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 6 Overview

This chapter will describe activities that a Children's Service Worker shall do with the child and family to support their out-of-home placement.

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Chapter Memoranda History: (prior to 1/31/07)

CD06-47, CD06-63

Memoranda History:

CD07-52, CD15-28

6.1 Out-of-Home Placement Support Activities

The child's Children's Service Worker should meet face-to-face, individually and jointly, with the child and the resource provider, at the placement, the next business day following placement for initial placements for children entering out-of-home care. For subsequent placement and moves, if the child's Children's Service Worker places the child, the follow up visit may be within five (5) business days. If someone other than the child's Children's Service Worker places the child, a host worker from the residence (placement) county may be requested to complete a 24 hour (next business day) face-to-face visit, with the child's Children's Service Worker visiting in person, in the placement within five (5) business days. This would be applicable to initial and subsequent placements. The worker should then meet face-to-face with the child and resource provider, a minimum of one time per month in the placement to monitor the placement and assess the safety of the child. Staff will likely visit with children more than once a month; however the state worker visit report will calculate compliance per calendar month based on the federal standard.

The Division has the authority to provide services to a child and parent when the child is not in custody but is under court ordered supervision by the Division. This includes visiting with the child. Face-to-face visits in the home should be done no less than once a month or more as needed to assure the safety of the child and to achieve the case goal. If the child remains in the custody of the parent, the Parental Home Visit Checklist, CD-83, should be utilized to document this contact. If the child is in a non-parental placement, the Worker/Child/Caregiver Visit Guide, CD-82, should be utilized. Safety of the resource home should be assessed:

1. Provide the necessary support to the resource family to involve them to meet the needs of the child and his/her parents, to include information, technical assistance, advice and counsel as follows:

    a. Assist the resource family in understanding the circumstances and behavior of the parent;

    b. Encourage the resource provider to be a model for good parenting. This will be beneficial to the foster youth and parents; and

    c. Encourage child care practices which promote and protect the psychological, physical, and emotional well-being of the child including the physical, developmental, and mental health screenings which are required every six months for children from birth to age 10 as long as the child remains in care.

2. Discipline deserves special mention since resource providers are vulnerable to the accusation of child abuse, and many children exhibit problematic and provocative behavior. **Physical punishment of foster youth is not permitted.** Resource providers shall use discipline methods which are consistent with Children's Division policy, Section 210.566, RSMo. It is crucial for children to be

exposed to alternative ways of problem solving aside from force or threat of force. Limit setting is necessary in a consistent and firm way. Resource providers must be offered training to manage the behavior of the child in ways other than spanking, slapping, or hitting. Briefly, depending on a child's age and capacity to understand, these ways include:

a. Distraction;

b. Isolating a child in his room when he is out of control until he quiets down and can discuss things. "Time out" should be understood by both the resource provider and the child before it is used;

c. Spontaneously rewarding a child for good behavior;

d. Removing a child from dangerous situations;

e. Removing dangerous objects;

f. Explaining; and

g. Specific natural or logical consequences ("If you fight with Jim, then you can't play with him today.").

3. Address the following issues with child and resource family or other care provider during regular placement support contacts and during Family Support Team (FST)/Permanency Planning Review Team (PPRT) meetings:

a. Stabilization in the child's life so that development and learning can proceed at a normal rate. (Excessive anxiety and insecurity interfere with normal development and learning.)

b. Help the child deal with the trauma of separation. Explore with him and reinforce the belief that he is not the cause of the family breakdown.

c. Assure the healthy growth and development of the child by reviewing the child's progress and response to care provided by the resource family, including integration of the Child Assessment and Service plan, CS-1, and any special evaluations, treatment and treatment recommendations.

d. Give attention to the child's special interests, talents, and vocational interests.

e. Assist the child in rebuilding parental relationship, if the child does not want to visit.

- Authorization from the court must be obtained if visits with parents are to be restricted.

f. Begin and maintain a "life book" with or for the child, to reinforce continuity in care and relationship to parents.

4. The Children's Service Worker should consult with the residential care provider, at a minimum, once a month to assure safety, monitor the placement and assess the progress of the child. See Section 4 Chapter 18 if the child is placed in level II, III, or IV residential treatment services.

Related Subject: Section 4 Chapter 18 Residential Rehabilitative Treatment Services.

- These providers also include any facility in which a child in Division custody has been placed through special arrangements.

5. Secure the provision of needed and specialized services to compensate for any current learning or developmental deficits caused by previous life experiences.

6. Implement any treatment recommendations made by the physician, dentist, other professional, and the psychological examiner, including any recommendations for assisting the resource family to participate when needed.

7. Assist the resource family to cooperate with the parent/child visiting plan:

   a. Visitation should be scheduled at a time that meets the needs of the child, the biological family members, and the resource family whenever possible. Recognizing that visitation with family members is an important right of children in foster care, resource providers shall be flexible and cooperative with regard to family visits, RSMo 210.566.

   b. Child visits with parents and siblings should occur within the first week of placement, and then weekly thereafter, when possible. The Visitation Plan developed through the Family Support Team process should include the frequency of the visits. It is the worker's responsibility to assure that the child is present for the visits and that a location is secured. Visits should not be canceled or rescheduled because of unexpected problems with the worker's schedule; a backup plan should be in place.

   c. Visits should occur in the parental home or in a homelike environment unless determined by the FST that the safety of the child or staff is an issue. Office visits are discouraged.

   d. Seek progress reports after each visit, if the resource providers carry out the visitation plan. The Visitation Reaction Form, CD-85, should be used for all visits whether supervised or unsupervised. If visits are supervised,

the Supervised Visitation Checklist should be completed by whoever supervises the visit.

e. Resource families must be informed that visits should never occur in homes in which a known or suspected methamphetamine laboratory exists or has existed unless it has been professionally treated or decontaminated by a hazardous waste clean-up agency according to the guidelines of the Environmental Protection Agency (EPA).

8. Assist the resource family in providing necessary guidance and behavior management of the child:

   a. Assess the need for residential treatment services via the Residential Referral Treatment form, CS-9, if:

      1. A child's behavior becomes such that resource family care can no longer meet the child's needs; and,

      2. A more structured, treatment-oriented environment is needed.

Related Subject: Section 4 Chapter 4 Attachment B: Guidelines to Placement Options, Criteria, and Selection; Section 4 Chapter 13 Placement of the Child with A Subsequent Provider; Section 4 Chapter 9 Permanent Outcomes for Children; and Section 4 Chapter 18 Residential rehabilitative Treatment Services if such placement planning becomes necessary.

9. Assist the resource family and child in terminating or maintaining the relationship to family and other significant persons as desired and as appropriate to the child's needs when the child is reunified with parents or is placed with another resource family.

   a. The resource providers shall make every effort to support and encourage the child’s placement in a permanent home, including but not limited to providing information on the history and care needs of the child and accommodating transitional visitation, Section 210.566, RSMo.

10. Prepare the child for adoptive placement if this becomes the child's permanency plan:

    - This shall be done irrespective of whether the child will remain with the family currently caring for the child or will move to a new family.

   a. Secure a medical examination, and report for same, within six (6) months prior to the child's adoptive placement, if adoption is the permanency plan for the child.

b. Secure a dental examination beginning at age three (3) years, and report for same, within six (6) months prior to the child's adoptive placement, if adoption is the permanency plan for the child.

- A Healthy Children and Youth assessment will meet the medical or dental examination requirement if one has been completed within the six (6) months prior to the adoptive placement. In those instances in which a report of abnormalities was received, a report of any treatment provided shall be secured.

The medical and dental requirements can be met, if the child is involved in a current and regular treatment regimen, by securing a report of the child's health status and continued need for treatment from the attending physician or dentist.

Physical examinations through the Healthy Children and Youth (HCY) program may be authorized as often as necessary in order to provide completeness regarding the child's physical condition.

c. Secure a psychological evaluation and report beginning at age three (3) years and within six (6) months prior to adoptive placement if the child's permanency plan is adoption.

- Developmental evaluations should be secured for any child from birth to age three (3) years, as indicated by the condition of the child.

Related Subject: Section 2 Chapter 4.1.12.3 Referral To Early Childhood Intervention, and Section 2, Chapter 4.1.14 Notification For Investigations Disposition

A psychological examination may be waived for a child age three (3) to five (5) years if a resource competent to perform a psychological examination cannot be located. A report of any psychological services provided as a part of the case/treatment plan may be used if this service was provided within six (6) months prior to adoptive placement and is a comprehensive evaluation.

d. Obtain reports of any specialized treatment (i.e., speech therapy, physical therapy, therapeutic child care, surgical procedures, etc.) currently being provided to the child if the child's plan is for adoptive placement.

- A synopsis of any of the above reports shall be included in the written summary provided to adoptive parents at the time of placement.

e. Maintain healthy growth and development through the provision of the usual community health, educational, religious (if appropriate) and socialization services.

11. Record all activities every 30 days.

12. Provide the resource provider with a copy of court reports regarding the placements in their home.

13. Explain to the resource provider they must use medical services for the foster youth placed in their home who are enrolled with MO HealthNet (MH) or MO HealthNet/Managed Care (MH/MC).

14. Explain to the resource provider that obtaining medical services from a provider not enrolled with MO HealthNet (MH) or MO HealthNet/Managed Care (MH/MC) will result in the resource provider paying for the services out of pocket and may not be reimbursed.

    Any invoice or paid receipt received by the resource provider for services provided to a foster placement in their home must be submitted to the foster youth's case manager immediately. The case manager will scan the invoice to the Medicaid Liaison at Central Office to review. If the claim cannot be paid by MH/MC, the Liaison will inform the case manager they need to utilize the Reimbursement Review process provided below.

    Reimbursement Review Process:

    - Submit Payment Request (PR) to FACES Payment Unit
    - If resource provider paid out of pocket, attach receipt for services to the PR
    - If resource provider received an invoice, attach the invoice to the PR
    - If the service is not covered by MH or MH/MC, attach the denial from the MH or MH/MC provider to the PR

15. The Medical Services Authorization Information Letter, CD-27, must be presented at all medical events for a foster youth. A resource provider should have with them at all times a Medical Services Authorization Information Letter, CD-27. A foster youth's worker must also present the letter if facilitating attendance by the foster youth at a medical event.

16. Explain to the resource provider the Reimbursement Review Process when a resource provider receives an invoice or has a paid receipt and letter from the medical provider, if applicable, for medical services provided to a foster youth placed in their home.

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

CD06-47, CD06-63

Memoranda History:

CD07-52, CD10-09, CD10-41, CD12-88, CD14-70, CD15-28

Attachment A: Creating a Life Book

A life book shall be started for each child within 30 days of placement in out-of-home care. The book shall accompany the child through the permanency process.

A life book is significant in helping the child form a link to his/her past. Through the collection of historical data, memorabilia, stories, and special events, the life book provides a picture of the child's life. The life book may help decrease the trauma of loss and separation a child experiences when placed in out-of-home care. Further, the life book:

1. Serves as a preventive health measure
2. Gives the child access to history while giving answers and straightening out misconceptions
3. Provides continuity, helping children develop an intact sense of identity;
4. Helps a child avoid fantasy and denial
5. Retrieves memories, and
6. Helps the Children's Service Worker identify child's unfinished business.

The life book may take various forms including a folder, packet, picture album, or a specially prepared box, which creates a permanent record for the child, the birth family, the foster family, or the adoptive family.

Ultimately, the child must determine what goes into his/her life book. However, the placement provider, the Children's Service Worker, and others who have contact with the child need to collect information to provide the child as he/she matures and asks more probing questions and needs more in-depth information. Further, the placement provider can supplement the child's own knowledge, provide accurate, factual information, and correct misperceptions and faulty memories.

The birth parents must be involved in developing the life book as much as possible and with the child's permission. Ideally, the birth parents will work together with the placement provider and the child on the life book. They can provide significant information about the child's life prior to placement. Further, cards, letters, and other forms of communication, from the birth parents may be included in the life book.

Material to Include in the Life Book

The life book should include all information available to the child. Material which may be included:

- Birth Information:
    - Height, weight, length
    - Day, time and date of birth
    - Weather
    - Place of birth (including picture of hospital)
    - Birth certificate and birth name
    - Baby pictures, footprints, baby hair
    - Special gifts/letters
    - Hospital bracelet
    - Name of the delivery physician
    - Hospital records, and
    - Any unusual birth circumstances including:
        - Pregnancy history of mother, and
        - Any substance abuse during pregnancy or history of drug use.
- Information About Birth Family:
    - Description of birth parents:
        - Picture
        - Nationality
        - Physical description, i.e., height, weight, eye and hair color, etc.
        - Medical history, especially hereditary conditions
        - Special talents of birth parents
        - Living or deceased

- Education/occupation/profession
- Date of birth
- Place of birth, and
- Extended family, including names, ages, addresses, physical description, medical history, etc.

- Information about siblings:
  - Names, ages (dates of birth)
  - Pictures
  - Physical description, i.e., height, weight, eye and hair color, etc.
  - Out-of-home placements, i.e., with whom, how long, current address, and
  - Significant events.

