placement, custody, visitation or reunification for minors who were determined to be either a victim or a perpetrator in an incident of abuse between minors may present significant difficulties for workers who are making placement decisions or enrolling children in Division custody in child care or in school.

Related Subject: Section 7, Chapter 34.1 Abuse of a Minor by a Minor

After review and assessment of case, the Circuit Manager or designee will make a decision and notify the local Children's Division office and the resource parent.

NOTE: This policy focuses on plan placements; however, there may be times of an emergency nature in which this policy may not be an option.

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[CD05-22](#), [CD05-68](#)

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Attachment D: Belongings Of Foster Child

Children in CD custody often come with few belongings but will accumulate items during their stay in care. These items should go with the child from placement to placement. However, there are times when the foster child leaves belongings behind (i.e. in an emergency move or residential placement). In these instances, the items will often come to the local office for storage. The following are guidelines on the return, maintenance, and/or removal of these belongings:

1. **Return of Belongings** – When a child returns home or to a placement in which they may have their belongings (i.e. to a foster home from residential), the items should be returned to the child. A notification letter should be sent to or contact made with the child or family to make arrangements to transfer the belongings to the child/family. If the placement is not in the county or circuit where the belongings are kept (or arrangements can not be made to return the belongings), the items will be mailed to the child. The cost of mailing the belongings will come out of the county budget. This protocol should also be followed if a child ages out of the system and an address is known for the child.
2. **Maintenance/Donation/Destruction of Belongings** – Any important legal documents or paper (i.e. birth certificate, medical papers, etc.) should be kept in the child's case record in a separate section or envelope. Toys and clothing should be inspected for usability and safety. If they are useable and safe, toys and clothing may be donated to local charities, foster parent associations, or local resources; utilized in local office visiting rooms, or kept as a resource for foster parents and emergency placements. Those items deemed not usable or unsafe should be placed in the trash for disposal. Any concern with normal disposal of items should be addressed by the local office management with a plan for disposal developed. Any items which do not fall under the categories of legal papers, toys or clothing should be kept, donated or destroyed at the discretion of the local management staff. Any question as to what to do with a particular item can be directed to Regional Office staff.

Timeframes – All belongings may be donated or destroyed, as outlined, if Division staff is unable to make contact with the child or family within 6 months of the child leaving custody.

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[CD06-55](#)

Memoranda History: