

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.

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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.

210.002 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.

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.

210.110. The Children's Division will develop an approach which will recognize and treat the specific needs of at-risk and abused or neglected children under the age of ten (10). A physical, developmental, and mental health screening must be completed within thirty days of a child's entry into custody and every six months thereafter as long as the child remains in care. Screenings may be offered at a centralized location and include, at a minimum, the following:

- a) A complete physical to be performed by a pediatrician familiar with the effects of abuse and neglect on young children;
- b) A developmental, behavioral, and emotional screening.

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.

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24.2 Medical Information to be Obtained when Child Enters Care:

1. The child's Children's Service Worker will ensure initial medical information is obtained from the parent/physician and given to the resource provider within 72 hours, if possible, but no later than 30 days following placement. The Foster Parents' Bill of Rights, Section 210.566, RSMo entitles foster parents to full disclosure of all medical, psychological, and psychiatric conditions of the child. Some examples of information to be provided 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 child's 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 log documenting medical information received while the child is in care. The log should record illnesses, medications and the amount given, visits to physician/therapist, and the purpose

of the visit. The log only documents medical information received while the child is in care. The medical log should be kept by the resource provider and submitted to the child's 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. 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 shall be completed no later than 30 days after the child is placed in Children's Division (CD) custody. In addition, children shall receive a developmental, mental health, and drug and alcohol screening within 30 days of the child's entry into care. If it is not possible to schedule the appointment within 30 days, the reason for the delay shall be documented in the child's case file and the examinations completed at the earliest possible date.

Section 210.110 RSMo requires all children under the age of 10 in the Children's Division (CD) custody to receive a physical, developmental, and mental health screening every six months, as long as the child remains in care.

Children, 10 years and older, who enter CD custody should have continued follow up as needed following the initial examination. It is the child's Children's Service Worker's responsibility to assure screenings and any follow-up services are conducted.

5. Ongoing medical care should be obtained in accordance to the HCY examination/immunization schedule and per Section 210.110 RSMo.
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 unless termination of parental rights (TPR) has occurred or the court has issued an order providing the parent/guardian should not have access to the information.

7. The child's Children's Service Worker 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. Staff shall clearly document in the record when and by whom this education was provided. Youth in foster care under the age of majority (18 years old) should be afforded the choice to obtain or refuse birth control. The decision for a youth to be prescribed birth control should involve the youth and the youth's medical provider. Missouri law does not require minors to have parental consent to obtain contraception, although it is the practice of some medical providers. If the medical provider requires signed parental/guardian consent, the Children's Division, resource provider, or parent – if appropriate - may provide the written consent.
8. In order to prevent further spread, unnecessary avoidance, and embarrassment, resources and information shall be made available to individuals providing care or services to children who have communicable diseases, parasites, sexually transmitted diseases or test positive for HIV exposure.
9. The child's Children's Service Worker shall ensure children with mental health or substance use disorders receive appropriate counseling, therapy and/or medication. Also, the worker must ensure the resource provider has the knowledge and skills necessary to provide appropriate care for the child.

24.2.1 Informed Consent

Informed consent is the consent to treatment given after the individual, legal custodian, and/or legal guardian has received sufficient information about the risks and benefits of a prescribed or recommended treatment. Every individual whose consent is required has the right to receive information regarding prescribed tests or treatments, including risks and benefits for the recommended treatment or test.

The healthcare provider should provide a verbal and/or written explanation about the prescribed treatment or test, explained in a way the patient and legal guardian fully understands which generally includes the following:

- a) Diagnosis for which the treatment/medication is prescribed;
- b) Nature of the medication, treatment, test, or procedure;
- c) Name of the medication, including both generic and brand names;
- d) Dosage and frequency of medication;
- e) Expected benefits;
- f) Possible risks and side effects;
- g) Availability of alternatives; and
- h) Prognosis with and without proposed intervention.

In deciding whether or not to consent to treatment, youth, parents, resource providers, or CD staff should ask for answers to the items above. Furthermore, staff/representatives should ask questions as needed and seek guidance from supervisory staff or their local Division of Legal Services (DLS) attorney if they have further questions.

Depending upon the setting and the healthcare provider, the individual or guardian may be asked to document their consent to or refusal for treatment. Should the consent be provided verbally, CD should request a written copy of the consent documentation from the healthcare provider to be filed in the case record.

24.2.2 Engaging Families in Informed Consent

1. Parents should be engaged in the informed consent process unless their rights are terminated or unless the child requires emergency medical care and it is not reasonably possible to confer with the parent/guardian under the circumstances.
2. In addition to the parent(s), the child's resource provider or Children's Service Worker should participate in healthcare appointments, when possible.
3. At the initial Family Support Team meeting, parents should be informed they will be engaged in healthcare decisions about their child, if TPR has not occurred.
4. In cases where the child is in the care and custody of the Children's Division, the parent(s) shall be informed at the initial Family Support Team meeting that, should they be unavailable to consult with CD or the foster parent about the provision of necessary healthcare treatment for their child, CD will make decisions about medical care for the child under CD's authority as the child's legal custodian/guardian. The parent(s) shall also be informed CD respects their role as the parent and will make every effort to engage them in healthcare decisions about their child. In cases where the child is in the legal custody of a third party (LS-3), the decisions relating to healthcare shall be made by the legal custodian or as may otherwise be ordered by the court.
5. If a parent is unavailable to consult with CD regarding treatment, the child's parent should be informed as soon as possible about the healthcare given and the need for any follow-up care. If the resource provider signs the consent for healthcare, the resource provider will notify the case manager as soon as possible. The case manager will then notify the child's parent(s).
6. Family Support Team meetings and Permanency Planning Review Team meetings shall include a discussion of mental health assessments and psychotropic medications, if applicable. Case managers will advise parents their attendance at appointments and involvement in their child's care, including their opportunity to be consulted regarding treatment, is expected and welcomed.
7. There may be special circumstances in which it may not be in the best interest of the child or youth for parent(s) to be involved in healthcare decisions about their child. In these cases, the case manager should make a referral to the Division of Legal Services.

24.2.3 Consent for Routine Medical Care

1. When the need for routine medical care arises, the parent should be engaged unless parental rights have been terminated, the court has otherwise restricted the parent's access to the child or the parent's involvement with the provision of medical care would be contrary to the child's best interests. Parents should be notified and given the opportunity to attend medical appointments, when appropriate.
2. If the child's parent(s) is unavailable for consultation regarding routine medical care, the child's Children's Service Worker or the resource parent are authorized to give consent.
3. If the parent or youth is in disagreement with the routine medical care, refer to Section 4 Chapter 24.2.9.

24.2.4 Consent for Emergency Healthcare Treatment

1. When the need for emergency healthcare treatment arises, the parent should be engaged unless parental rights have been terminated. Parents should be notified and given the opportunity to be present for treatment, when appropriate.
2. If the child's parent(s) is unavailable for consultation regarding treatment, the child's Children's Service Worker or the resource parent are authorized to give consent. The child's Children's Service Worker should notify the parents regarding treatment.

24.2.5 Consent for Surgical Procedures and/or Anesthesia

1. When the need for surgical procedures and/or anesthesia arises, the parent(s) should be engaged in all preoperative decisions and appointments unless parental rights have been terminated. Parents should be notified and given the opportunity to attend medical appointments, when appropriate.
2. If the parent(s) is unavailable for consultation regarding the surgical procedure and/or anesthesia, the child's Children's Service Worker shall seek approval for treatment from the Family Support Team, and notify the parents regarding the procedure.
3. If the parent or youth is in disagreement with the surgical procedure and/or anesthesia, refer to Section 4 Chapter 24.2.9.

24.2.6 Consent for Routine Mental Health Treatment

1. When the need for routine mental health treatment arises, the parent should be engaged unless parental rights have been terminated. Parents should be notified and given the opportunity to be present for treatment, unless termination of parental

rights (TPR) has occurred or the court has issued an order providing the parent/guardian should not have access to the information.

2. If the child's parent(s) is unavailable for consultation regarding treatment, the child's Children's Service Worker, or the resource parent are authorized to give consent. The child's Children's Service Worker should notify the parents regarding treatment.
3. Youth in foster care have rights with regard to mental health services. Youth have the right to:
 - Know their diagnosis
 - Understand all the treatment options
 - Ask questions about potential benefits and side effects
 - Receive support from the family support team to help with medical decisions

24.2.7 Consent for Psychotropic Medication

1. When the need for psychotropic medication arises, the parent(s) should be engaged in all medication decisions and appointments for the child, unless parental rights have been terminated or the court has issued an order restricting the parent's participation in the decision making process. Parents should be notified and given the opportunity to attend and be present for treatment, when appropriate.
2. When a psychotropic medication is prescribed, the child's Children's Service Worker should obtain information regarding the benefits and side effects of the medication to help make an informed decision.
3. If the child's parent(s) is unavailable for consultation regarding treatment, the child's Children's Service Worker or the resource parent are authorized to give consent. Prior to administering the medication, the resource parent must notify the child's Children's Service Worker to obtain approval for the child to begin the medication. The child's Children's Service Worker should notify the parents regarding treatment.
4. If the parent or youth is in disagreement with the prescribed psychotropic medication, refer to Section 4 Chapter 24.2.9.
5. Informed consent is provided for a specific child for a specific psychotropic medication(s) and may not be used to imply informed consent for another child or another medication.
6. If a child/youth enters custody on psychotropic medication, the parent should be consulted regarding continuation of the medication. If a parent disagrees with the

continuation of the medication, the child's Children's Service Worker will provide consent until the child is further evaluated.

24.2.8 Emergency Administration of Psychotropic Medication

If an emergency administration of a psychotropic medication is deemed necessary for the protection of a child in custody, the medication may be administered per physician order. Consent is not needed prior to the emergency administration, but the child's Children's Service Worker and parent(s) shall be notified by the resource provider at the earliest possible opportunity.

A copy of the consent documentation must be obtained from the healthcare provider and kept in the case record.

24.2.9 Refusal

1. Any person refusing treatment (parent, child, resource provider) should be appropriately informed regarding the impact of such refusal.
2. In cases of refusal, the child's Children's Service Worker will consult with the prescribing healthcare provider to determine if:
 - a) The treatment or medication is medically necessary,
 - b) If the child may be harmed if he/she does not receive the treatment or medication, and
 - c) If there are any less invasive alternative treatments or medications available.
3. After obtaining the information listed above from the healthcare provider, the child's Children's Service Worker should revisit the discussion with the parent(s). If the parent or youth still disagree with the treatment and the child is in the care and custody of the Division, CD will make the decision under its authority as the legal custodian.

24.2.10 Documentation

1. Efforts to involve the parent(s) in decisions about the healthcare of their child will be documented in the narrative by the Children's Service Worker.
2. Documentation includes the parent's actual involvement or reasons why the parent could not or should not be involved.
3. If the parent cannot be located, the Children's Service Worker will document any efforts taken to notify them.
4. In situations when the parent(s) is unavailable, efforts to notify the child's parent about the healthcare given and the need for any follow-up care will be documented in the narrative by the Children's Service Worker.

5. Any case of healthcare service refusal will be documented in the case narrative. Documentation should include information regarding steps taken to inform the person refusing about the impact of the refusal and to consult with the treating healthcare provider.

24.2.11 Categorical Exclusions and Extraordinary Medical Care

1. CD does not typically provide consent for medical treatment or procedures not medically necessary. However, those decisions will be made by the case manager and supervisor on case-by-case basis considering the best interest of the child.
2. CD does **not** provide consent for the following procedures:
 - a) Removal of Life Support (refer to Section 4 Chapter 24.10)
 - b) Do Not Resuscitate Orders (refer to Section 4 Chapter 24.10)
 - c) Abortion

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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.
- Resource parents should seek medical providers who are enrolled with MO HealthNet (MH) or MO HealthNet/Managed Care (MH/MHMC).
- 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.
- When a resource parent receives an invoice for medical or mental health services for a foster placement in their home, the invoice must be submitted to the foster youth's case manager immediately.

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.

Two separate DMH divisions deal with the following:

- Behavioral Health, which includes Alcohol and drug abuse; and
- Developmental Disabilities;

It is important to make the referral to the Division that deals with the specific mental health need, if there is a need of services from both Divisions a referral will need to be made to each Division separately. 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 problems and the involvement of the foster parents in caring for the child, if applicable.

Related Subject: Section 4, Chapter 15 Medical Foster Care

24.3.11 Medical Services Authorization Information Letter

The Children's Division (CD) participates in the development and implementation of coordinated social and health services which includes preventive, maintenance, and long-term medical and mental health care for children placed in the legal custody of the Children's Division.

Services for foster youth medical and mental health needs should be provided by service providers who are enrolled in the state Medicaid plan, MO HealthNet. If a provider who is not enrolled with MO HealthNet is used for a foster youth, the resource provider may have to pay for the services out-of-pocket and not be reimbursed. If the resource parent is reimbursed, it will be at the Medicaid rate. Any reimbursement to the resource provider will be from Children's Treatment Services (CTS) funds.

In the event that a resource parent uses a medical or mental health provider who is not enrolled with MO HealthNet or a MO HealthNet Managed Care Plan the CD-27 must be presented prior to the foster youth receiving services.

When a resource parent pays for a medical or mental health service out-of-pocket, the receipt for services must be submitted to the foster youth's case manager immediately.

When a resource parent receives an invoice for medical or mental health services for a foster placement in their home, the invoice must be submitted to the foster youth's case manager immediately.

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

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

Memoranda History:
CD14-70

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) Community Mental Health Center and/or DMH Regional Office staff; and
- Representatives of current placement and treatment providers.

If the child has developmental disabilities that can best be served by 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 Central Office 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 instructions 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 following protocol has been developed to divert youth from entering state custody **solely to access mental health services**. This protocol is predicated on the belief that no parent should *voluntarily* have to relinquish custody of their child 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 be experiencing a great deal of stress at these times, due to conflicting information or information that encourages them to relinquish custody to obtain treatment for their child. Many facilities may not be aware of community based alternatives available to the family. Professionals must recognize the families' need for help and provide them with objective information and realistic treatment options. This protocol is not meant to replace or detract from the standard referral process to a community mental health center, Regional Center or CSTAR Provider. If CD or the Juvenile Office is contacted to obtain information regarding mental health services, the CD or JO should simply provide the individual with the community resources available including the appropriate telephone numbers to call.

Strategies to be considered to further advance this protocol include:

1. Advance notice regarding discharge from facilities will be important in these situations.
2. Courts cannot be eager to relieve the family of custody to obtain mental health services.
3. Public and private agencies must understand alternatives to long term residential treatment.
4. Resources to address the need for emergency placements should be developed.
5. Targeted education should be provided to professional staff within private psychiatric hospitals.

Entry

A parent/legal guardian contacts a representative of a Juvenile Court or Children's Division/Dept. of Social Services (CD) noting that they wish to voluntarily relinquish custody of their child to the state. CD or the juvenile office staff should assess the basis of the voluntary relinquishment and if it is solely to access mental health services a referral to the Custody Diversion protocol may be made if the following conditions are met.

1. The parent/legal guardian is a legal resident of the state of Missouri;
2. The parent does not receive adoption subsidy on behalf of the child;
3. There is no allegation of abuse and/or neglect;
4. There is no current referral to the juvenile office on which the juvenile office will be taking any level of action besides making a referral for mental health services;
5. The parent has already contacted the appropriate DMH provider (community mental health center, Regional Office, Adolescent CSTAR provider) in an attempt to obtain services but continue to want to relinquish custody of their child. If they have not contacted a DMH provider, CD or the juvenile office staff will provide

- contact information for the appropriate provider, and a referral to the protocol is not made;
6. The child is currently residing in the parents' or legal guardian's home (this excludes an acute psychiatric admission);
 7. The parent/legal guardian commits to allowing the child, if placed out of the home, to return to their home when deemed clinically appropriate.
- If a recent referral had been made to the appropriate DMH provider and the legal guardian still wants to voluntarily **relinquish custody, the JO or CD staff should provide the parent/legal guardian with the contact name and information for the community mental health center's designated contact for the protocol in their area AND** explain that custody will not be accepted at this time and an assessment process must first occur. If the child is currently in a psychiatric hospital they should be informed that no decisions will likely occur for 3-7 days. To initiate the Custody Diversion Protocol process the juvenile office or CD must complete the top half of the Screening Form and forward it to the custody diversion designee at the community mental health center.
 - If a parent/legal guardian comes in person to the local CD or Juvenile Office with the child the process should be explained and the parent encouraged to contact the CMHC 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.
 - It is the responsibility of the CD or JO staff receiving the initial call to ensure that utilization of the Custody Diversion Protocol is appropriate. The Custody Diversion Protocol is to be utilized only in those circumstances where the parent has made the decision to voluntarily relinquish custody of their child. The agency receiving the initial call shall complete and forward to the contact person identified by the CMHC the screening information after obtaining witnessed oral permission from the legal guardian. The screening information ensures that the protocol is being applied under appropriate circumstances. **The Diversion Protocol is initiated by completion of the Screening/Feedback form by the CD or JO and receipt of the Screening/Feedback Form by the CMHC.** If this is not completed by the CD or JO the protocol will not have been initiated.
 - Staff from the local juvenile office, local CD office, community mental health center, Regional Office, or Adolescent CSTAR program **shall not** recommend a custody diversion protocol to the parent without the parent first initiating relinquishment of custody. Rather they should assist the family within the means of their respective agency to meet the child and family's needs through the provision of services or making referrals to other agencies for services.

DMH Contact

- When the community mental health center receives a Custody Diversion Protocol Screening Form from the juvenile office or CD, the Administrative Agent/CMHC will arrange with the parent/guardian of the child for a level of care assessment to be completed as soon as possible or no later than within 2 business days of the receipt of the Screening/Feedback Form. The CMHC will determine if there are psychiatric, developmental and/or substance abuse issues to be addressed. If there is a psychiatric history, then the CMHC should do an assessment. If there is no psychiatric history or indicators of a mental illness, the CMHC will forward the Screening form to the appropriate division provider in their area.
- 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 shall be contacted by the CMHC to participate in the assessment process. If there is information that the youth requires substance abuse assessment and treatment, the CMHC should contact the local Adolescent CSTAR provider to participate in the assessment process.
- If the child is currently in a psychiatric hospital, the DMH assessment will likely occur at the hospital.
- The DMH assessment shall examine the child/youth's current mental health needs, 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. The parent/legal guardian and the child (if age appropriate) should be **actively** involved in the assessment and development of the plan.
- If abuse and neglect is suspected the CA/N Hotline should be contacted as required by law, RSMo 210.115.
- Upon completion of the assessment and/or if there is a significant delay in arranging the assessment the CMHC/Regional Center/Adolescent CSTAR provider should complete the lower half of the received Screening/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 safety concerns in the interim AND/OR to notify the referring party of the outcome of the assessment. If the assessment has not yet been completed within 2 working days but the referring agency notified the referring party of the delay, the assessment and recommendations should be forwarded to the referring party as well as DMH Central Office when the assessment and recommendations are completed. (see screening form for details).
- 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 may then be accepted by the parent and implemented with no need for a change in custody.

- If through the assessment it appears that a temporary placement outside of the family home would be clinically appropriate, a Voluntary Placement Agreement (VPA) through the CD can be explored. The CMHC/Regional Center/Adolescent CSTAR provider should provide a brief explanation of a VPA to the parents and explain that a referral could be made to the CD to provide a review to determine if CD has additional resources to keep the child in the home and if needed to access this agreement. If the parent is agreeable, the CMHC/Regional Center should contact the CD requesting a screening for a VPA and a meeting set up with the parents, CD and CMHC/Regional Center/Adolescent CSTAR provider to review the assessment, discuss the proposed plan and identify any additional resources and/or to access the VPA.
- 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 their child to CD, then the local CD representative should be contacted.
- The CMHC/Regional Center/Adolescent CSTAR provider 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.
- If a child is currently in a hospital outside of their county of residence, the CMHC, Regional Center or Adolescent CSTAR provider can elect to contact the CMHC, Regional Center or Adolescent CSTAR provider that serves the county in which the hospital operates and request a courtesy evaluation. However, it is the responsibility of the CMHC, Regional Center or Adolescent CSTAR provider in the county of residence for making the final determination and developing, implementing, and coordinating the service plan unless specifically agreed to otherwise.

CD Contact

- CD, upon notification from the CMHC/Regional Center/Adolescent CSTAR provider representative, with appropriate consents for information release, or via the Hotline, will initiate a screening to be completed as soon as possible or no later than within 2 business days.
- 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 should be followed relating to the observation of the child. This screening will determine whether there is a need for services through the CD either for the VPA as DMH has recommended a temporary out-of-home placement or if there are

community-based services CD can add to the plan OR if there is evidence of abuse or neglect whether CD should become involved and if any court action is required.

- Upon completion of the CD screening, the CD designee, CMHC and/or Regional Center and/or Adolescent CSTAR provider designee and parent/legal guardian will meet to discuss the screening and to develop a plan.
- This plan can take one of three paths:
 - If DMH has recommended a temporary out-of-home placement and the VPA is needed, the CD may approve the use of the VPA and enter into an agreement with the parents.
 - CD is able to provide additional community supports to add to DMH services with support from the parents and the child can be maintained in the community.
 - CD screening found reason to suspect abuse or neglect and CD policy related to abuse/neglect is instituted.
- The Voluntary Placement Agreement is to be used **only in conjunction** with the Custody Diversion Protocol and in those circumstances where the child clinically requires a placement out-of-the home due to their behaviors, the instability of the home environment or lack of access to intensive community-based services. In consideration of the child's and family's needs short-term out-of-home placements may be considered such as emergency respite, crisis beds, out-of-home in-depth assessments in addition to residential treatment. The Voluntary Placement Agreement is an agreement between the parent/legal guardian and the Children's Division.
- If the parent accepts the services offered, the CMHC, Regional Center, and/or Adolescent CSTAR provider should implement the plan through the Family Support Team process.
- If the VPA is utilized, the DMH provider is responsible for locating an appropriate out-of-home placement and for monitoring that placement. The DMH provider will work closely with the child and family in continuing to assess the need for services and accessing appropriate services. The DMH should notify the CD mental health liaison of any outstanding issues related to the child and/or family while the VPA is in place. After the VPA has been in place for 100 days, the CD will arrange for a Family Support Team meeting to begin planning for the child's needs in preparation for the termination of the VPA after 180 days of initiation. Issues to be addressed would be the child's progress in services, the family's involvement in the treatment, the need for the child to continue in an out-of-home placement or the plan to transition that child back into their home community. CD will also contact the CMHC, Regional Center and/or CSTAR provider at 150 days and a FST meeting will be held to again review the child's progress and plan for transition from the out-of-home placement.

- If the parent/guardian rejects 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) (depending on the finding of the CD screening).

Court Involvement/Early Reunification

- CD will notify the juvenile/family court of the need to obtain temporary custody of the child based on the CD screening and/or meeting outcome cited above.
- CD, Juvenile Office, CMHC, Regional Center and/or Adolescent CSTAR provider will develop a temporary plan for placement and services that best meets the child's needs.
- 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.
- If the court has ordered custody pursuant to 211.031. (1)(d)** , then pursuant to 211.181.1(5)*** this team will propose a plan and submit it to the court within 30 days, per current CD policy. The court will then determine whether to return the child to the custody of the parent or adjudicate.

***Note: CD policy currently requires a multidisciplinary approach with a 72 hour meeting and 30 day meeting consistent with the above protocol, irrespective of 211.031(1)(d).**

****RSMo 211.031(1)(d)**

Juvenile court to have exclusive jurisdiction, when--exceptions.

211.031. 1. Except as otherwise provided in this chapter, the juvenile court or the family court in circuits that have a family court as provided in sections 487.010 to 487.190, RSMo, shall have exclusive original jurisdiction in proceedings:

(d) The child or person seventeen years of age is a child in need of mental health services and the parent, guardian or custodian is unable to afford or access appropriate mental health treatment or care for the child;

(1) Involving any child or person seventeen years of age who may be a resident of or found within the county and who is alleged to be in need of care and treatment because:

(2) The child or person seventeen years of age is a child in need of mental health services and the parent, guardian or custodian is unable to afford or access appropriate mental health treatment or care for the child;

*****RSMo 211.181.1(5)**

Order for disposition or treatment of child--suspension of order and probation granted, when--community organizations, immunity from liability, when--length of commitment may be set forth--assessments, deposits, use.

211.181. 1. When a child or person seventeen years of age is found by the court to come within the applicable provisions of subdivision (1) of subsection 1 of section 211.031, the court shall so decree and make a finding of fact upon which it exercises its jurisdiction over the child or person seventeen years of age, and the court may, by order duly entered, proceed as follows: ...

(5) The court may order, pursuant to subsection 2 of section 211.081, that the child receives the necessary services in the least restrictive appropriate environment including home and community-based services, treatment and support, based on a coordinated, individualized treatment plan. The individualized treatment plan shall be approved by the court and developed by the applicable state agencies responsible for providing or paying for any and all appropriate and necessary services, subject to appropriation, and shall include which agencies are going to pay for and provide such services. Such plan must be submitted to the court within thirty days and the child's family shall actively participate in designing the service plan for the child or person seventeen years of age.

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

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[CD09-133](#)

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.

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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

When a child becomes pregnant while in foster care, all efforts should be made to ensure the child receives complete prenatal care. 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 situations 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 dies:

- 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.
- Supervisor shall initiate the Fatality/Critical Event Reporting and Review Protocol.

Related Subject: Section 2, Chapter 4.3.8.3, Fatality/Critical Events Reporting and Review Protocol

If the child died under suspicious circumstances, or if there is reason to believe the child died from child abuse or neglect, the 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.
- **Immediately make personal contact with the biological parents** to notify them of their child's death. *Do not notify the family of the child's death by phone or by mail.*
- If the biological parents reside in another county or out of state, the worker shall request assistance from the worker in the other county or state to make personal notification.
- The worker should coordinate efforts with other persons involved who may be communicating with the family or coordinating services, such as another worker, 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.

The child's death will have a profound impact on the parent and placement provider. The worker 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 applicable.
- 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.

- 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
- Update the SS-63, close the SS-61, and assure that the information in FACES is updated as soon as possible.
 - The Supervisor is to complete and submit a Critical Event Report (CS-23) to the Circuit Manager, or designee to allow enough time for review so that summary can be forwarded to central office.
 - 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 worker 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.

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If the biological family is not able to assume responsibility, the worker 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 through SAMII. An itemized list of expenses will need to be attached to the payment.

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

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

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