- Pictures of:
  - Parents, siblings, relatives or kinships
  - Placement providers including all family members, pets, the home, child's room, etc.
  - Child over time including school pictures
  - Other significant people including teachers, coaches, etc.
  - Birth family home
  - Picture of child care facility, schools, church, etc. attended by child
  - Activities in which the child participated, i.e., camp, Scouts, sporting events
  - School activities, such as plays, prom, etc., and
  - Other pictures of persons or events significant to the child.

- Religious information:

- Places of worship child attended
- Name of minister, Sunday school teachers, etc.
- Baptism, confirmation and other similar records, and
- Papers and other materials from Sunday school

- Genogram/Ecomap/Timeline:
  - Provides information about family members
  - Includes significant dates in each family member's life (i.e., birth, marriage, divorces, serious illness/hospitalizations, death, etc.), and
  - May include significant information such as nationality, occupation, disabilities, cause of death, etc.

Information About all Placements

- Reason for placement:
  - This will provide the child an understanding of the need for placement.
  - Dates and addresses of placements.
- Identify the decision makers:
  - Clarifies that decisions are made by adults:
    - Judge
    - Juvenile officers
    - Children's Service Workers, and
    - Birth, foster, and adoptive parents
- Regional information:
  - Country, city, state
  - Climate, season

- Terrain, and
- Customs.

- Anecdotal information, family stories.
- Family traditions - Special events:
  - Holidays, smells, senses, and
  - Vacations
- Meaningful items and possessions, security items

Life and Growth Information:

- Developmental Milestones (all firsts, such as first word spoken, first steps, etc.):
  - Physical
  - Language
  - Social, and
  - Temperamental characteristics
- School information:
  - School systems attended
  - Favorite subjects
  - Favorite teachers
  - Report cards, and
  - Drawings completed by the child
- Activities/Interests:
  - Likes/dislikes
  - Hobbies
  - Strengths and Weaknesses

- Organizations (i.e., Scouts, church groups, sports teams)
- Awards, recognition, newspaper clippings, and
- Friends

Health and Medical Information:

- Medical Information:
  - List of clinics, hospitals, etc., where the child received care, surgery, etc.
  - Immunization record
  - Diseases
  - Allergies
  - Medical history of birth family, particularly hereditary conditions, and
  - Record of child's illnesses which may identify a significant pattern
- Process of dealing with loss, separation, attachment, and past abuse/neglect:
  - Therapist's name
  - Frequency and duration of therapy
  - Therapy goals
  - Contacts, and
  - Correspondence

Creating the life book is an ongoing process that produces a living record of the child's growth and development.

The process may be painful at times for the child therefore the Children's Service Worker or caretaker must be acutely aware and sensitive to the child's feelings. The child should be allowed time to connect with the past and assimilate information and feelings before moving forward.

Creating a life book may help the child resolve the past, satisfy his/her need to know, and fill in the missing pieces.

Sources:

Three Rivers Adoption Council, Creating and Using Lifebooks: A Guide for Adoptive Parents, Pittsburgh, Pennsylvania: 1990.

Adoption of Children with Special Needs: A Curriculum for the Training of Adoption Workers, Pasztor, 1982.

Lifebooks: Tool for Working with Children in Placement, Backhaus, 1984.

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

Memoranda History:

CD13-90

Attachment B: Direct Service Worker Duties

Direct Service Worker Duties:

1. Provide any services indicated and needed as identified in the in the Written Service Agreement, CD-14B.

2. Discuss with all families the importance of primary and preventive health care, including the impact of planning the spacing of children on the mother's and the family's health, prenatal care, well-baby and postnatal care, and sexually transmitted diseases (STDs). Timely referrals shall be made and assistance provided to access care. Barriers to accessing the services may include lack of transportation, lack of knowledge, inadequate or no insurance, lack of service providers, access to clinical services (i.e., inconvenient clinic hours), etc. If barriers to these primary health care services persist, they shall be discussed in supervisory conference, in order to identify ways to overcome the barriers.

   If no medical provider has been chosen by the family, the county health department may be a resource for them. Assistance may be provided in creating a linkage between the family and the health department or medical home, i.e., accompanying them on the first visit. Transportation services are available through some county health departments to assist in accessing needed health services.

3. Refer child to a MO HealthNet physician for a Healthy Children and Youth (HCY) physical examination within 24 hours of custody with physician completion of the appropriate HCY form. 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.

   Section 210.110, RSMo, requires **all** children from birth to age 10 in the custody of the Children's Division to 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 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.

4. Plan with resource providers and other appropriate team members to ensure that all children in out-of-home care receive education on sexual development, appropriate to their age, life experiences, and living conditions. This information should include information on sexuality and venereal diseases.

5. Review and approve each resource provider's family emergency plan. This plan will become part of the resource provider's Family Development Plan. The worker will document in the provider's file every six months the date and time that the resource provider reviews their Family Emergency Plan with the foster youth in their home.

   Related Subject: Section 6 Chapter 1 Attachment F Foster Parents Emergency Procedures

6. Initiate, maintain and update case records and share copies as planned with the case manager county. Submit any reports requested by case manager county.

7. Assist child as needed with appropriate referrals for financial benefits or rehabilitation services.

8. Make presentations about case activity at Family Support Team (FST)/Permanency Planning Review Team (PPRT) meetings and other staffings.

9. Obtain clearance, prepare authorizations, and monitor use of contractual and other treatment services, which have been initiated in the direct service county.

10. Notify the case manager county of any major events occurring for the family or child, including the need to obtain court approval for extraordinary medical care.

11. Provide transportation, as necessary, when appropriate to the case plan and when it has been determined another resource is not available. When providing transportation for children under eight years old, children must be in a child safety seat. The following chart details proper child safety seat usage:

	INFANTS		TODDLERS	YOUNG CHILDREN
WEIGHT	Birth to 1 year & less than 20 lbs	Less than 1 year & 20 to 35 lbs.	1 to 4 years & at least 20 to 40 lbs.	Over 40 lbs. 4 to 8 years, unless they are 4'9" tall

TYPE OF SEAT	Infant-only *or* rear-facing Convertible	Rear-facing Convertible	Convertible *or* Forward-Facing Only *or* High Back Booster/Harness	Belt-Positioning Booster (no back, base only) *or* High Back Belt-Positioning Booster
SEAT POSITION	Rear-facing only	Rear-facing only	Forward-facing	Forward-facing
USAGE TIPS	• Never use in front seat where an air bag is present. • Tightly install child seat in rear seat, facing the rear. • Child seat should recline at approximately a 45 degree angle. • Infant's head should not extend beyond the top of the seat's backrest. • Harness straps/slots at or below shoulder level. • Harness straps fit snug on the child, leaving no more than one finger's width between the child and harness; harness clip at armpit level.		• Never use in a front seat where an air bag is present. • Tightly install child seat in rear seat, facing forward. • Harness straps should be at or above shoulders. • Harness straps fit snug on child, leaving no more than one finger's width between the child and harness; harness clip at armpit level.	• Booster base used with adult lap and shoulder belt in rear seat. • Shoulder belt should rest snugly across chest, rests on shoulder; and should NEVER be placed under the arm or behind the back. • Lap-belt should rest low, across the lap/upper thigh area – not across the stomach.

12. Coordinate and monitor visits between parent(s) and child.

13. Complete and update the Alternative Care Client Information and Family-Centered Services Information screens in FACES, and the following forms: Income Withdrawal Document, CS-KIDS-2, and Emergency Assistance Services form, CS-EAS-1, as needed. Assist the case manager county in completing and updating other forms necessary to the case plan. Prepare and update the SEAS Request and Eligibility Form, CS-67, and SEAS Authorization Form, CS-67A, when appropriate.

14. For youth, ages 13 through 21, assist the case manager to assure the youth's participation in the development of their permanency plan and attendance at all FST/PPRT meetings.

15. For youth turning 14 or already 14 and older, assist the case manager to complete Older Youth Program Referral, CD-93, Adolescent FST Guide and Individualized Action Plan, CD-94, Life Skills Strengths Needs Assessment Reporting Form, CD-97, and the Ansell-Casey Life Skills Assessment, (ACLSA) for referral or continued services in their region from the Chafee Foster Care Independence Program (CFCIP).

Related Subject: Section 4 Chapter 21 Older Youth Program (OYP), Section 4 Chapter 2.3.2 Children's Service Worker Preparation for the Hearing, Section 4 Chapter 7 Begin Work with the Family/Child(ren), Section 4 Chapter 5 Placement in a Resource Family

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CD04-91, CD05-72, CD06-33

Memoranda History:

CD09-05, CD10-41

Attachment C: Working With Families Needing/Wishing To Communicate In Their Native Language

Parents and children whose native language is not English have the right to communicate together and with the worker in their native language during the CA/N Investigation, protective services, and alternative care services process. Guidelines for ensuring these rights include the following:

- Allow parents and children the choice of communicating in their native language;
- If the Children's Service Worker needs to monitor the communication for counseling or therapeutic purposes, the client should be advised that it is important for everyone to know what is being said. The client may speak in English or a language in which the worker is fluent. If the client chooses to speak in his/her native language, an interpreter may be needed;
- If the Children's Service Worker has reason to believe that parents and/or children are using their native language to circumvent the authority of Children's Division (CD) or the courts in matters of child custody or out-of-home care placement, the worker shall make reasonable efforts to obtain an interpreter in the family's native language, at no cost to the family. The interpreter should be able to speak and understand the native language fluently;

  NOTE: "Reasonable efforts" in this instance, are defined as attempts made to determine the presence of an interpreter in the community, or within a reasonable access to the community who can assist during visitation.

- If the Children's Service Worker is unable to obtain a qualified interpreter, all efforts made to obtain the services of such an interpreter should be documented;
- Payment for interpreter services may be made through SEAS, if contracted, or through CSIPS using appropriate forms.

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

Memoranda History:

Attachment D: Families Together Program (IM Program For Temporary Assistance)

Families Together Program is designed to assist parents/caretakers in their efforts to regain custody of their child(ren) living in out-of-home care by expanding the eligibility to receive a cash grant for up to 60 days after a child enters out-of-home care and 60 days immediately prior to reunification. Parents and any other caretakers who may be eligible for temporary assistance payments may utilize this program. Family Support Division (FSD) staff will determine eligibility for the cash grant, while Children's Division staff will be responsible for the coordination of treatment and aftercare planning, including referring the family to FSD staff.

Case Manager Duties

In accessing this program the following procedures are to be used:

When Children Are Removed:

1. When a child is removed from their home by the court and enters out-of-home care, the Children's Service Worker shall determine if the family is receiving temporary assistance.

2. If the family receives temporary assistance, the Children's Service Worker shall immediately provide written notice to the participant's FSD/Futures worker/case manager and invite them to the 72-hour Family Support Team Meeting (FSTM).

3. During either the FSTM or the initial meeting, both FSD and Children's Division staff shall discuss with the family the prognosis of early reunification and any needs which could impact the child returning home sooner. Generally, the goal of expedited permanency and the status of most families will benefit from the continuation of the temporary assistance cash grant. However, there must be a clear plan agreed upon by the team to return the child to the home within 60 days. This will allow the family to continue receiving temporary assistance for up to 60 days following the child's removal.

4. If at any point the child's status changes with regard to reunification causing them to be either not reunited or to enter out-of-home care again, the Children's Service Worker shall be responsible for immediate written notification to the FSD staff involved.

When Children Are Returned

When a child who has been in out-of-home care will be reunited with their parent/caretaker, the following procedure shall be used:

1. When reunification may occur within 60 days and is the documented case plan, the Children's Service Worker shall ascertain if the family is currently receiving or may be eligible for services from FSD.

2. The Children's Service Worker shall schedule a FSTM and invite the participant's FSD/Futures worker/case manager. In situations where services were stopped or never existed, the FSD staff who will be expected to take the family's application, should they decide to apply, shall be invited to attend.

   NOTE: Follow local office procedure in determining how the Children's Service Worker is to identify and invite the appropriate FSD staff person assigned to take the family's application.

3. The purpose of this meeting shall be to assess the family's needs and make aftercare plans. In the event that the family wishes to resume the receipt of temporary assistance or initiate a new request, the FSD staff person shall explain the appropriate procedures for the family to follow to apply for temporary assistance.

4. When the family is approved for temporary assistance, the Children's Service Worker shall coordinate the closing of Medicaid coverage on the SS-61 with the FSD person who will be reopening it via temporary assistance.

5. If at any point the child's status changes with regard to reunification causing them to be either not reunited or to enter out-of-home care again, the Children's Service Worker shall be responsible for immediate written notification to the FSD staff involved.

When the Children's Service Worker closes the Medicaid coverage on the SS-61, children in MC+ areas will be affected as follows:

1. The child will now be on FSD Medicaid, which means that the child will receive mental health services through the MC+ plan.

2. The FSD case head of household (usually the mother) will need to choose the MC+ plan of choice and the out-of-home care (foster parent or kinship) provider will need to take the child to the primary care physician of the parent/caretaker's choice.

3. The Children's Service Worker should coordinate discussions between the parent/caretaker and the out-of-home care provider regarding this necessary action so that there is no disruption of medical care for the child.

4. Medical plan changes can no longer be made at will.

5. Primary care physician changes can no longer be made at will.

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

Memoranda History: