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SECTION 4 CHILDREN IN CARE

401 Scope and Purpose

The primary child welfare goal of the Division of Family and Children is the safety of children and to help children attain permanency. This is accomplished by focusing on the safety and best interests of the child. Any decision regarding the child is to be consistent with this goal.

If the safety and best interests of the child are best served by removing the child from the home, then out-of-home care is to be considered. Out-of-home care may be provided through kinship care in the home of a relative or through foster care in a foster family home, or a group-care setting, depending upon the individual needs of the child. The family case manager (FCM) is responsible for working with all persons involved in the child's care. Our interests always must focus on the child. The FCM's goal is to ensure the safety of the child and develop a permanency plan for the child, utilizing input from the child's legal parent(s), appropriate relatives, and foster parent(s); and to implement that plan as efficiently as possible consistent with the child's well-being and within the parameters of state and federal statute, rules and regulations.

402 Legal Base

Federal Law: 42 USC 620-628(b); 42 USC 629-629(e); 42 USC 670-679(b);42 USC 671; 42 USC 675 and 42 USC 677.
Indiana Juvenile Code: IC 31-9; IC 31-10-2; IC 31-16-10; IC 31-34; IC 31-38; IC-31-40; IC 12-17-9, IC 12-17-10, and IC 12-17-11.

403 The Placement Process

It is in a child's best interests to have as few changes in placement as possible. Movement of the child from one placement to another is to be kept to a minimum. Therefore, any out of home placement, including what is thought to be a short-term initial placement, is to be made with as much consideration as time allows to matching the needs of the child with the strengths of the out-of-home care resource. Each move the child makes is to be made as though it were the last move.

There are many placement options available when out-of-home care is required for a child. A thorough assessment of the child's needs provides the foundation for determining what type of placement will be in the child's best interests. The following information delineates the placement process.

403.1 Types of Placements

The following presents the types of placement resources available for children needing out-of-home care:

403.11 Relative Homes (Kinship Care)

IC 31-34-6-2, as amended by PL 142-1993, requires a court to consider placing a child alleged to be a child in need of services (CHINS) with an appropriate family member before considering any other placement. Kinship care often offers the child a family-like living experience that most closely resembles the child's own home. Therefore, the county office of family and children (COFC) is to attempt to locate relatives as placement resources first. A relative placement may be considered appropriate when the minimum sufficient level of care for the child is met and the

relative can demonstrate that the safety and best interest of the child are the primary focus.

Any child in substitute care is entitled to equal protection. Therefore, the approach to obtain licensure for a relative home placement is to be the same as that for licensure of a foster home placement. That is, the basic procedures regarding evaluation, case documentation, training offered and required, supervision, and opportunities for receiving financial assistance are to be the same. Licensure is to be obtained in a timely manner. See Section 6 regarding licensure of a relative home. See Section 9, subsection 903.22 and 903.221 regarding the IVE-FC eligible child in relative placement.

403.12 Foster Family Homes

A foster family home provides a family-like living experience for a child who is suited for family relationships. The Division of Family and Children (DFC) licenses foster family homes based upon the recommendation of the COFC or a licensed child placing agency. Refer to IC 12-17.4-4 concerning foster family home regulation and Section 6 of this manual regarding licensing of foster family homes.

403.121 Special Needs Foster Family Homes

The category of "special needs foster family home" is established in PL 211-1999. It is defined, for purposes of regulatory statute (IC 12-17.4), as a foster family home that:

(1) provides care for a child who has a mental, physical, or emotional disability; and who will require additional supervision or assistance in behavioral management, activities of daily living, or management of medical problems; and

(2) meets additional requirements specified in IC 12-17.4-4-1.7 as outlined below.

Training requirements for a special needs foster family home include:

(1) participating in the 20 hours of pre-service training required to be licensed as a foster family home; and,

(2) within one (1) year of licensure as a foster family home and annually thereafter, participating in 20 hours of in-service training - 10 hours as required to maintain a foster family home license and an additional 10 hours that includes specialized training to meet the child-specific needs.

A special needs foster family home may not provide supervision and care to more than eight (8) individuals each of whom is less than 18 years of age or is at least 18 and is receiving care and supervision under an order of a juvenile court. No more than four (4) individuals may be under the age of six (6) years. These totals include the children for whom the provider is a parent, stepparent, guardian, custodian, or other relative. The Division of Family and Children (DFC) may grant an exception to this limitation if it is

determined that placement of siblings in the same special needs foster family home is beneficial. The DFC is to consider the unique needs of each special needs foster child in determining the appropriate number of children to be placed in the home. The DFC may require a special needs foster family home to provide supervision and care to less than the maximum number allowable based on the special needs of the child(ren) to be placed there.

403.122 Therapeutic Foster Family Homes

The category of "therapeutic foster home" as defined by IC 12-7-2-190.8 is established by PL 211-1999. It is defined, for purposes of regulatory statute (IC 12-17.4), as a foster family home that:

(1) provides care to a seriously emotionally disturbed or developmentally disabled child;

(2) provides the setting in which the child receives treatment via an integrated array of services supervised and supported by qualified program staff from Family and Social Services Administration, a managed care provider contracted by the Division of Mental Health and Addiction, or a licensed chlld placing agency; and

(3) meets additional requirements under IC 12-17.4-4-1.5 as outlined below.

Training requirements for a therapeutic foster family home include:

(1) participating in 30 hours of pre-service training that includes 20 hours of pre-service training for licensure as a foster family home and an additional 10 hours of pre-service training in therapeutic foster care; and,

(2) within one (1) year of licensure as a therapeutic foster family home, and annually thereafter, participating in 20 hours of training that includes 10 hours of training required to maintain a license as a foster family home and an additional 10 hours of training required to maintain a license as a therapeutic foster family home.

A therapeutic foster family home may not provide supervision and care to more than two (2) foster children at the same time, excluding the children for whom the applicant or operator is a parent, stepparent, guardian, custodian, or other relative. The Division of Family and Children may grant an exception to this limitation if the placement of siblings in the same therapeutic foster family home is beneficial or in the best interests of the foster children residing in that home.

403.13 Group Care Facilities

The following types of group care facilities are licensed by the Central Office of the Division of Family and Children:

(1) Group Home

The capacity of a group home is limited to 10 or fewer children, six (6) years of age or older who are apart from their parents or guardian on a 24 hour a day basis and who have demonstrated the ability to follow direction and take appropriate action for self preservation. (470 IAC (Indiana Administrative Code) 3-14-13) Group homes may be considered for children who can live safely in the community and do not pose a public safety threat but who require a more structured experience than a foster family home. Also, group homes may be used to provide a transition for children leaving institutional care and returning to community and family living.

(2) Child Caring Institution

The child caring institution has a capacity of more than 10 children six (6) years of age or older (470 IAC 3-11) and may be used for children who cannot adapt to the living experiences in a foster home or group home. For appropriate children, an institution can provide specialized services and a group living program in accordance with an individual treatment plan for each child.

(3) Shelter Care Facility

A shelter care facility may be licensed as either a group home or an institution (470 IAC 3-15; 470 IAC 3-12). These facilities usually accept children for a defined temporary period of time (usually less than 30 days) while more permanent plans are being developed, and thus are designed for emergency, short-term placement as opposed to more extended placement periods.

403.14 State Institutions/Hospitals

Several Indiana state agencies operate residential facilities that serve children. The Department of Health, the Department of Correction and Family and Social Services Administration's Division of Mental Health and Addiction each operate facilities for the care and treatment of children who present severe physical, mental, and emotional problems. These facilities are described in the following subsections:

(1) State Department of Health Institutions for Children

The Indiana State Department of Health (ISDH) operates several specialized state schools for children with various qualifications and needs.

(a) The Indiana Soldiers' and Sailors' Children's Home: A residential institution for children in need of services. While the home is open to all Indiana children, preference is given first to those who are the children of current and former

armed forces personnel and second to specified relatives of such military personnel. There is no residency requirement other than the child being in Indiana immediately prior to application for admission. Application is made directly to the home. IC 16-33-4-11 requires that a review committee, of which a designee of the Secretary of FSSA (DFC) is to be a member, is to determine the appropriateness of placement at the facility. If a placement is considered to be appropriate by the committee, the superintendent is to receive the child into the home, if the child meets the criteria for placement. The home will not accept a child who requires residential placement in a detention center or a secured facility. The social work staff provides casework to individual children and has responsibility for liaison work in the child's home community. (IC 16-33-4)

(b) The Indiana School for the Blind: An educational institution for children who are educable but who cannot make satisfactory progress in regular public schools because of a serious visual deficiency. The institution offers education, care, and special disability-based training for children three (3) years old through high school age. Admission is by direct application to the school. (IC 16-33-1)

(c) The Indiana School for the Deaf: An educational institution for children who cannot make satisfactory progress in regular public schools because of a serious hearing deficiency. The institution offers education, care, and special disability-based training for children three (3) years old through high school age. Admission is by direct application to the school. (IC 16-33-2)

(d) Silvercrest Children's Development Center: Provides educational diagnosis, needs assessment, evaluation, short-term training and retraining of children with serious disabling conditions who cannot make satisfactory progress in public schools or special institutions of the state. Eligible children are those Indiana residents up to 22 years of age with 2 or more identified disabilities, whose physical care can be managed in the residential setting. The center will provide information, but admission is through the school corporation of the child's place of residence. (IC 16-33-3)

(2) Department of Correction Institutions for Children

The Plainfield Juvenile Correctional Facility and the Indianapolis Juvenile Correctional Facility serve a population of adjudicated delinquent children made wards of the Department of Correction (DOC) by the juvenile court. Once custody of the child is awarded to the DOC, juvenile court jurisdiction is discontinued. (IC 31-30-2) The expense of maintaining a child in either of these facilities is shared equally by the county through the county general fund and the DOC.

Once a child has been dismissed from a correctional facility, wardship of the child does not automatically revert to the COFC. IC 31-30-2-2 requires the DOC to notify the juvenile court that awarded the guardianship of the impending release of the child from DOC custody at least 10 days prior to the release. The juvenile court has 30 days from receipt of such notification to reinstate jurisdiction over the child, on its own motion, in order to modify the court's original dispositional decree. Otherwise, probable cause warranting a CHINS petition would need to exist in order to reestablish jurisdiction.

(3) State-Operated Facilities: [State-Operated Facility: a state institution administered by either the Division of Disability, Aging and Rehabilitative Services (DDARS) or Division of Mental Health and Addiction (DMHA) of the Family and Social Services Administration (FSSA)]

FSSA emphasizes community-based services and the promotion of individual and family self-sufficiency. One of the objectives of FSSA is to enroll identified individuals in institutions into community-based services. All divisions of FSSA are to discuss and share information concerning a child on an inter-divisional basis before and during a child's admission to a state-operated facility. This is to ensure that:

(a) the state-operated facility placement is the least restrictive environment that can meet the child's needs;
(b) the child does not remain in a state-operated facility placement any longer than necessary;
(c) the transition of the child to the community is coordinated to meet the needs of the child; and
(d) permanency remains the major priority.

The State of Indiana operates several facilities through the Division of Mental Health and Addiction (DMHA) and the Division of Disability, Aging and Rehabilitative Services (DDARS). Some of these serve mentally ill children and some serve mentally retarded/ developmentally disabled children. To access resources on behalf of mentally ill, mentally retarded, or developmentally disabled children with whom the COFC is involved and who meet the criteria for such services, the following procedures are to be utilized:

(a) For assistance in obtaining treatment for a mentally ill child, COFC staff is to contact the area community mental health center (CMHC). Web addresses for CMHCs appear in the Family and Social Services Administration (FSSA) Service Entry Points listing in Appendix A of this section. Additional information concerning these centers can be found in Appendix B.
(b) For assistance in obtaining services for children relative to mental retardation (MR) and developmental disabilities (DD),

contact the area Integrated Field Services (IFS) office, if the COFC is seeking family support services or residential placement for an MR or DD child. Do not contact a state developmental center directly. Web adresses for IFS offices appear in the FSSA Service Entry Points listing by county in Appendix A of this section. Additional information concerning IFS offices can be found in Appendix C.

(c) For assistance in obtaining only developmental or educational services rather than family support or placement services for children relative to MR or DD contact:

(i) the First Steps office, for children under three (3) years of age (See Appendix D for information regarding First Steps.); or
(ii) the local school corporation for children age three (3) through 18 or 21.

See subsection 404.332 for further information regarding the role of the school corporation in obtaining appropriate services for special needs children.

The following is an outline of requirements, procedures, and responsibilities for placing agencies and state-operated facilities relative to the placement of children in such facilities:

(a) No child will be admitted to a state-operated facility (including education placements made through procedures outlined in Indiana's Special Education Rules, see 511 IAC 7-27-12) unless the facility's admissions committee has met and recommended placement in the facility. The admissions committee must draft a discharge plan for the child before the child is admitted to a state-operated facility. For children whose placement is not an Article 7 placement, upon admission, the child's records shall be reviewed for the appropriateness of Article 7 services.

(b) It shall be the responsibility of each state-operated facility superintendent to formulate procedures under which the admissions committee will operate and be incorporated into the facility's admissions process. The admissions committee's procedure shall be approved by the appropriate Division Director and, subsequently, by the FSSA policy staff.

(c) If the admissions committee determines that a child who is a CHINS should be admitted to a state-operated facility, the county office shall do so on a voluntary basis in accordance with FSSA Policy AD 1-13, unless otherwise directed by the juvenile court judge.

(d) Once a child is admitted to a state-operated facility, the facility shall send a copy of all treatment team minutes or interdisciplinary team minutes, within the limits of applicable confidentiality laws, to the members of the child's admissions

committee. Parents shall be notified and invited to attend all treatment team or interdisciplinary team meetings.

(e) For children who are CHINS, close contact between the child's home county family case manager (FCM) and the facility are to be maintained. Copies of all treatment team meetings or interdisciplinary meetings are to be sent to the child's FCM at least quarterly. The FCM is expected to participate in treatment team meetings or interdisciplinary team meetings, as appropriate, to the maximum extent possible.

(f) The state-operated facility will be involved actively in the child's education and cooperate with the child's home school corporation and serving school corporation. If the child is in need of special education services, a state-operated facility representative will participate in the development of the child's Individual Education Plan (IEP). If the child is in need of special education services and is a CHINS, the child's home county FCM must participate in the development of the child's IEP. If residential placement is identified by the IEP, the State Department of Education, Division of Special Education shall be contacted.

(g) When a state-operated facility and either a community mental health center (CMHC) or an integrated field service (IFS) office jointly determine that a child has reached maximum potential and is ready for discharge, all other divisions of FSSA are to work cooperatively to facilitate discharge. No division of FSSA is to block the discharge of a child from a state-operated facility.

403.15 Criteria for Selection

Below are some basic guidelines to consider when selecting an out-of-home placement for a child.

403.151 Relative and Foster Family Homes

Relative homes are to be given primary consideration when placement of a child is required. Relative and foster home placements typically may be most appropriate for the following children:

(1) Preschool-age children. Child caring institution and group home regulations prohibit the licensing of any facility for children under age six (6) unless the Central Office of the Division of Family and Children grants a special waiver to do so. Under no circumstances will a waiver be granted for a child under two (2) years of age.

(2) Sibling groups. Sibling groups are not to be separated if at all possible. If separate placements are made, a visitation plan must be developed and implemented within a specified time frame. See subsection 403.33.

(3) A child of any age who can accept and benefit from the closer relationship present in a relative or foster family home.

When possible, the legal family is to be involved in every step of the placement planning process. It is easier for parents to be supportive of the child's placement if they feel that they have had some choice and have had input in the placement process. This involvement of the legal parent also has been shown to have an impact on the child's positive adjustment in substitute care.

When considering foster family home placement for a child, the placement process must consider the child's special needs. These might include, but are not limited to age, physical special needs, behavioral special needs, blood disorders; hearing, speech and vision impairments, cardiac disorders, developmental disabilities, emotional impairments, educational challenges, facial deformities, seizure disorders, and more restrictive placement. A "Special Needs Checklist" can be accessed in ICWIS in the Service/Case Management module. The use of the "Special Needs Checklist" helps to ensure that the child is matched with an appropriate family. The foster family with whom the child is matched is to be willing and able to meet the child's special needs. For foster family homes, the following types of placements are not advisable:

(1) Placement of more than the maximum number of children permitted under the definition of special needs or therapeutic foster family homes unless the Division of Family and Children grants an exception on a case-by-case basis.

(2) Placement of a sexually acting out child in a home with younger children or other children who are at risk of being sexually abused.

(3) Placement of an aggressive child in a home with younger children.

At the time the foster parent is contacted about accepting placement of a child, the family case manager shall share all known risk factors with the foster parent. If a child has been sexually abused, it is critical to share the circumstances of the maltreatment with the foster family, including the context of sexual abuse, location, duration, means used to gain the child's compliance, and relationship with the perpetrator. Refer to subsection 403.2, Preparation for Placement.

All relative and foster family homes must be licensed by the Central Office of the Division of Family and Children. See Section 6 - Licensing for additional information.

403.152 Institutions

Institutional placements may be considered for school-age children who present physical, mental, or emotional problems that are best treated in a group home or institutional setting. These children, particularly older ones, often have strong ties and loyalties to their biological parents that make it difficult for them to adjust to a substitute family. An institutional

placement for a child is selected by matching the child's particular needs with the treatment program and specialized services offered by the institution.

All facilities used must be licensed by the Central Office of the Division of Family and Children except those which are operated by another state agency such as the Department of Correction or Indiana State Department of Health.

403.16 Local Coordinating Committees

According to IC 31-9-2-21, 80, 103, and 113 and IC 31-38, which was effective July 1, 1988, a local coordinating committee (LCC), hereafter also referred to as "committee", is established in each county. One purpose of the committee is to review restrictive placements whenever a referring agency proposing such a placement convenes a meeting of the committee. If the referring agency is the court, the COFC is to convene the meeting. **NOTE: The convening of a committee meeting by a referring agency to review a proposed restrictive placement for a child is optional. (IC 31-38-2-2)** When the committee receives a referral, the committee must make a recommendation as to the most appropriate placement and treatment plan. The committee is also charged to identify services that are needed but not currently available within the county.

403.161 Committee Membership

The LCC includes the following members:

Voting members:

(1) The director of the county office of family and children, or the director's designee.

(2) The director of the community mental health center or a managed care provider, as defined in IC 12-7-2-127(b), serving the child's area of residence, or the director's designee.

(3) The superintendent of the school corporation in which the child is legally settled, or the superintendent's designee.

Non-voting members:

(1) The child's parent or guardian.

(2) The child's guardian ad litem, if one has been appointed.

(3) The child's court appointed special advocate, if one has been appointed.

(4) A representative of the local health department, if requested by the chairperson.

(5) A representative of another agency or community organization, if requested by the chairperson.

Any member of the committee, voting or non-voting, may appoint a designee and shall grant the designee the same authority to commit agency resources, relative to participation on the committee as the appointing member has. The Child Protection Team in each county can serve as a local coordinating committee (LCC) provided that the agencies listed above are represented as specified. If a member of the committee appoints a designee, the designee shall have the authority to commit agency resources for the purpose of participating on the committee.

NOTE: The membership of the committee is to reflect persons specifically related to the child whose restrictive placement is under consideration.

A majority of the voting members of a committee constitutes a quorum. The committee may act only by an affirmative vote of a majority of the voting members present at the meeting. However, if a quorum of the committee cannot obtain a majority vote for any of the proposals or recommendations under consideration, the committee is required to report all of the proposals/recommendations to the referring agency.

403.162 Restrictive Placement

A restrictive placement is a residential placement of a child at a residence other than:

(1) the home of the child's parent, grandparent, sibling, aunt, uncle, cousin, stepparent or guardian; or

(2) a residence that is located in the child's county of residence and maintained by a person as that person's home.

This term includes foster placements located outside the county of the child's primary residence.

The LCC is not required to review the following restrictive placements:

(1) Predispositional detention, if a child is charged with a delinquent act as described in IC 31-37-1 through IC 31-37-2, not to exceed 60 days.

(2) Placement of a child in an in-patient psychiatric facility, not to exceed 30 days.

(3) Emergency placement in a shelter care facility, not to exceed 60 days.

(4) Hospitalization for purposes other than psychiatric care.

(5) Transfer of a child from one restrictive placement to another.

Restrictive placements which do not require review as listed above are treated as any other restrictive placement after the time limits set in this statute expire. It is the responsibility of the referring agency that placed the child under these provisions to inform the local coordinating committee (LCC) at least 15 days before the placement expires that the limits for the emergency placement will expire.

403.163 Referring Agency

Agencies that may make a referral to the committee for the purpose of reviewing a proposed restrictive placement include a:

(1) juvenile court;

(2) court having civil jurisdiction;

(3) community mental health center;

(4) county office of family and children;

(5) school corporation.

The referring agency is responsible to convene the meeting of the committee to review the proposed restrictive placement. Also, the referring agency is to:

(1) confirm that all pre-referral requirements have been met. This involves completion of the following forms:

(a) Referral Case Summary;
(b) Advisement to Parent/Guardian/Custodian;
(c) Release of Information.

See Appendix E for these forms and instructions. Although the Central Office of the Division of Family and Children made these forms available for use by the local coordinating committees, they are no longer available. Committees may continue to use copies of those forms or may develop others to meet their needs.

(2) provide voting and non-voting committee members with written summaries and reports including copies of family history, psychological reports and school reports five (5) days prior to the meeting. All materials are to be stamped "CONFIDENTIAL".

(3) schedule the case review (time and date) and notify appropriate parties.

If the referring agency is the COFC, the family case manager who is assigned the case will be responsible for performing the above tasks.

If the referring agency is the court, the COFC is required to convene the meeting. All pre-referral information and documentation needs to be completed by the probation officer most familiar with the proposed placement. The director of the COFC chairs the meeting in this case. At all other meetings, the chairperson is the voting member representing the referring agency unless the members of the committee agree on another method of selecting a chairperson.

403.164 Committee Responsibilities

Each local coordinating committee (LCC) shall:

(1) review any proposed restrictive placement that a referring agency brings to it by convening a meeting except those that are mentioned in subsection 403.132 of this section which do not require a review unless the time limits expire.

(2) consider alternative placements or treatment plans and make recommendations to the referring agency using the Committee Action Plan Form. (See Appendix E.)

(3) develop and recommend a long-range treatment plan for the child, including a treatment plan following the child's discharge from a restrictive placement. The Committee Action Plan Form is used for this purpose. (See Appendix E.)

(4) exchange information concerning services for children available in the county with members of the community, referring agencies, and other community organizations.

The committee shall review proposed restrictive placements before:

(1) the placement may be made; or

(2) the referring agency may submit its placement recommendation to the person authorized to make the placement.

If upon receipt of the case summary, the voting members agree unanimously that the referring agency has recommended an appropriate action plan including a discharge plan, a meeting may take place by a conference call initiated by the referring agency.

403.165 Confidentiality

Unless prohibited by federal law, information concerning a child that is confidential to one referring agency may be disclosed to another referring agency on a "need to know" basis. See subsection 403.133 for a list of such agencies. However, the receiving agency shall treat that information as confidential.

Information that is confidential in nature may be discussed among members of the local coordinating committee (LCC) for each child. The

members of the committee may discuss the child's information before, during, and after meetings. They may release this information to any person that will help in the completion of a treatment plan for each child in accordance with IC 31-38-2-7 and the guidelines for the particular agency using the information. Members of the committee may share the information with members of their own agency. Before members of the LCC may share this information, they shall weigh the benefits to each child and the necessity for sharing the information so that services may be rendered properly.

NOTE: For further information regarding the purpose, function and conduct of local coordinating committees, persons should review the manual- Opportunity: Indiana's Approach to Improving Opportunities For Multi-Needs Children.

403.2 Preparation for Placement

Children have feelings of loss, anxiety and confusion when removed from familiar surroundings and placed in an unfamiliar environment. Caregivers from whom the child is being removed may experience the same feelings. These feelings often are increased when faced with a lack of information regarding what will happen next and what action they may take relative to the situation. Having determined that a child is in need of placement outside of the home, the family case manager must prepare the child for the move to the fullest extent that time permits. Efforts are to be made as soon as possible to clarify the situation for the previous caregiver and, whenever possible, to involve the previous caregiver in the placement process in a positive way for the child's sake.

403.21 Preparation in Emergency Situations

Even in emergency situations, steps can be taken to lessen a child's anxiety and to facilitate the transfer of attachment to a new caregiver.

(1) The child is to be encouraged to take a familiar item to the new home.

(2) Every effort is to be made to ensure that siblings are placed together whenever possible.

NOTE: See subsection 710.4 for a full discussion of policy regarding preserving the sibling bond in placement.

(3) As much information as is appropriate for the child's age is to be shared with the child.

(4) Information regarding the home or institution to which the child is being taken is to be shared.

(5) The family case manager is to outline anticipated procedures affecting the child and the legal family, including time factors.

403.22 Preparation in Non-Emergency Situations

In non-emergency situations, whenever possible, the child is to be prepared by one or more pre-placement visits to the proposed new residence. Pre-placement visits are an especially important element in the ultimate success of placements in foster homes, residential child caring facilities and group homes. This process affords the child the opportunity to become more familiar with the new setting and routine prior to placement, thus enabling the child to cope more successfully with the change. If possible, it is beneficial to enlist the cooperation of the birth parents to accompany the child at least to the initial visit. Such participation on the part of the parents serves to encourage the child to form a positive attachment to the new caregiver. The pre-placement visit also helps the new caregiver by giving that person an opportunity to become acquainted with the child before the child establishes residence. It is also an opportunity for the former and new caregivers to become acquainted and to form the groundwork for sound rapport and cooperation in future visitations.

403.3 Placement Policy/Procedures

The following is information regarding general out-of-home placement policy and procedures as well as procedures for placing children in out-of-county and out-of-state facilities.

403.31 General Information

For placement in any type of substitute care (i.e., a relative home, foster family home, group home, or child caring institution), the following areas are to be defined clearly and understood by the COFC and the person(s) who is responsible for the care of the child:

(1) Case plan. (See subsection 306.62 for case plan requirements.)

(2) The role of the family case manager, relative caregiver and other members of the treatment team in the implementation of the case plan.

(3) Financial responsibilities.

(4) Frequency and conditions of parental visitation.

(5) Case review requirements.

(6) Time-limited goals of placement.

(7) The child's special needs and functioning in previous placements.

When the determination is made that a group home or institution would best meet the needs of the child, the COFC is to contact the director of the child caring facility to make application.

403.32 Non-Discrimination in Placement Decisions

All recommendations regarding placements in foster care will be made to achieve permanency and on the basis of the child’s specific needs and best interests and the ability of the caregiver(s) to provide the resources necessary to meet the child’s needs. No placement in out-of-home care will be delayed or denied on the basis of race, color, or national origin of the caregiver(s) or the child in need of placement.

403.33 Preserving the Sibling Bond in Placement

Indiana recognizes the importance of the bond that exists between siblings, especially when they are taken into care and are separated from their primary caregivers. The bond between siblings is often the longest lasting relationship most people have, and these bonds help children develop their own unique personal identity throughout their lifetime. It is the responsibility of the DFC to maintain this sibling bond throughout the child's involvement with the agency whenever possible. This includes the time from the point at which the child is taken into care by the agency until after a permanency plan is developed and implemented.

403.331 The Importance of Placing Siblings Together

Biological siblings share the same genetic makeup. This becomes very important as children move into foster and adoptive families where they differ in appearance, medical predisposition, talents, and intellectual capabilities. When placed with siblings, they are less likely to feel isolated. Biological siblings share past experiences and family history. When children from dysfunctional families are placed in substitute care, a sibling is the only other person who knows how things were in the family of origin and the subsequent history of foster placement. Children need to integrate their past with their future in order to have continuity and to develop a clear understanding of their identity.

It is often difficult to find foster families who are able and willing to accept large siblings groups. It is the responsibility of the COFC to develop foster home resources sufficient to meet the needs of large sibling groups. Often, there is a tendency to place siblings separately in foster and adoptive homes. There are, in fact, many families who are willing to foster or adopt groups of four or more children. It is the responsibility of the COFC to ensure recruitment and retention of these homes. Facilitating sibling placements might entail issuing a provisional license or waiver to accommodate an increased number of children in a home or searching for foster homes or facilities in other counties that will accommodate larger sibling groups. Again, it is the responsibility of each COFC to recruit and maintain families that are willing to foster or adopt sibling groups.

Children coming into care typically have troubled backgrounds, and this may result in moderate to severe behavior problems. When a sibling is removed from a home because of behavior problems, the remaining children may feel that the same thing can happen to them. This reduces their sense of trust in their caregivers.

Siblings are often separated when one is victimizing another. Separating the siblings does not guarantee that the abuse will not continue in another home. Therapy, with a safety plan in place, may be an appropriate

intervention. In all instances, these circumstances are to be brought to the attention of the court.

The complex bonds linking brothers and sisters are universal and among the most important in life. They become even more important as we age. In the final analysis, sometimes sibling relationships may be all that remain of the family of origin after foster care placement. For siblings, these relationships form the blueprint for later relationships with peers, friends, marriage partners, and their own children. Siblings who remain together learn how to resolve their differences and develop strong relationships.

403.332 Policy Regarding Placing Siblings Together in Out-of-Home Care

The reasons for siblings being separated when placed in out-of-home care are many and varied. However, the policy of the Division of Family and Children with regard to the placement of siblings in out-of-home care is as follows:

In the absence of a strong reason to the contrary, groups of siblings are to be placed together whenever possible in order to maintain existing ties and supports and to minimize the degree of loss to the children. Therefore, it is Division policy that children who are not initially placed together have contact within 48 hours of placement, excluding weekends and holidays. It is also the policy that children are to be placed together within 10 working days. An exception to this policy would occur when one of the children is in residential placement, hospitalized, or in a juvenile detention center. Nevertheless, efforts are to be made for children to have ongoing contact.

While it is often not possible to place siblings together immediately when they are taken into care, it is important that siblings be reunited as soon as possible. The same policy is to apply when additional siblings are taken into substitute care at a later date. When children from the same family are wards in two or more different counties, it is the responsibility of the directors of those counties to initiate a visitation plan and facilitate placement together.

If parental rights are terminated on a child or the permanency plan for a child is adoption, and if the child's sibling(s) is in a pre-adoptive placement, the family who has the sibling is to be approached about accepting the other sibling(s). In the event of previously finalized adoptions, the adoptive parents of those children are to be approached regarding the placement of new siblings free for adoption. The emphasis continues to be on the child's essential connections and respecting the power of those connections in achieving a successful adoption for the child.

403.333 The Decision to Separate Siblings

Separation of siblings requires as careful consideration as severing parent-child attachments. Any decision to separate siblings before, during, or after placement must be handled as an exception to policy.

The following guidelines are to be followed:

(1) Keep the focus on the best interests of the child and on permanency.

(2) Never make the decision alone. Include the court, current and former caregivers such as foster parents, therapists, supervisors, counselors, guardians ad litem (GALs), court appointed special advocates (CASAs) and any others who have played an important role in the child's life.

(3) Consider the child's wishes as part of the decision-making process.

(4) Document all of the reasons for and against separating the children. Making a list will force an examination of the pros and cons. Provide clear documentation of the circumstances leading up to the decision.

(5) Special attention must be given to any sibling relationships known and remembered; and even unacknowledged ones are to be explored in terms of their later developmental impact on children in care.

(6) If separation is necessary, efforts are to be made to help all the children involved understand and grieve for the loss.

(7) The plan to separate is to be supported by a specific, concrete plan for future contacts between the children.

403.34 Out-of-County Placements

Whenever possible, placement is to be within the county having responsibility for the child. The COFC is to have a sufficient number of licensed foster homes to accommodate the number of children in the county who are in need of this type of placement. Nevertheless, it may be necessary to use an out-of-county resource. Out-of-county placement resources are subject to the same Central Office requirements regarding licensing and service delivery as those within the county. If the out-of-county placement is more restrictive than the environment that the child is currently in, the local coordinating committee may review the placement if the referring agency convenes a meeting concerning the proposed placement. See IC 31-38.

If the county in which the child resides is in need of an out-of-county foster home, assistance in locating such a home may be obtained from other county offices of family and children (COFCs) and child placing agencies. If a prospective foster parent contacts the local office in the foster parent's county of residence with a request to provide care for a child in another county, the local office receiving the request is to notify the COFC in the child's county of residence of the inquiry. If an

out-of-county resident directly contacts the COFC in the child's resident county and expresses interest in providing care for the child, that county office must contact the COFC in the county of the applicant's residence to secure permission to use the home. Use of the home is inappropriate if the local office in the applicant's resident county recommends the home not be used. The COFC placing the child is responsible to set the appropriate per diem based on the child's needs. Refer to subsection 615 for further information regarding the use of out-of-county homes.

NOTE: Family case managers are to document information regarding out-of-county placements on the Restrictive Placement screen that is accessed from the Placement Details screen.

403.35 Out-of-State Placements

See Section 5 of this Manual.

403.4 Special Considerations Regarding Foster Family Home Care

The following subsections contain policies concerning issues that are specific to foster family home care:

403.41 Personal Characteristics to Look for when Assessing Potential Foster Parents

Foster parents are to be persons who:

(1) care about others and respond appropriately;

(2) enjoy being parents;

(3) are able to give affection and care to a child without expecting immediate returns;

(4) demonstrate flexibility in their expectations, attitudes, and behavior in relation to the age, needs, and problems of children, as well as an ability to use help when needed to address problems of family living;

(5) have sufficient energy, mental and physical stamina, and patience to cope with the demands of a child who is experiencing the loss of a parent and the insecurity of a new living arrangement;

(6) are able to acknowledge the child's relationship with the child's parents and with the agency;

(7) have worked out satisfactory and stable adult relationships, are comfortable with their own sexual identity, and are able to model and exemplify stable adult relationships;

(8) are able to identify and handle strong feelings, including anger, depression, and loss;

(9) are able to maintain meaningful, positive relationships with members of their own families and with persons outside the family;

(10) are emotionally stable and able to function adequately in relation to family responsibilities and employment, as indicated both currently and in the history of the family;

(11) have reputable characters, values, and ethical standards conducive to the well-being of a child; and

(12) are able to accept the temporary nature of foster care and assist the Division in permanency planning for a safe, secure permanent future for the child.

403.42 Responsibilities of the Foster Parent

The following constitutes a breakdown of the responsibilities that individuals assume when they become foster parents:

(1) General responsibilities include:

(a) giving love, acceptance, and care to a child without expecting a demonstration of appreciation from the child;
(b) providing the child with opportunities for normal growth and development;
(c) assisting in preparing the child for reunification or permanent placement;
(d) maintaining confidentiality as it relates both to the child and the child's family;
(e) encouraging the child toward independence and self-reliance in age-appropriate ways;
(f) providing input into the child's case plan and needs.

(2) Responsibilities to the child include:

(a) providing a safe and warm environment;
(b) modeling adequate parenting skills and demonstrating healthy behavior;
(c) making a commitment to keep a child for a planned period of time;
(d) providing understanding and emotional support to the child as it relates to the separation trauma the child is experiencing;
(e) giving support related to: school and academic achievement, extra-curricular activities, church and religious involvement, and arranging or providing for transportation needed to be a part of these community activities.

(3) Responsibilities to the foster child's legal parents include:

(a) presenting a positive image of the legal parents to the child;
(b) cooperating with visitation between the child and the child's legal parents;
(c) being a temporary substitute, but not a replacement, for the child's legal parents.

(4) Responsibilities to the agency include:

(a) complying with the general supervision and direction of the agency concerning the care of the child;
(b) helping in establishing a case plan and then working to implement the plan;
(c) keeping records of important issues related to medical, school, social, and family matters that would be of interest to the agency;
(d) being willing to cooperate with community support services that may be available;
(e) participating both in pre-service and in-service training as determined by the agency.

(5) Additional personal responsibilities include:

(a) being aware of community support and resources to meet both personal and social needs;
(b) being aware of local, state and national support groups;
(c) knowing oneself and being aware of personal strengths and limitations;
(d) using respite care, family support or day care as a means of reducing long-term stress.

403.43 Responsibilities of the Division

The following constitutes the responsibilities the Division assumes when placing a child in a foster home.

(1) Reasonably assist the foster parents in securing and maintaining their foster care license issued by the Division of Family and Children, including the provision of required training, while treating the foster parents with respect and appreciation.

(2) Provide a copy of current licensing rules of the Division and written guidelines of the COFC or LCPA and ensure compliance with the written requirements as they apply to foster care.

(3) Provide an explanation of the Division's policies on discipline, matching, foster parent role, visitation and the Division's role and responsibility.

(4) Provide an explanation of the Division's case conferencing policy which operates on the basis of shared and clarified information between the COFC and foster parents and requires the involvement of the foster parents in case plan development and change. This policy also includes a methodology for resolving conflicts between foster parents and the COFC. See subsection 403.47.

(5) Provide foster parents with the names and phone numbers of foster care family case managers and a copy of the Division or LCPA policies and procedures related to notification, including a plan for emergency "after hours" contact.

(6) Provide information, education and training on cultural awareness and promote cultural and minority sensitivity.

(7) Provide information regarding a child's religious preference.

(8) Provide foster care per diem, clothing allowance and necessary dental and medical expenses including eye care and arrange any other special medical or psychological services.

(9) Secure the proper authorizations for the administering of any non-emergency treatment to the child, and consult with and assist the foster parents in providing treatment or referring them to an appropriate service provider.

(10) Provide an allowance for education needs including tuition, supplies, rental fees and any approved fees for supplemental education. This may or may not be a part of the per diem to the foster home. County expenditures are limited to education in public accredited schools.

(11) Develop a case plan for each individual child in foster care, seeking input from the parents, child, and foster parents. The plan is to be shared with the foster parents so that they are familiar with the case goals and specific needs of each child placed in the foster home.

(12) Provide a copy of SF 2956 Case Plan, which defines appropriate foster care for the individual foster child related to such aspects of foster care as discipline and visitation.

(13) Assist in arranging visitation, and encourage communication between the foster children and their parents or other individuals. The COFC will provide such notice as is proper to the foster parents under the circumstances.

(14) Monitor and supervise the implementation of the case plan, making face-to-face contact at least once every two (2) months with the child and the foster parents or more often as the case dictates.

(15) Consider input from foster parents and other appropriate persons, and make final decisions concerning the care and well-being of foster children, within the legal framework established for the Division.

403.44 Role of the Division

The agency role in the placement of children in foster family care is multi-faceted. The legal relationship the Division has is sanctioned by the juvenile court relative to the foster child and by the Indiana statute governing the licensing of foster family homes relative to the foster parents. Beyond the legal role/relationship, the agency staff must facilitate a team effort with the child's parents, foster parents and service providers to meet the needs of the foster child and provide a permanent plan for the foster child relative to all service programs.

The team approach requires agency staff to ensure that communication among team members remains open and that information sharing will result in a well thought out plan that ensures a family-centered, child-focused approach to family service delivery. See subsections 403.452 and 403.46 for additional information concerning conflict resolution among foster care team members.

403.45 Role of the Foster Parent

Foster parents play multiple roles relative to placement issues. The following constitutes a delineation of those roles:

403.451 As a Team Member

Foster parenting is the provision of a substitute family for a child who has to be separated from the legal parents. Such a placement is temporary and is planned to encompass a specific period of time. If reunification with a child's own family is not possible within prescribed time frames, foster families provide care to the child in transition who is preparing for a new permanent family.

Foster parenting involves two simultaneous roles: parenting and substitute parenting. The parenting tasks require general child care, which any birth parent would provide. The substitute parenting tasks require a commitment to permanency planning, and involve working in partnership with the agency, court, legal parents, and adoptive parents.

Foster parents enter into a partnership with the COFC staff to be part of a team that will work together to develop a permanency plan for each child. The dictionary defines teamwork as the "cooperative effort of an organized group to achieve a common goal." As applied to foster care, the team's goal is the protection of children while developing and implementing a plan for permanency.

The team approach requires the cooperation of members who have interdependent skills and differentiated knowledge. It encourages the development of individual expertise and provides more points of view upon which to base sound decisions. Difficulties arise when there is a lack of commitment to or clarity about the goal and when overlapping tasks create confusion. "For the team process to work effectively, it is crucial for team members to know each other and develop ongoing relationships which foster trust and mutual respect. Since members must make difficult decisions, it is important that they understand each other's personal and professional perspectives. Members must also be able to define and articulate their professional role on the team". (Ziefert and Faller, 1981).

403.452 In Reunification

The option of choice for permanency for the child is reunification with the child's legal parents when it is believed to be in the best interests of the child and when it provides protection for the child. While child welfare services are focused on the family as a unit, the primary concern is the best interests, health and safety of the child. When reunification is the goal, the role of the foster parent involves a partnership between the Division and the foster parent to the extent that the foster parent is a contributing member of the child welfare treatment team. With appropriate training, encouragement, and support, foster families can become a substantial resource in enabling the child's parents to resume their legal responsibilities to the child and in fostering the return of the

child to the legal family. Rather than competing with legal families for the child's affection, foster parents are to be a source of emotional support for the legal family, a model of healthy family relationships, and a source of parenting expertise.

The foster family's concern and support for a child's family increases the legal family's self-esteem, reinforces their efforts toward return of the child, and models specific behaviors. Perhaps most importantly, cooperation between legal and foster families provides a more consistent emotional environment for the child that tends to eliminate situations that confuse the child as to whom the child should love or with whom the child should identify.

(1) Tasks

There are several tasks that foster parents are to keep in mind when working with the legal family. They are:

(a) maintaining confidentiality of case information;
(b) respecting the legal parents and their right to their child;
(c) understanding the importance of the legal family to the child;
(d) cooperating in carrying through with visitation plans;
(e) cooperating with the worker and other team members;
(f) understanding the dynamics of loss and separation as it pertains to the child and the legal parents;
(g) maintaining knowledge of community resources.

(2) Specific activities

Specific activities related to the foster parent's role in working with the child's legal parents include:

(a) teaching or modeling appropriate behavior and parenting skills;
(b) sharing in decision-making with the legal parent and the agency;
(c) including legal parents in special events such as school conferences, birthdays, holidays, as appropriate;
(d) helping the child find ways to express love to the legal family (gifts, writing letters);
(e) seeking information from the legal parent regarding the child's progress in reconnecting with the legal parent;
(f) maintaining active communication with the family case manager;
(g) assisting in planning visitation, including planning for transportation for the child;
(h) facilitating an atmosphere conducive to quality visits and suggesting visitation activities which are related to the child's developmental age (Legal parents should be encouraged to become involved in child care tasks.);
(i) attending permanency planning meetings;

(j) documenting progress and significant events involving the legal parent-child relationship.

403.453 In Adoption

Each child is to have a permanent family in which to grow up. When that family cannot be the child's parents, adoption by relatives or non-related persons is the preferred plan, since adoption gives the child a new set of legal parents. The following information defines the tasks of the foster parents based upon the assumption that the foster parents are not interested in adopting the child in their care.

(1) Tasks

The foster parent's tasks relative to adoption include:

(a) working cooperatively with the agency to identify potential adoptive parents who can meet the child's needs in the best possible way (This statement assumes that the foster parents have chosen not to attempt to adopt the child in their care.);
(b) helping prepare the child for this very important change in the child's life.

(2) Specific activities

Specific activities related to the foster parent's role in adoption include:

(a) working cooperatively with the family case manager to explain to and discuss with the child what adoption means;
(b) listening to the child's feelings (fears, anger, uncertainties) about what is going to happen to the child;
(c) being honest in telling the child why the foster parent cannot adopt the child and listening to the child's feelings about that;
(d) preparing the child for the possibility of being photographed or of talking with new family case managers who will be helping to find the right family for the child;
(e) giving complete and accurate information to the family case manager so that the family case manager can provide accurate information about the child and find the best home for the child;
(f) assisting the family case manager in planning visits with potential adoptive families and preparing the child for these visits in cooperation with the family case manager;
(g) watching the child's reactions and behaviors; being patient and sympathetic with the child during this difficult time, and continuously providing information to the family case manager regarding the child's feelings, reactions, and behaviors;
(h) finding someone to help with personal feelings as the child leaves;

(i) giving the child permission to become attached to adoptive parents and sharing information and experiences related to the child's placement in the foster family home with the adoptive parents;
(j) helping the child prepare for visits with birth family/siblings to say good-bye, in cooperation with the family case manager;
(k) preparing or helping the child prepare the child's belongings, life book, and important papers to make the move to the adoptive home (See subsection 404.51 for additional information regarding life books.);
(l) cooperating with the agency and adoptive parents as agreed following the placement of the child.

403.454 In Providing Independent Living Skills

Older foster children eventually come to the point when they must move out of their protective foster family environment and make it on their own. This usually occurs at age 18, unless they are allowed to remain in foster care for educational purposes or because they have a disability. If they have not been prepared, formally and informally, they will not survive in a productive manner. Foster families must be a part of the process that teaches as many independent living skills as possible to each child, regardless of whether the child will return home or choose to live independently. See subsection 404.4 for more detailed information regarding independent living services.

Foster families must work with the agency to provide formal or informal training in independent living, and they must be aware of the issues that face each child when the time comes for the child to leave the home.

(1) Tasks for All Foster Parents

The tasks of foster parents of any foster child relative to independent living include:

(a) understanding the importance of each child's case plan as it pertains to independent living;
(b) having a basic understanding of child development;
(c) working with the family case manager or service provider to assess the child's daily living skills;
(d) working with the family case manager or service provider to establish goals for daily living skills; i.e., chores, personal care, independent living skills.

(2) Tasks for Foster Parents of an Adolescent

The tasks for foster parents of an adolescent foster child relative to independent living include:

(a) performing all tasks listed in (1) above; and

(b) advocating for the child to receive formal services for independent living;
(c) taking advantage of opportunities to learn about issues in independent living, what the child's needs are, and what independent living programs are available;
(d) being aware of community resources for the child; i.e., church, school, government, and community agencies;
(e) helping the child to build support systems; i.e., friends, family, college, military service, community groups;
(f) allowing the child to verbalize positive and negative feelings about leaving. The child may resist services to emancipate.

(3) Specific activities

Teaching independent living skills must be a process that is implemented for all youths in substitute care, regardless of their possible future living arrangements. Independent living skills can be divided into tangible and intangible skills as listed below:

TANGIBLE SKILLS	INTANGIBLE SKILLS
Educational skills	Decision-making
Vocational skills	Problem-solving
Job search skills	Planning
Money management skills	Communication skills
Home management skills	Interpersonal relationships
Consumer skills	Time management
(taxes, insurance)	Self-esteem
Community resources	Confronting losses, anger, rejection
Transportation	Social skills
Health care	Emotional preparation for transition to independent living
Understanding laws	
Obtaining housing	

403.46 Placement Disruptions

Disruption in a child's placement must be considered carefully, because it has the potential to jeopardize the child's capacity to trust the environment, including the adults around the child. Disruption can have serious negative consequences for the child's sense of security and self-worth. The decision-making process must include not only an evaluation of the factor(s) immediately precipitating the planned move, but also an analysis of the historical overview of both the child and the foster family. The specific issues that are to be addressed are:

(1) the age of the child and the child's capacity to understand the reasons for the removal;

(2) the emotional connections between the child and the foster parents;

(3) the length of time that the child has resided in the current placement;

(4) the number of prior placements;

(5) the child's ability to reattach and to adjust to a new environment;

(6) the availability of a suitable alternate placement and the risk of future disruptions;

(7) the child's concept of the child's own essential connections;

(8) Child Protection Services intervention;

(9) the foster family's history with the agency as it relates to cooperation and the ability to endure/resolve problems, and the family's history with other foster children;

(10) any mitigating factors in the foster family home which contributed to an isolated incident or deteriorating conditions such as temporary over-crowding, stress, medical or financial problems, physical and dependency needs of young children, severe behavior problems of birth or foster children, or the inappropriateness of the placement;

(11) the availability of support services to the foster family; i.e., homemaker, child care, respite care, and counseling services;

(12) the willingness of the foster family and child to join with the COFC in developing and implementing a corrective action plan;

(13) the child's personal view of why disruption is needed or desired;

(14) whether the removal is an emergency or non-emergency.

403.461 Types of Removal

Despite our best efforts to avoid it, removal of a child from a foster family home for reasons other than the reunification of the foster child with the legal family, adoption, or implementation of another permanency plan sometimes becomes necessary. The following delineates procedures to be used in various types of removal.

403.4611 Emergency Removals

Although, legally, the COFC family case manager may remove a foster child with or without the foster parents' consent, it is advisable for the family case manager to make every effort to secure the cooperation of that foster parent. See subsections 403.462 and 403.47 below for more information regarding resolving disagreements between the COFC and foster parents. However, a child must sometimes be removed from a foster home on an emergency basis due to the inability of the COFC to ensure the safety and well-being of the child. The need to ensure

safety and well-being supersedes reaching consensus with the foster parents. If the foster parents attempt to physically prevent a child's removal, the family case manager is to request the assistance of law enforcement or obtain a court order if necessary.

403.4612 Non-Emergency Removals

In some instances, foster parents may decide that circumstances call for a cessation in participation in the foster parent program or that they are no longer able to meet the needs of a particular foster child. Therefore, they request removal of the child(ren) on a non-emergency basis.

In other instances, the COFC may determine that while the child is not at imminent risk, the best interests of the child might be better served through a change in placement. The factors listed below may influence such a determination.

(1) There is clear evidence that:

(a) the foster family ostracizes or segregates the foster child from normal foster family activity, despite attempts to encourage change.
(b) the foster family continues to make inappropriate or derogatory remarks about the child or about the child's family, despite repeated attempts by COFC to encourage the family to express more positive attitudes.
(c) the foster parent continues to use ridicule, threats, rejection, or other words or actions, such as breaches of confidentiality, which are emotionally damaging to the child, despite repeated attempts by the COFC to encourage the foster parent to treat the child more appropriately.
(d) the foster parent has demonstrated a pattern of interfering with or subverting the goals of the case plan.
(e) the foster parent has a pattern of violating agency policy, despite attempts by the COFC to encourage compliance with policy.

(2) The foster parent disagrees with the case plan and pursues an independently developed case plan without first attempting to resolve the disagreement with the COFC through more appropriate channels.

(3) The foster parent and the COFC have determined that the placement is not in the best interests of the foster child or the foster family. However, the foster family has not given the COFC the requisite two (2)

weeks notice prior to the child's removal. This would classify the removal as a non-emergency, unless the foster parent feels that conditions require the child's immediate removal or unless the court orders emergency removal.

Requests for non-emergency removals may be initiated by the foster parent or by the child. Procedures for each situation are outlined below:

(1) Non-Emergency Removals - Foster Parent's Request

Two (2) weeks notice must be given to the Division by the foster parents prior to any removal. Such notice is critical to ensure adequate opportunity to make suitable alternate arrangements for the child. No request by the foster parents for a child's removal is to be dismissed from attention, even if the foster parents change their minds and decide to keep the child. The request to remove the child may be a signal that the family has problems and that services should be considered.

Whenever foster parents request that a child in their home be removed, the family case manager must determine the reasons for the request. The family case manager must note in the contact log those reasons that have been cited by the foster parents as causing the placement change request. The child's level of understanding, reaction, and desires should also be noted in the contact log. This information, whether or not a placement disrupts can be useful in developing a foster care plan for the foster placement, as well as providing information that is useful in the ongoing life book process. See subsection 404.51 regarding life books. Based on the foster parents' explanation, the family case manager may suggest appropriate support measures such as therapy, respite care, child care, temporary homemaker services, or emergency financial assistance that might ameliorate some of the presented problems.

The family case manager is to schedule a personal meeting with the foster parents to further discuss the potential disruption. If the foster parents remain firm in the desire to have the child removed, the family case manager is to initiate a change of placement request with the foster care case manager within one (1) working day. Also the family case manager is to schedule a meeting with the foster parents and child to discuss the placement change, family issues, the

child's reaction to and understanding of the move and the future emotional/psychological implications of the move to the child.

There are some occasions when a child must be removed from a foster home as soon as possible, despite the agreement to provide two weeks notice for a removal. The following occasions may require earlier removal:

(a) The child is believed to be at risk of serious physical or emotional harm if allowed to remain in the foster home, whether or not the belief is based upon Child Protection Service intervention.
(b) The foster family is, or perceives itself to be, at risk or harm if the child is allowed to remain in the foster home.
(c) The foster family has experienced a personal emergency and is unable to make alternative plans for the child.

Procedures for Foster Parent Requested Removal

Responsibility : Action Required

Foster Parents: Tell family case manager that they want child removed and why.

Family Case Manager: Explore services with foster parents that might alleviate need for a placement change.

Schedule home visit to discuss move with child, if child is at age of understanding, giving consideration to child's mental capabilities and mental health. Also discuss move with foster parents.

Schedule date for child's anticipated removal, if foster parents see no other way to help maintain the placement (two weeks notice).

Initiate placement change; give information to foster care placement case manager, if applicable.

Family Case Manager and Foster Parent: Help child resolve any feelings about the move.

Foster Parent: Give child photo of foster family and of child in their home and any other items or information for life book.

Go through child's clothing list to see if clothing still fits and is in good condition.

Send all personal belongings, including clothing, with the child.

(2) Non-Emergency Removals - Child's Request

A request by any child to leave a foster home placement must be considered very seriously. However, a child who indicates discomfort in a particular foster home may, in fact, be talking about other, more critical issues. When the family case manager discusses a requested move, the following possibilities are to be considered:

(a) The child's request may be attributable to the stage of placement.
(b) There are underlying problems in the foster placement about which the child feels uncomfortable verbalizing, such as sexual abuse, physical abuse, neglect, harassment, emotional abuse or neglect, sibling problems or prejudicial treatment.
(c) The child believes that a disruption of the foster family home placement may result in a return to the birth parent or a return to a former family to whom the child feels attached.
(d) The child has had a recent disagreement with a member of the foster family, and the request is reactionary.
(e) The foster child is intimidated, harmed by, or in some way disturbed by the physical environment, including neighborhood, home, or school and does not know how to deal with the difficulty.
(f) The child has a history of frequent moves and resists any family with whom an attachment might be formed.

The family case manager is to determine through a personal interview if there are any underlying reasons for the child's request to leave the foster home. If the child requests that the information conveyed during the interview be kept confidential, the family case manager is to make a decision based on both respect for the child's right to privacy and

any need or requirement to share the information. In some instances, the child is to be advised that the problem cannot be resolved if the confidence is kept.

If the family case manager suspects that the child may be at risk, the child is to be removed immediately. If the child does not appear to be at risk, the child is informed that a decision about removal will be made within five (5) working days. The family case manager must respond with a decision directly to the child and not via any other member of the foster family. It is essential to encourage the child to engage in open, forthright conversation with the foster parents to resolve problems. The family case manager may need to facilitate this discussion.

The family case manager must first discuss every removal requested by a child with the family case manager's supervisor, the foster parents, and the guardian ad litem (GAL) or court appointed special advocate (CASA), if one has been appointed, prior to making any decision unless emergency removal is warranted. The family case manager is to record in the child's case record the results of the interview with the child, other consultations, and the final determination. If the decision is to remove the child, the family case manager initiates the removal process. Otherwise, the family case manager is to explain the decision to the child and attempt to resolve the child's difficulty. If the child remains adamant about leaving, the child may request a conference with the family case manager, supervisor, and the CASA representative. However, the child must agree to continue in the current foster home pending the conference. The child may withdraw the request for conference at any time. The conference is to be scheduled within 10 business days, and all parties are to be advised of the conference; i.e., the family case manager, the family case manager's supervisor, and the CASA representative.

Procedures for Child Requested Removal

Responsibility / Action Required

Child: Advise family case manager of desire to make a change in placement.

Family Case Manager: Respond to any request by the child for confidentiality, either indicating that the

confidence can be kept or that the resolution of the problem requires that information be shared.

Attempt to assess the underlying causes of the child's request to move.

If the child appears to be at serious risk of abuse or neglect, the child is to be removed immediately. See subsection 403.21. If there appears to be no immediate need to remove the child from the foster family home, discuss child's request with the supervisor and the foster parents to determine whether removal is in the child's best interests.

Encourage child to talk to foster parents regarding problem.

Help child resolve any feelings about the move.

Request a conference with case manager, supervisor, GAL/CASA representative and foster parents, if advisable.

Foster Parents: Help child resolve any feelings about the move.

Give child photos of foster family and of child in their home as well as other personal items or information for life book.

Go through child's clothing list to see if clothing still fits and is in good condition.

Send all personal belongings, including clothing, with the child.

403.462 Disagreement with Removal or Proposed Removal

In all instances, the primary responsibility of the COFC is to ensure the safety of the child and to promote the child's best interests. For non-emergency removal decisions, it is incumbent upon all of the principals, current caregivers, and appropriate agency representatives to try to resolve disagreements prior to removal and before a court hearing. However, there are times when a child must be removed without first obtaining consensus between the COFC and the foster parents regarding the move. Nevertheless, an attempt must be made to resolve outstanding issues to the extent possible.

403.47 Enhancing Communication with Foster Parents

It is the goal of the Division and foster parents to ensure the safety of the child in out-of-home care while developing a permanency plan. When the safety of the child is

felt to be at risk, the usual process for investigating all allegations of abuse or neglect will be followed. Any child protection service (CPS) ruling will take precedence over any attempt to reach consensus with foster parents regarding decisions made during the CPS investigative process. In addition, decisions of the court will supersede any and all other agreements made by any other parties.

In all situations other than those defined above, it is important to achieve consensus, if at all possible, between DFC and foster parents for the benefit of the child's well-being. In a continuing effort to enhance the working relationship between the DFC and foster parents, the policy directive outlined below is to be followed. It is designed to identify those occasions when the input and participation of the foster parents are expected and required for the purpose of establishing consensus on what is in the best interest of the children in care. The DFC and foster parents, working together, can build and support a safe environment in which information will be shared and valued.

403.471 <u>At the Local Level (Case Conferencing)</u>

Foster parents and family case managers are to work together on the basis of shared information, adequately clarified for all parties, as far in advance as possible. This is especially important with regard to anticipated changes in placement. Foster parents are to be included in the development and changing of the case plans for the children in their care.

Foster parents must first try to resolve issues by discussing them with the appropriate family case manager. Issues involving parenting or licensing practice are to be discussed with the foster family's licensing case manager. See Section 6-Licensing for further information. Issues involving the foster child's case plan or removal from the foster family home are to be discussed with the child's family case manager.

If the foster parent does not agree with the family case manager's response to the issues, the foster parent may contact the family case manager's supervisor. If the foster parent is not satisfied with the supervisor's response, the foster parent may contact the COFC director. The foster parents may contact a representative of the Indiana Foster Care and Adoption Association, Inc. (IFCAA) and/or another foster parent or foster care provider to attend this meeting. Such a representative is to be available to the foster parent as a source of consultation and advice, if requested. The child's family case manager and/or the licensing family case manager may also attend.

If, after following these steps, issues remain unresolved, a formal case conference is to be convened. However, if the unresolved issue is removal of the child from the foster family home and the safety of the child is at risk, removal is to occur prior to a case conference. As previously stated, if the safety of the child is felt to be at risk, the usual process for all allegations of abuse or neglect is to be followed; and any CPS ruling will take precedence over any attempt to reach consensus between the COFC and foster parents. Court rulings also supersede consensus-building endeavors. A case conference is <u>not</u> required if the

foster parents and COFC staff are in agreement about the placement and removal of a child.

The COFC, foster parents, or guardian ad litem (GAL)/court appointed special advocate (CASA) may request a case conference. The staff of the COFC is to arrange the conference and notify parties of the meeting within five (5) working days following the request for a conference. The case conference is to convene within 10 days and is to be held in the COFC or other location agreed upon by the parties.

The core group of the case conference is to include such COFC staff as the family case manager or supervisor, and foster parents, legal parents/legal guardians, the GAL or CASA; and the child, if appropriate. In addition, teachers, counselors, and other persons having knowledge or relevant concerns regarding the situation under consideration may be invited to attend by any member of the core group.

An informal case conference may be held when it is not practical to convene the entire committee. This may be done by phone or with individual meetings. However, each person on the committee must be contacted; and the contacts and recommendations must be documented by the family case manager in the contact log. An informal case conference may not be utilized when developing or changing the case plan or when there is disagreement about the removal of a child from a foster home.

NOTE: If at any time any member of this core group feels that the policy of the Division is not being followed, the director of the COFC is to be contacted. If the foster parent is still concerned that policy is not being followed, the Central Office of the Division of Family and Children Foster Care Consultant is to be contacted at (317) 232-7116. This contact may be made either by the foster parents or the Indiana Foster Care and Adoption Association (IFCAA) representing the foster parents.

If the core group cannot reach consensus concerning a recommendation to the court, the COFC director will review the case and try to bring the group to consensus. If the foster parents are still not in agreement with the decision, the matter can be taken through the Communication Enhancement Procedure. See subsection 403.472 below.

403.472 At the Regional Level (Communication Enhancement Procedure)

In building a foster care team, it is essential that there be viable communication between foster parents and the county office of family and children (COFC) staff. However, there will be times when conflicts or disagreements arise between these parties that cannot be resolved at the local level.

If the issue cannot be resolved at the local level, the foster parent is to request a review of the issue by the Regional Communication Enhancement Procedure Committee (RCEPC). This request shall be in

writing and addressed to the Regional Manager or designee (name and address to be provided by the county office director).

A Regional Foster Care Communication Enhancement Procedure Committee is to be comprised of the following persons:

(1) the COFC director or designee;

(2) a family case manager or supervisor;

(3) two (2) licensed and/or approved foster parents; and

(4) a community representative.

The director and the family case manager or supervisor, when practical, are not to be from the same COFC, and the foster parents are not to be licensed and/or approved through the same COFC. The community member may be a member of the Local Coordinating Committee or local Child Protection Team but is not to be a current or former agency staff person or foster parent. However, this member is to be knowledgeable regarding child welfare and foster care issues. The regional manager shall appoint all members of the RCEPC.

All members of the RCEPC must be willing and able to commit a minimum of one (1) year to serve on this committee. The regional manager (or designee) shall assess the RCEPC membership annually regarding effectiveness and continuing membership. Each RCEPC is to be available to meet on a monthly basis.

Upon receipt of a written request from a foster parent for review by the RCEPC, the regional manager is responsible for convening a meeting of that committee. If the issue for review concerns the placement or removal of a child in the foster home, the RCEPC must meet within 10 working days of receipt of the written request. All other reviews must be held no later than 30 days after receipt of the written request. The regular communication enhancement procedure will be utilized and adhered to as outlined in the Foster Family Handbook.

The foster parent may wish to be accompanied by another foster parent when attending this review. A member of the Indiana Foster Care and Adoption Association, Inc. may be available, if requested, for support and advice. The director of the county office of family and children will determine who presents the Division's information.

A majority vote of the members of the RCEPC shall constitute the decision of the Committee. If the RCEPC is unable to reach a majority decision, the regional manager shall cast the deciding vote. The majority decision of the RCEPC shall be final and binding on the Division and the foster parent. If the regional manager casts the deciding vote, that decision shall be final and binding on the Division and the foster parent.

Appropriate issues for the RCEPC to review include, but are not limited to the following:

(1) Differences in interpretation regarding placement and child caring issues between family case managers within the agency.

(2) Lack of use of the foster home for placement by the licensing agency.

(3) The involvement of foster parents in the choice of child(ren) placed in the foster home.

(4) Access to and availability of the family case manager.

(5) Removal of the child from the foster home, except by court order.

(6) Conflicts, difficulties, or differences between foster parent and family case manager.

(7) Implementation or interpretation of licensing practices.

(8) Involvement in the development of the case plan for the child.

(9) Failure of the agency to reassess the request for a special needs per diem for the care of a child requiring extraordinary care, as defined by the county having wardship of the child.

(10) Failure of the agency to allow a person to apply for licensure and to complete the licensing process in a timely manner.

Inappropriate issues for the RCEPC to review include, but are not limited to the following:

(1) Decisions made by the courts.

(2) Decisions made through an administrative appeal process.

(3) Licensing rules.

(4) Issuance, denial, or revocation of a foster home license.

(5) Established foster care per diem rates.

403.5 Responsibilities of the Institution and COFC During Placement

There are times when a child who is in need of out-of-home care requires placement in a facility that will provide the child with more structure and discipline than would be available in the home of a relative or a foster family home. In such cases, the child will need placement in a group home or child caring institution or hospital. The following is a summary of the different responsibilities that the institution and the placing agency have for the child during placement.

403.51 Institutional Responsibilities

The rules for group homes and child caring institutions define the responsibilities of the facility. The facility must make the following provisions for children in their care:

(1) A daily program planned to meet the physical, mental, emotional, educational, social and spiritual development and adjustment needs of the children.

(2) A treatment plan based upon the child's identified needs and the agency's case plan for the child.

(3) Quarterly written reports of the child's adjustment, and future placement planning to the placing agency and to the court reviewing the child's case, including placement status.

(4) Prompt notification to the placing agency regarding any serious problem encountered in the implementation of the treatment plan.

(5) Maintenance of the medical passport. Updates of medical passports are to be sent to the COFC quarterly.

When a child's placement is in a non-licensed facility; i.e., in an in-state facility operated by another state agency or in an out-of-state facility licensed by the state in which it is located, it is the responsibility of the COFC, as placing agency, to make arrangements with the facility to obtain quarterly reports, including medical and educational records, regarding wards placed there.

403.52 COFC Responsibilities

The COFC, as the placing agency, is responsible for the following activities:

(1) Facilitating court reviews as necessary.

(2) Developing and updating the case plan as necessary in cooperation with the facility and the child's parent or guardian.

(3) Initiating school transfers, as described in subsection 404.331.

(4) Maintaining ongoing contacts with the institution and the child, both by visits and by correspondence with the residential director.

(5) Having face-to-face contact with the child in accordance with the risk and needs service level assessed. See Appendix F Family Case Manager Contact Standards. If the distance between the facility and the COFC is such that it precludes regular contact, arrangements must be made and formalized in writing with an appropriate agency to provide supervision. If an agency, out of legitimate need, requests the COFC in the county in which the agency's ward is placed to provide courtesy supervision, the request is to be honored.

(6) Maintaining contact with the parents or substitute parental figures to assist them in reaching the goals or decisions necessary for the child's future well-being;

(7) Encouraging and arranging parental visitation and contact while the child is in the facility.

(8) Notifying the facility of any major changes in the child's situation.

(9) Sending a quarterly updated medical passport generated from Indiana Child Welfare Information System (ICWIS) in those instances in which a Medical Passport is required. See 404.322 regarding the medical passport.

(10) Notifying Central Office of the Division of Family and Children (DFC) of child care facilities that are substandard or in which abuse or neglect of residents has occurred. If the concerns involve non-compliance with licensing standards, this information is to be directed to the Division's Residential Licensing Unit. If there is reason to suspect abuse or neglect of any child in the facility, this information must be directed to the county office of family and children (COFC) Child Protection Service Unit via numbers listed in Appendix CC of Section 2 of this Manual.

404 Services for the Child in Out-of-Home Care

The county office of family and children (COFC) is responsible for providing the same mandated case management activities for children in out-of-home care as it provides for all children under its supervision. This includes responsibility for case management services and supervision which involves the following:

(1) Establishing and implementing goal-oriented case plans with measurable outcomes formulated with the child's family and utilizing input from the child's caregiver(s).

(2) Determining what services the child, the child's family, and the child's caregivers need and providing and coordinating the provision of these services based on knowledge of available community resources.

(3) Monitoring compliance with court orders and the progress of family and child.

(4) Reassessing and evaluating the needs of child, family and caregivers on an ongoing basis in conjunction with all of these individuals.

(5) Documenting the case as outlined in Section 11 of this manual.

NOTE: The Juvenile Code specifies that the foster parent and COFC shall cooperate in the development of the case plan. The COFC shall discuss with at least one (1) of the foster parents the foster parent's role regarding services to the child and family, visiting arrangements, and services that are required to meet the special needs of the child. The format used to implement this collaboration between COFC and foster parents is State Form 2956 Case Plan. This form also provides health and education information to the foster parent that is a federal requirement.

404.1 Minimum Contact

The COFC must be aware of the placement status of a child at all times. The frequency of face-to-face contacts between the family case manager and the child, foster parent(s) or residential facility staff, and the legal parent(s) or guardian(s) shall be consistent with the service level established through the completion of risk and needs assessments. Contacts are to be

documented in ICWIS in the contact log. There are specific circumstances that require more frequent contact, even as often as once per week. Every case opened for ongoing services, whether services referral agreement (SRA), informal adjustment (IA), or a wardship case, will have a service level based on risk and needs levels combined. Each service level has specific family contact standards; i.e., there are a minimum number of face-to-face contacts and collateral contacts the assigned family case manager is to have with the family each month. See Appendix F. Also, see subsection 1106.41 for additional information.

NOTE: It is the policy of the Division of Family and Children that every child in out-of-home care is to have face-to-face contact with the COFC no less than every 60 days.

404.2 Visitation Policy

It is a fundamental right for children to visit with their parents. Ideally, the relationship developed by a child with a parent should always be one of bonding, dependency, and being nurtured. Each of these elements of the parent-child relationship must be protected for the emotional well-being of the child. When family circumstances require temporary placement of a child outside the family home, it is of extreme importance for a child not to feel abandoned in placement by the child's parents. It is also important for a child to be reassured that no harm has come to either parent when separation occurs.

NOTE: The term “parent”, as used throughout this policy regarding visitation, is defined as the biological parent, adoptive parent, guardian, or physical custodian of a child.

Likewise, it is important for a child to maintain contact with any sibling from whom the child is separated while in placement. As stated in subsection 403.33 of this manual, the bond between siblings is often the longest lasting relationship a child has. This bond helps children to develop their own unique personal identity throughout their lives. Ultimately, it is the responsibility of the Office of Family and Children (OFC), through OFC staff or contracted service providers, to maintain this sibling bond throughout the child’s involvement with OFC whenever possible. While placing the children together is the optimal situation for children in out-of-home care, circumstances may temporarily prevent placement of siblings in the same home. In such circumstances, regular visitation among siblings is essential.

In addition, there are often relatives and significant others who have had a very positive influence on a child who has come from a detrimental home situation. Maintaining contact with these relatives and friends can help the child defend against feelings of isolation, fear and being less than normal.

Visitation for a child, then, is an opportunity to reconnect and reestablish the parent/child/sibling relationships. For parents, visitation is an excellent time to rethink old patterns of parenting, examine and practice new concepts of parenting, and to assess their own ability to parent. For the OFC, visitation is a time to assess the relationships among participating family members and significant others. Visitation can provide an atmosphere in which the primary issues that led to the child's removal can be addressed and the degree of change that must occur prior to return of the child can be defined. Visitation can serve as a motivator for the return of the child to the parents when parents can feel positive about their progress in applying new parenting concepts. If sufficient progress is made and return is an option, visitation can ease the transition period when the child moves from a foster home to the home of the parent(s) by maintaining the parent/child/sibling relationship. Without these relationships, there can be no successful return to the family home. Through careful and complete documentation of visitation in the visitation log,

family case managers and foster parents can assist the court in the decision-making process regarding the child's permanency options.

Some revisions to the visitation policy have been developed based in part upon the "Indiana Parenting Time Guidelines" which became effective March 31, 2001. The Guidelines do not apply to "…situations involving family violence, substance abuse, risk of flight with a child, or any other circumstances the court reasonably believes endanger the child's physical health or safety, or significantly impair the child's emotional development". However, they do offer good baseline information regarding what the minimum needs of children in different developmental stages are relative to maintaining contact with family members in divorce situations. See "Indiana Parenting Guidelines" in Appendix G of this section.

404.21 Frequency of Visitation

Time frames and other stipulations relative to various types of visitation are addressed below. These time frames represent the minimum amount of time required for visitation by various parties.

(1) Initial Contact: Contact is to take place between the child and the legal family within 48 hours of the removal of a child from the home. Exceptions are when it is otherwise ordered by the court or the child refuses contact. When there are concerns for the child's safety, visits should be supervised. Contact can be a telephone call, contact at a court hearing, or supervised visits in the agency, a neutral setting, foster home, or parental home.

(2) Face to Face Contact: Contact is to occur within five (5) working days of the removal of the child from the parental home, unless otherwise ordered by the court or the child refuses contact. When there are concerns for the child's safety, visits are to be supervised. Face-to-face contact is to be made with both legal parents, and with siblings and any significant others. Contact is to take place in a neutral setting with supervision provided by COFC staff, if required. Otherwise, supervision may be provided by a foster parent, a service provider or another appropriate individual.

(3) Regularly Scheduled Visits: Contact is to be made on at least a weekly basis, unless otherwise ordered by the court. Initially, visits should be supervised in order for the family case manager to assess both the strengths and weaknesses of the legal parents to adequately parent the child. As the visitation progresses, the visitation plan is to include arrangements for increased visits, overnight visitation, and extended visits to provide opportunity for family members to practice new skills and ease the transition of the child returning home.

Face-to-face visitation with siblings in other placements is to occur at least every other week; and any significant others may visit at that time as well, or more often if ordered by the court. However, if a sibling is placed in a residential facility, hospital or other type of institution, the frequency of face-to-face visitation with other siblings is reduced to one visit per month. In such cases, communication via telephone and mail is to be encouraged.

Contact is to take place in a neutral setting with supervision provided by COFC staff, if required. Otherwise, a foster parent, a service provider or another appropriate individual may provide supervision. When there are concerns for the child's safety, visits are to be supervised until assessment determines that the child is considered safe in the visitation arrangement; and even then, a safety plan must be in place.

404.22 Visitation Plan

The family case manager is to complete a visitation plan with the parents, foster parents, and significant others. This plan is to be generated in ICWIS and is to be completed within five (5) working days after the initial visit. See Appendix H for a copy of the format generated in ICWIS for a visitation plan, which can be found in Tracking, Documents, Plan. The plan is to be a written agreement detailing the time of visits, as well as the place and frequency of visits, transportation arrangements, notification of change in a visit; who is allowed to visit, including siblings, and to what degree visitation is to be supervised. Also, it is to include recommendations from the court, issues brought by the parent or child, and documentation. The planning of visitation is a process of careful decision-making and provides a time to inform all parties of visitation arrangements.

The following is a delineation of activities and procedures involved in making a plan for visitation:

(1) Pre-planning: The family case manager must make an assessment to determine with whom the child has formed primary attachments. Primary attachments are defined as "persons whom the child loves most in all the world".

(2) Notification: The family case manager or the service provider is to be responsible for notifying all involved parties of the date, location, and time of visits.

(3) Transportation: The COFC shall be responsible for arranging transportation of the child to regularly scheduled visits. The COFC is to be responsible for assisting parents, when parents need help, in locating transportation to regularly scheduled visits.

(4) Location: If possible, the visitation is to take place at a location that will produce the most interaction between parent and child. A setting that is more home-like; i.e., the parental home or foster family home, generally will provide the best environment for interaction. In choosing the location, certain factors are to be taken into consideration:

   (a) Suitability for developmentally related activities; i.e., the site should allow for positive interaction conducive to the child's development.
   (b) Parents' attitudes and feelings about the child's foster parents, and their ability to handle contact with one another.
   (c) Foster parents' interest, willingness, and capacity to be involved in parent-child-sibling contacts as well as their feelings and attitudes toward the child's own parents.
   (d) Factors that might preclude visitation taking place in the parents' or foster parents' homes.
   (e) Consideration for the child's physical safety and emotional stability.

(5) Who Visits: Family case managers are to consider and plan visitation to include significant people in the child's life. In addition to parents and siblings, significant others might include grandparents, an aunt and uncle, babysitter or special friend. The court order may detail who should be included in visitation. Visitation is to be supervised by agency staff or a contracted provider if assessment indicates the child's physical safety or emotional stability would otherwise be at risk. The following persons must be considered for visitation:

(a) Parents. Parents are to be encouraged to visit together, if that is not precluded by their respective work schedules, medical, or relationship/family problems. Individual visitation plans may be necessary if it is requested by the parents at any of the court hearings or, for divorced or separated parents, if visitation is ordered by civil divorce court.
(b) Siblings, including half-siblings and step-siblings.
(c) Grandparents, if ordered by the court, or if consent is given by parents or if the child requests the visitation.
(d) Significant others, if requested by the child and if it is determined by the COFC that visits by those persons would not place the child at risk.

(6) Supervision of Visits: Initially, visits are to be supervised in order for the family case manager to assess both the strengths and weaknesses of the parents to adequately parent the child. As the visitation progresses, the visitation plan is to include any change in supervision from fully supervised, to intermittently supervised (the supervising person need not be in same room as visitors at all times) to unsupervised arrangements. If return to the family home is determined to be an option, the plan also must reflect changes in the length of visitation. Examples include the addition of increased visits, overnight visits and extended visits. Such changes provide opportunity for family members to practice new skills and ease the transition of the child returning home.

(7) Court Jurisdiction: At all times, the juvenile court having jurisdiction has authority to permit or deny visitation.

(8) Alternatives: If the parents or the child's significant others disagree with the visitation plan and those disagreements cannot be resolved by the parties to the plan, the parent or significant others are to be notified in writing of their legal rights and options which include the ability to:

(a) seek representation;
(b) file a petition requesting a judicial review and modification of the visitation plan;
(c) discuss modification of the visitation plan with the family case manager's supervisor. The visitation plan is an integral part of the child's case plan and is to coincide with goals, problems, and services outlined in the case plan.

The family case manager is to document the disagreement in the contact log. During the resolution period, visitation is to continue in some form unless otherwise ordered by the court, and an interim written visitation plan is to be given to all parties.

404.23 Foster Parent Role in Visitation

The degree of foster parent involvement in visitation is to be a mutual decision reached through consensus building involving the foster family, the parents and the family case manager. The involvement varies on a continuum from maximum to minimum involvement that should be dictated by the nature of the child's situation. Foster parents' activities which support the foster child's identification and relationship with the family, or which acknowledge and support the parents' continuing role as parents can be identified as follows:

(1) Extensive supervised or unsupervised face-to-face contact (maximum).

(2) Telephone contact or public or supervised face-to-face contact (moderate).

(3) Activities that do not involve face-to face contact between the child and parents (minimum). This should only occur when parental rights have been, or are in the process of being terminated, or the child has been abandoned.

With maximum involvement with parents, foster parents are to:

(1) allow and encourage visits in the foster family home and provide appropriate levels of supervision during the visits;

(2) coordinate visitation arrangements as agreed in the plan;

(3) invite parents to participate in family gatherings and birthday parties;

(4) assist parents in developing parenting skills through teaching and modeling;

(5) encourage parents to visit with foster parents when the child is not in the home; and

(6) allow and encourage a continued relationship with child and family during post-placement.

With moderate involvement with parents, foster parents are to be encouraged to:

(1) allow and encourage phone calls with siblings and other people who are significant to the child;

(2) allow and encourage visits in the foster home with the family case manager supervising the case;

(3) discuss decisions to be made about the child with parents on the telephone or in person;

(4) invite parents to attend activities such as school conferences and functions, or clinic appointments; and

(5) allow and encourage similar post-placement involvement.

If foster parents are minimally involved with parents during visitation, foster parents are to be encouraged to:

(1) talk with the child regarding the child's feelings about the missing parent(s) and any siblings placed in other placement resources and help the child with grief concerning separation;

(2) provide progress reports to the family case manager concerning the child;

(3) help the child to obtain gifts and cards for parents, siblings and other significant people on special days;

(4) encourage parental participation in decision-making by providing information about the child to the family case manager and requesting parental opinions and feedback;

(5) prepare the child for visits and encourage the child's open expression of feelings about the visits;

(6) share the child by allowing the child to spend special days with parents as requested and when approved by the agency;

(7) refrain from demeaning the child's parents, siblings and other people significant to the child either to the child or to others;

(8) respect the confidential nature of all information; and

(9) allow and encourage appropriate post-placement involvement (cards, letters, sharing of pictures).

404.24 COFC Role in Visitation

Relative to visitation, the COFC is responsible for:

(1) talking with foster parents regarding the child's reaction to separation from parents, siblings, and others important to the child. Certain behaviors that may be perceived by foster parents as negative often occur with initial separation and following visits with parents, siblings, etc. Such behaviors are usually the result of the child's feelings of loss and grief relative to the separation and the child's hopes for a better future within the family. The behaviors indicate that the child is dealing with those issues, which is healthy for the child. Helping foster parents to understand what is behind the behaviors can assist foster parents in helping the child deal with the feelings.

(2) acting as message bearer and encouraging the child and foster parents to share information by notifying foster parents of special days and keeping foster parents informed of the visitation plan.

(3) being available to foster parents to provide knowledge about parents.

(4) keeping foster parents informed of progress in preparing the child and parents for changing situations and advising the foster parents of possible reactions on the part of the child and family concerning those changes.

(5) being supportive of the foster parents' involvement with parents and being available to interpret and mediate when appropriate.

(6) clarifying roles with the foster parents and supporting foster parents in the role agreed upon.

(7) listening carefully to and considering the point of view of the foster parents.

404.25 Restricted Visits/Special Conditions/Termination of Parental Rights

Once the visitation plan has been developed, certain issues may arise which require further clarification:

(1) Restricted Visits: The visitation plan shall not be violated unless:

(a) the child is placed in a situation that would seriously impair or endanger the child's emotional or physical health. Should this arise, a discussion between all parties involved in the visitation plan is to be held with the immediate goal being to resolve the problem and protect the child. Issues and results of these discussions are to be recorded in the visitation log.
(b) the court having jurisdiction orders a visitation plan different from the one established. In this case, the court order shall take precedence.

(2) Special Conditions: Conditions could arise that would make the visitation plan temporarily invalid. Examples of such circumstances include a parent or child who is in an accident, in the hospital, arrested, admitted to a psychiatric hospital, suffering illness; hampered by inclement weather which closes schools, offices, or roads. If such a condition arises, it is to be explained to the child immediately; and a temporary alternative schedule is to be initiated or an alternative site selected. When visitations take place in another location, this change needs to be entered into ICWIS on the visitation plan screen by modifying the schedule for the visitation plan (change location). If visitations are canceled or rescheduled, this is to be recorded in the visitation log. A new written visitation plan is to be created anytime there is a change in the plan and distributed to all parties.

(3) Termination of Parental Rights: If, during the course of the child's placement, it has been decided that reunification is not possible; and a decision to file for termination of parental rights is made, visitation shall continue as planned unless:

(a) a court order prohibits visitation;
(b) parents reply in writing that they no longer wish to visit; or
(c) the child is placed in a situation that seriously impairs or endangers the child's emotional or physical health, at which time a court order shall be sought to cease visitation on these grounds.

404.26 Disrupted Visitation

Disruption, as it relates to visitation, can be defined as a situation in which modification of the visitation plan is indicated because all parties do not agree with the current plan. The visitation plan can be disrupted by any of the participants involved. Once the plan is agreed upon and visitation has begun, should a disruption occur, the family case manager shall be responsible for contacting all parties involved in the visitation plan and for establishing a meeting time to discuss the problem. Prior to this meeting the family case manager should consider reassessing risks and needs of the child and family, if there have been changes in the case that may be causing the disruption. The family case manager shall discuss with parents and foster parents the long- and short-term goals of the agency for the child, and the assessments will help all parties to focus on what needs to be accomplished. Disruptions to a plan are recorded in the Disruption screen opened from the visitation plan screen.

Modifications can be made at this time, if all parties are in agreement. If a decision is not reached which is agreeable to all parties, the family case manager is to:

(1) refer parents to legal counsel or for counseling.

(2) discuss the situation with the child and possibly refer the child to counseling to address fears or concerns the child may have about visitation.

(3) refer the matter to the court for a specific order or for modification of the existing order regarding visitation.

404.3 Minimum Provisions

The COFC shall provide, in a timely manner, the following for each child in out-of- home care:

404.31 Clothing

The COFC is responsible for providing the child with clothing. The method may vary from county to county. The COFC director, through written local guidelines, must ensure that COFC staff and foster parents have a clear understanding of clothing provisions. Foster parents are to be provided a written copy of this guideline.

Regardless of the system used to purchase clothing for a foster child, the COFC is to provide to the foster parent a minimum clothing list. This will assist the foster parent to provide the minimum clothing required at all times. The minimum clothing shall be available to the child if the child is transferred from one foster home to another.

404.32 Medical and Dental Care

Licensing rules prohibit placing a child having a communicable or contagious disease if there are other children in the home unless plans are based on competent medical advice. Therefore, the COFC is to make arrangements for a medical examination of the child prior to placement or immediately following an emergency placement. The COFC is responsible for providing ongoing medical and dental care for all children in placement, or for seeing that the care is secured by the home or facility.

Licensing rules also require that the health of the foster parents "be such that it will not be detrimental to the health and welfare of the children." If a communicable disease is contracted, the foster child "shall not be permitted to remain there unless suitable health precautions are taken."

404.321 HIV/AIDS Policy for Foster Care

Please refer to Appendix I for general information regarding HIV/AIDS and for the "Preamble and Rationale for HIV Policy for Foster Care", which policy appears below. The information in the preamble is an updated version of the product of a task force initiated by the Indiana State Department of Health to address concerns of agencies providing services to children with HIV/AIDS and is directed to those agencies in general.

TESTING

Policy (Testing): HIV is a life-threatening blood-borne pathogen that requires continued vigilance in terms of controlling transmission. Testing for HIV infection is to be considered for children who have signs or symptoms of HIV infection confirmed by a physician, or who are at high-risk of HIV infection. Children in the following categories are considered high-risk:

(1) Children who have received blood products prior to March 1985. NOTE: Hemophiliacs and others receiving blood products after 1985 are not to be considered at high-risk on that basis.

(2) Children from countries with a high rate of transmission of HIV.

(3) Children with histories of high-risk behavior, including intravenous drug use and prostitution.

(4) Children who have had oral, anal, or vaginal penetration by a high-risk person.

Procedure (Testing):

Determination of need for testing:

If a child has signs or symptoms that may be consistent with HIV infection, the child is to be evaluated by a physician to determine if testing is necessary and appropriate.

Testing is to be completed on any foster child whose medical provider determines testing to be necessary. For infants under the age of 18 months, viral load testing is to be done at one (1) month, two (2) months and six (6) months of age or greater. Three (3) negative tests indicate an HIV negative status. Children who are 18 months of age or older are to be tested for positive blood antibodies.

There is not a strong correlation between sexual abuse of children and HIV infection. Children with documented exposure to HIV are be tested. Children who have been molested by oral, vaginal, or anal penetration by a high-risk or unknown person are to be evaluated by a physician to determine if testing is necessary and appropriate.

Children with a documented exposure are to be tested at the time that the incident is reported to determine baseline status and again after three (3) and six (6) months to determine if seroconversion (infection) has occurred. Children who are HIV seropositive at the time of initial testing are unlikely to have been infected from the episode in question, unless there is a delay of greater than two (2) weeks between the event and the testing. If a child tests negatively six (6) months after the exposure, the child may be considered uninfected from the reported incident.

It is important to realize that if repeated molestation or other high-risk events; i.e., intravenous drug use, occur during the six-month period, it is necessary to continue testing the child until six months from the last possible exposure.

If a child is asymptomatic and is judged not at risk for HIV infection, testing is not necessary or recommended. However, the child and/or the child's parent, guardian, or custodian is to be advised of the indications and availability of HIV testing.

Informed consent for testing:

State law requires obtaining informed consent prior to HIV testing (IC 16-41-6). See Appendix I. If testing is deemed appropriate and the child is not in the legal custody of the agency, voluntary informed consent must be obtained from the child's parent, guardian, or custodian. The informed consent is to include:

(1) the purpose and meaning of HIV testing;

(2) the interpretation of test results;

(3) basic information about HIV infection;

(4) the legal consequences of having a HIV seropositive status, including mandatory reporting and the duty to inform sexual and needle-sharing partners; and

(5) possible psychosocial consequences to the child and/or family if the child is HIV-infected.

If consent is not given, permission to test may be sought from the court on the following bases:

(1) There is a physician-certified medical emergency or need for continued post-emergency medical care requiring knowledge of

HIV status for diagnostic or treatment purposes (IC 31-32-12). NOTE: This would not require obtaining a CHINS petition.

(2) Filing a CHINS petition based upon medical neglect is appropriate under IC 31-34-1-1 and medical reason exists to test for HIV.

(3) A parent, guardian, or custodian refuses medical treatment for a child on religious grounds, and it is believed that the child's health requires knowledge of HIV status for medical treatment. IC 31-34-1-14 permits the court, without a formal CHINS petition, to order medical treatment for a child, if the child's health requires it, despite the objections of the parent, guardian, or custodian on religious grounds.

If the child is in the legal custody of the agency, court approval is to be sought for HIV testing if the child's situation meets the high-risk criteria of this policy. The child may have been adjudicated a CHINS, and the court may have authorized the provision of routine medical care as part of a standing order. However, the matter of obtaining HIV antibody tests is to be discussed with the court prior to obtaining any such test in order to determine how the court wishes to proceed in such cases.

Financial considerations (Testing):

Responsibility for expenses of HIV antibody testing, initial or subsequent, will fall to the parent, guardian, or custodian first and then ultimately to the COFC legally responsible for the child's care.

If the child is eligible for and on Medicaid, Medicaid will pay for testing as long as there is a medical need to test. This includes testing for children who are symptomatic and for the children who are asymptomatic but at high-risk for AIDS. Testing does not require pre-authorization.

The Indiana State Department of Health operates free Counseling and Testing Sites (CTS) throughout the state. Persons age 13 or older may be counseled and tested at these sites without charge. Children under the age of 13 may have special needs and require counseling beyond the capability of staff at these sites. The CTS offer both anonymous (without name or identifiers) and confidential (with name and identifiers) testing. Clients must understand the difference between anonymous and confidential testing as legal or other considerations may exclude use of anonymous testing.

If a child meets the criteria for the diagnosis of AIDS, the child may be eligible for benefits such as Supplemental Security Income and/or Medicaid. If the child is eligible for and on Medicaid, Medicaid will pay for the normal range of services that are medically necessary. Standard Medicaid requirements regarding pre-authorization for payment apply to AIDS cases.

Psychosocial consideration (Testing):

If a child is found to be HIV-infected, the parent, guardian, or custodian may find this information very stressful. Because of the association of HIV infection with stigmatized populations, some people may fear "guilt by association" and believe that social reprisal, including destruction of personal property or reputation, loss of employment or educational status, will result if the child's HIV status becomes publicly known. Since HIV infection is a stigmatized disease, HIV-infected children, their parents, guardians, or custodians may avoid the usual resources of friends and extended family.

Families of children with HIV infection require education concerning appropriate infection control practices, although in most situations, the need for such precautions is minimal. See Universal Precautions below.

Many persons believe that HIV infection is synonymous with AIDS or implies impending death. Even if reassured that the child may have relatively good health for a period of years, caregivers will have many questions and concerns about their ability to deal with a stigmatizing, chronic, and ultimately fatal disease. Many issues, including the child's immediate and future medical care, financial concerns, and the family's well-being will be raised and need to be addressed. These needs go beyond the usual post-test counseling, and resources must be developed to address these needs. While the agency may contract with private or public agencies to provide counseling for families with HIV-infected children, it is recommended that appropriate agency staff be aware of the content of post-test counseling for HIV-infected persons. It is also recommended that all counselors used by the agency be trained according to the Centers for Disease Control's pre- and post-test counseling for HIV antibody testing. Simple and clearly written pamphlets containing necessary information and referrals are to be made available to ease family concerns and facilitate appropriate follow-up care for the child.

CONFIDENTIALITY

Policy (Confidentiality): IC 16-41-8 protects the confidentiality of positive HIV status. See Appendix J.

Persons with HIV infection are vulnerable to discrimination. This may be due to the public's association of HIV infection with stigmatized populations such as homosexuals and intravenous drug users. In addition, despite scientific evidence that HIV is spread by limited means and is difficult to acquire, the public remains fearful of contagion. Consequently, the issue of confidentiality is extremely important to the overall physical and emotional well-being of the infected child.

The policy of the Division is to share information concerning a child's HIV infection with the child and with specific persons who clearly require knowledge because of their relationship with the child; e.g., the parent. It is believed that clear and accurate information about HIV

infection and appropriate infection control measures must be given to parents, foster parents, guardians, or custodians to enable them to make an informed decision about their ability and willingness to provide care to the child. If caregivers make such an informed decision, the possibility of having to move the child from the placement is decreased; and the caregiver is in a position to act in the best interests of the child.

It is acknowledged that caregiver education and training may be required before the caregiver feels capable of providing care for an HIV-infected child. The Division will provide or arrange for such training on a regular basis or as needed. The Division should incorporate infectious disease information in all pre-service training curricula and should require a periodic "refresher" in infectious disease information for all licensed foster parents.

Procedure (Confidentiality):

The following persons are to be informed regarding a child's positive HIV status:

(1) Specified agency personnel

If a court order is in effect assigning responsibility for a child to an agency, HIV viral load (see Appendix H) or antibody test results shall be returned to the administrator or the administrator's designee in a sealed enveloped marked CONFIDENTIAL. If a COFC is the agency responsible for a child who is tested for HIV infection, the person designated to receive the test results is the COFC director. The person receiving information may share it with appropriate staff on a need-to-know basis. All Division staff having information regarding a child's HIV status must maintain that information as confidential.

(2) The court

If there is a court order in effect regarding the child, the court should be advised of the child's positive HIV status by the agency legally responsible for the child. A policy for conveying this information to the court that preserves strict confidentiality is to be developed which meets court-specific requirements. Those developed by COFCs will need to be in accord with Central Office policy also.

(3) The child

The child is to be advised of the HIV status in an age-appropriate fashion by the agency legally responsible for the child in accordance with expert advise and with assistance from appropriate professionals from other disciplines as necessary.

(4) The child's biological parents or legal guardian

Biological parents and legal guardians are to be advised unless their rights pertaining to the child have been terminated. It is recommended that the parent or guardian be informed in a meeting with a counselor or health care professional, trained according to the Center's for Disease Control's pre- and post-test counseling for HIV antibody testing, and the child's family case manager. Further consultation with a knowledgeable physician or health care professional is to be available on a referral basis for ongoing technical or medical information. The notification of parent or guardian is to be documented in writing with copies of the medical determination of the positive HIV status available. Available services for the child and family can be discussed at this meeting. Follow-up meetings are to be planned as needed.

(5) Child's prospective adoptive parent

The fact that a child is HIV seropositive is not to be directly stated in any adoption exchange information but is to be referred to as a medical problem and shared with prospective adoptive families. Prospective adoptive parents are to be informed if a child is HIV positive. Initially, this information is to be conveyed orally. If interest in adopting the child remains intact, written information concerning the child's HIV status may be provided to the adopting parents with the provision that, if the child is not adopted, the written information regarding the child's HIV status is to be returned to the family case manager.

(6) Specified providers of substitute care

Persons acting in loco parentis are to be advised of the child's HIV positive status. Every residential institution or group home is to have clear policies and guidelines determining "need-to-know" and the management of information pertaining to HIV status. In the interest of confidentiality, other types of facilities, such as child care centers and schools, are not to be notified by the agency of a child's HIV positive status.

Any written communication emanating from the agency concerning the HIV status of a child must be marked CONFIDENTIAL on each sheet and on the mailing envelope with copies maintained in a locked file.

Because of the existence of a documented lack of transmission of HIV within a family or home setting, it is inappropriate, and may be considered a breach of confidentiality, for staff to reveal a child's HIV status to other foster children, children in group homes or other institutions, or to the natural parents of these other minor residents.

UNIVERSAL PRECAUTIONS

Policy (Universal Precautions): State law, in IC 16-41-11 and 410 IAC 1 in the Indiana Administrative Code mandates the use of Universal Precautions. See Appendix I. Universal precautions consist of the use of

appropriate barrier precautions (such as gloves) by workers with occupational exposure to blood to prevent contact with blood or other body fluids capable of transmitting HIV infection. Since HIV status is rarely known, all persons should be potentially considered HIV-infected; and precautions are to be taken whenever blood or other specified body fluids are handled. Since all persons are considered potentially HIV-infected, there is no need to identify those who are known to have HIV infection, as appropriate measures will be taken in all cases.

Procedures (Universal Precautions):

All personnel whose occupation makes contact with blood or other infectious fluids probable will be educated in the appropriate use of universal precautions in accordance with Indiana law. In addition, designated agency staff will be able to provide or arrange for the provision of information and education about universal precautions as appropriate to HIV-infected children, their parents, guardians, or custodians, and to foster parents.

NOTE: In the family, school, or home setting, the primary risk of HIV transmission occurs from exposure to blood. Body fluids such as tears, saliva, urine, feces, vomitus and nasal secretions, if not visibly contaminated with blood, are not infectious; and gloves or other barrier precautions are not necessary for routine child care, including diapering/toileting, feeding, or burping. These same body fluids, if visibly contaminated with blood, are to be considered potentially infectious; and universal precautions are to be utilized.

If any child has diarrhea or an acute, communicable disease, it is prudent to use barrier precautions (such as wearing gloves) when handling that child's body fluids, regardless of HIV status, in order to prevent acquiring or transmitting these infections to others in the home, school, or institution. It is important to note that whether or not barrier precautions are used in any given situation, thorough hand washing is essential after handling any body fluid in order to avoid spreading other sources of infection contained in the fluids.

SCHOOL ATTENDANCE:

Policy (School Attendance): HIV-infected children are to lead lives that are as normal as possible. Every effort is to be made to ensure that they develop and maintain age-appropriate social relationships and receive a formal education. In general, there is no health reason for denying most HIV-infected children admittance into most schools or child care programs. However, a more restricted environment is advisable for some children such as:

(1) the infected preschool-age child, particularly the child who is at the stage when everything goes into the mouth;

(2) some handicapped children who lack control of their body secretions or who display aggressive behavior; and

(3) those children who have oozing or bleeding lesions that cannot be covered.

In some instances, such as the occurrence of an outbreak of chicken pox or measles, it may be necessary to keep the HIV-infected child at home for the child's well-being.

NOTE: Relative to school attendance, parents, guardians, or custodians of HIV-infected children under the care and supervision of the Division are to discuss their child's immunization and health status with a knowledgeable physician, preferably the primary health care provider for the child. In the event that a school refuses admittance to an HIV-infected child, state law provides the child with recourse to the ruling of the local health officer whose decision can be appealed to the State Health Commissioner. Schools are also subject to the Americans with Disabilities Act and other state and federal anti-discrimination laws. Legal remedies to a school's exclusion from a place of public accommodation may be available under these laws.

Procedure (School Attendance): HIV-infected children may attend child care, nursery, grade, high, or other schools.

The Indiana State Department of Health, in its guidelines for school attendance of children with HIV infection, makes the following recommendations:

(1) No child, regardless of HIV status, is to attend regular school if the child lacks control of bodily functions, exhibits biting behavior, or has open sores that cannot be covered.

(2) No child, regardless of HIV status, is to attend regular school if the child has acute febrile, upper respiratory, or diarrheal illnesses.

(3) Someone within the school setting; e.g., the school nurse, is to be responsible for advising the local health officer or private physicians of outbreaks of communicable diseases in the school.

If a school denies attendance of a child on the basis of HIV alone, the family is to contact the Indiana State Department of Health (1-800-433-0746).

404.322 Medical Passport Program

In response to P. L. 344-1989 passed by the Indiana General Assembly, the Central Office of the Division of Family and Children (DFC) developed procedures and related forms for implementing a medical passport program. These procedures and forms were updated in 1998 due to the development of the booklet entitled "Medical Passport" (DFC PAM 036 (4-98) 3631), commonly referred to as the "Blue Book"; and the electronic Indiana Child Welfare Information System (ICWIS). The combination of the Blue Book and appropriate screens in ICWIS

constitutes a system for obtaining and maintaining the medical care records of Indiana children under the care and supervision of the COFC who are in foster care, including some in child care institutions. Specifics related to the legislation are as follows:

Target Population

The law requiring a medical passport program applies to all children who receive foster care that is funded by the DFC or the COFC, including Indiana children in out-of-state placements. The term "foster care", as used in the law and in this subsection, means care provided in a foster home. Indiana statute mandates maintenance of a medical passport for children in foster care only. However, once a medical passport has been established for a foster child, the policy of the DFC requires maintenance of the medical passport for that child, if:

(1) the child is placed in any other type of residential care setting directly from a foster home; and

(2) a CHINS status is maintained on an uninterrupted basis.

Legal Base

The authority for developing these procedures/forms comes from three chapters of the Indiana Code, IC 12-17-9, IC 12-17-10 and IC 12-17-11.

404.3221 Definition of Medical Passport

IC 12-17-11 requires the COFC placing a child in foster care to issue a medical passport booklet for the child to the child's foster parents at the time of placement. In 1998, the Medical Passport or “Blue Book” was established for use as a means for foster parents to maintain a written record of a foster child’s medical and dental care while in out-of-home placement. ICWIS also has a section for the family case manager to maintain an electronic record of the child’s medical information. See Appendix K for a copy of the Blue Book and for the Medical Passport as generated via ICWIS. See the following subsections under this topic for procedures concerning gathering and exchanging medical passport information prior to or at placement of a child in foster care, at the conclusion of the foster care placement and in inter-county/state placements.

Two other forms that are to be given to the foster parent are:

(1) SF 45093/FPP 3319 Authorization for Medical Care (see Appendix G in Section 11 of this manual); and

(2) a copy of a consent form for release of mental health information if a child is to be seen by a mental health

provider. A sample copy of such a form appears in Appendix L of this section.

The passport must remain with the child until the child returns home, is adopted, or is placed according to another permanent plan, at which time the passport shall be returned to the placing county that issued the passport.

404.3222 Medical Passport Procedures Prior to or at Foster Care Placement

Prior to or when a child is placed in foster care, the family case manager is to speak to the parent, guardian, or custodian about all topics in the Blue Book and record the results. For purposes of the Blue Book, "provider" means a physician, dentist, registered nurse, licensed practical nurse, optometrist, chiropractor, physical therapist, psychologist, audiologist, speech-language pathologist, home health agency, hospital, or nursing home facility. The family case manager is to determine if the child is on Medicaid or is eligible to receive Medicaid benefits. The information obtained from the parent(s) is to be entered into ICWIS in the appropriate fields, and the Blue Book is to be given to the foster parents. The family case manager is to discuss an arrangement for exchanging information from the Blue Book to ICWIS and vice versa with the foster parents. This exchange is to occur at least on a quarterly basis, preferably during a collateral visit; and an electronic medical passport is to be sent to the foster parent to be sure the same records are being maintained by COFC and foster parent. Foster parents are to be advised that they may sign for routine medical treatment but that the COFC must be contacted as soon as possible if the treatment is anything other than routine care. They also need to be aware that the COFC must sign a consent form for mental health treatment prior to the child being taken to a mental health provider. (IC 16-36-1.5)

(1) When the Child Has a Previous Provider

If ongoing care has been provided to a child and the previous provider is a physician, the COFC is to request the provider to assist in verifying information about the child in the Blue Book. If the physician has not seen the child recently (within the past six (6) months), the physician may want to examine the child in order to recommend future health care needs. The family case manager or foster parent is to arrange an appointment for this examination as soon as possible. If possible and appropriate, the parent of the child is to attend any initial examination.

Request the provider to complete the section on Physical Examinations in the Blue Book (DFC PAM 036 (4-98) #3631) as a part of the examination. If the provider identifies a medical problem, request the provider to complete the Blue Book section on Identified Medical Problems (problem identified, date identified, date resolved, and signature). The foster parent or the family case manager can complete the provider's address and telephone number.

(2) When the Child Has No Previous Provider

When a child comes into care and has not been seen by a doctor, or if the family case manager cannot ascertain whether the child has been seen by a doctor recently, the child is to be taken to see a provider used by the COFC. The child is to be given a physical examination appropriate for the child's age. The provider is to be requested to complete the periodicity schedule and information concerning identified medical problems in the Blue Book according to the instructions in (1) above.

404.3223 Medical Passport Procedures During Foster Care Placement

When a foster child requires medical treatment, the foster parent is to arrange an appointment with a Medicaid provider who is approved by the COFC. At the time of treatment, the foster parent can use the SF 45093 / FPP 3319 Authorization for Medical Care provided by the COFC to authorize provision of routine and emergency medical treatment as required by the provider. The foster parent is to provide the Blue Book and request the provider to complete the line on the Identified Medical Problems page in accordance with instructions in subsection 404.3212 (1).

If the child is eligible for Medicaid, the physician is to bill Medicaid according to procedure. If the child is not eligible, the provider is to bill the COFC in the manner agreed to by both agencies.

404.3224 Medical Passport Procedures at Exit from Foster Care

When a permanent placement (return to the biological parents, adoption, or other permanent plan) has occurred, the family case manager is to review the child's Blue Book with the foster parent(s) to determine if there is a current recommendation for the future health care needs of the child. If the child has not been examined by a physician within the last 12 months or has a chronic condition, the

child is to be examined again to obtain a current recommendation from the provider regarding the child's ongoing health care needs. Post-examination procedures for obtaining recommendations for the child's future health care needs and for billing by the provider are identical to those contained in the previous portions of this subsection.

At the time the child is transferred from foster care to a permanent placement, the family case manager is to obtain the Blue Book from the foster parent. An electronic medical passport is to be provided to the child's permanent caregiver by the COFC. Care must be taken to preserve confidential identifying information, if the permanent caregiver is an adoptive parent.

404.3225 Medical Passport Procedures in Inter-County and Interstate Placements

If a child is placed in foster care out-of-county/state, the COFC placing the child is responsible for the following:

(1) Issuing the child's Blue Book and other forms necessary to procure medical care for the child to:

   (a) the appropriate governmental entity in the county/state in which the child resides in foster care that is responsible for the child; or
   (b) directly to the child's foster parents by agreement with the appropriate governmental entity in the county/state in which the child resides.

(2) Advising the child's foster parents of the procedure for billing the child's medical services to Medicaid or to the COFC and establishing a procedure for updating the electronic medical passport.

(3) Collecting the Blue Book and any other completed medical records when the child is returned to the biological parents, adopted, or placed according to another permanent plan.

All other maintenance responsibility for the Blue Book rests with caregiver. The appropriate governmental entity in the county/state in which the child resides or the child's caregiver is to be advised of the requirement to consult with the placing agency prior to provision of anything but routine medical care as defined by the child's condition.

Regarding any placement of a child in foster care in another state, it is not possible to enforce the Indiana requirement

for medical passport maintenance. However, cooperation in this regard is to be sought from the caregiver.

404.33 Educational Needs

The COFC is responsible for the educational needs of the child in care. The child is to attend only accredited public schools unless the parents approve or request that the child continue or be placed in a private school and are willing and able to pay for all related costs. County expenditures for education in private schools are not allowable. Within the framework of these parameters, unless parental rights have been terminated, parents have the authority to make educational decisions for their children. Subsection 404.332 deals with the special educational needs of children in care.

404.331 School and Tuition Transfers and Reporting Requirements

In 1996, the Juvenile Code was modified to require the court to make findings regarding the "legal settlement" of all children placed in residential or foster care. This information is required in order to determine responsibility for payment of education costs. (IC 31-34-20-5 and IC 31-34-21-10)

If the child is placed in a school within the school corporation where the child has legal residence, no transfer tuition is required, of course. However, if the child is placed in a school corporation within the county or out-of-county/state that is different from the school corporation where the child has legal settlement, the school corporation where the child has legal settlement is required to pay transfer tuition. No later than 10 days after a county initially places or changes the placement of a child, the county that placed the child is required to notify:

(1) the school corporation where the child has legal settlement; and

(2) the school corporation where the child will be attending school

regarding the placement or change of placement. The form to be used is SF 47412/FPP 0016 Notification of Change of Placement in School Corporation. The element dealing with the date that the court ordered the placement of a child is to be completed whether or not the court ordered the specific placement of the child. If a court has granted blanket permission for the COFC to make whatever placement changes it deems to be in the child's best interests, the date that this language appears in the initial court order authorizing placement is to be used.

NOTE: If the juvenile court makes or changes a placement or reviews the implementation of a dispositional decree under IC 31-34-21, the court is legally required to provide notification of placements and changes in placements to school corporations as outlined above. However, this task may very well be assigned to the COFC.

Before June 30 of each year, a county that places a child in a home or facility shall notify the school corporation where the child has legal settlement and the school corporation in which a child will attend school whether the child's placement will continue for the ensuing year. Absent the existence of any plan to move a child at the time the above-noted report is due, the child would be reported as remaining in placement for the next year. The form to be used is SF 49812/FPP 0027 Annual Notification of Continuation of Placement in School Corporation.

The notifications and reports outlined above are to be made by the county office of family and children if that office placed or consented to the placement of the child. Otherwise, the court or other agency making the placement would make these reports/notifications. (IC 20-8.1-6.1-5.5)

404.332 Special Education and the Surrogate Parent Program

Federal law in 20 USC 1401 et seq. (1976), and Indiana law in IC 20-1-6, requires that every student between the ages of 3 and 22 with a disability will be provided a free appropriate public education (FEPA). This law is implemented through Article 7, formerly known as Rule S-5, which is based upon the federal "Individuals with Disabilities Education Act" (IDEA) and provides for special education programs and related services without charge by the public schools of Indiana. This includes the Indiana School for the Deaf, the Indiana School for the Blind, Silvercrest Children's Development Center; Northern Indiana, Evansville Psychiatric Children's Center, Muscatatuk and Fort Wayne State Developmental Centers; Madison, Logansport and Richmond State Hospitals; and LaRue D. Carter Memorial Hospital.

In effect, Article 7 guarantees that children with disabilities receive appropriate public education through the development and implementation of an individualized education program (IEP) designed to meet the assessed educational needs of each student. It assures that testing and evaluation materials, procedures, and interpretation of results are not biased, and that each student with disabilities will be educated within the least restrictive environment appropriate to meet the student's needs.

All procedural safeguards of due process are provided to protect the rights of children, parents, and surrogate parents. The child, parent, teacher, school administrator, or the child's family case manager may initiate a referral of the child for an educational evaluation. For children with disabilities whose parents are unknown or unavailable or who are under the care and supervision of county offices of family and children and reside in foster homes, group homes, child care institutions or nursing homes, an educational surrogate parent must be assigned at the time of referral. The administrator of the special education program that the child attends is responsible for assigning the surrogate parent. A surrogate parent may be a parent, foster parent or volunteer, over the age of 18, who has been trained to assume the responsibility of representing the eligible child in the special education decision-making process.

Because of the potential for conflict of interest, employees of the state or local agencies responsible for the care and education of a child; i.e., any employee of Central Office or a COFC may not serve as that child's surrogate parent. However, the COFC has an obligation to notify the director of special education of any child under the care and supervision of the COFC who may require special education assistance so that the student's IEP can be implemented in a timely manner. The foster parent may be the surrogate parent, if they have received training and are assigned to the child by the special education director of the local school corporation.

The rights of a surrogate parent are to:

(1) have a free, appropriate public education for their child;

(2) inspect and have a copy of all records with regard to their child's educational program;

(3) request changes, if inaccurate or inappropriate information is contained in their child's records;

(4) have an appropriate and nondiscriminatory educational assessment for the child in the child's primary language;

(5) be fully informed about evaluation procedures, tests, and all results;

(6) seek an independent evaluation of the child, if the surrogate parent thinks the school's evaluation methods or results were inappropriate;

(7) participate fully in planning the child's individualized education program (IEP);

(8) know about special education services available to the child;

(9) have the child educated in the most normal setting possible;

(10) question the appropriateness of the child's educational program;

(11) decide if a proposed special education placement is appropriate for the child by signing, or refusing to sign, for placement;

(12) talk with people involved in the child's education and receive regular progress reports and other communications routinely given to parents;

(13) give informed consent before any major change is made in the child's education program;

(14) call for a parent/school conference, new evaluation, or planning meeting whenever necessary;

(15) be accompanied by another person during any school meeting;

(16) be notified in writing when the child is being tested, a change in placement is being discussed, a change in the educational plan is being considered, or a case conference or educational planning meeting is being called;

(17) be informed of, and initiate due process procedures; and

(18) participate as a partner with the school in planning the child's individualized educational program.

The responsibilities of a surrogate parent are:

(1) learning about the child's educational needs by observing the child at school, talking with the child, reviewing the child's records, looking at the child's school work, and talking with teachers, therapists, family case managers, counselors, etc.;

(2) participating in school meetings and sharing information that has been gathered;

(3) monitoring the child's educational development during the school year and participating in a review of the program at least once a year;

(4) serving as the child's advocate by requesting appropriate services or making complaints about services or the lack thereof, if necessary;

(5) negotiating with the school, if there is any disagreement about the child's special needs or education program;

(6) representing the child in any complaint or due process procedures;

(7) using discretion in sharing information about the child with personnel from the school and care facility and complying with laws concerning confidentiality; and

(8) facilitating interaction between the school and other agencies that work with the child, such as the COFC, nursing home, or state hospital.

Family case managers are to assist surrogate parents who are foster parents by securing needed educational records for the foster parents' review and by sharing their understanding of the child's educational needs. To develop that understanding, the FCM is to attend each of the child's IEP and ITP conferences and any additional educational program reviews that are held.

IC 20-1-6-19 is the state statute that provides for the placement of severely handicapped children in private in-state or out-of-state schools. A child considered under this statute must have severe physical, intellectual, sensory, or social-behavioral deficits which prohibit the child's ability to function in and benefit from special programming in the local school corporation. The COFC may contact the local school corporation and request that a child be referred for an evaluation to alert the school regarding a child who is possibly in need of a special educational placement setting, since the local school corporation must initiate the application for consideration under Article 7. A surrogate parent must be assigned by the local school corporation at the time of referral, if this has not already been done.

A case conference procedure is to be utilized to determine if a local school corporation has exhausted all local options for providing the related services and special education the child needs. If it is determined that the child's educational needs cannot be met locally, the local school corporation can make application for private special school attendance (Article 7). A special review committee appointed by the Department of Education (DE), Division of Special Education, reviews the application and determines if the child is eligible for placement in a state-operated facility or private special school. Each placement is reevaluated at the end of the school year to determine if the child is eligible for continued placement or if the local school corporation could provide the needed program.

If a child is eligible for placement in a private in-state or out-of-state special setting, the state may, be subject to available funding, be required to pay the costs of the services that exceed the regular cost of educating children of the same age and grade level in the child's school corporation. The local school corporation is to pay the share of the total tuition cost that is the regular per capita cost of general education in that school corporation. IC 20-1-6-18.2, IC 20-1-6-19, 511IAC 7-27-12 and 511IAC 7-27-13 places limitations on transportation for individualized education programs and residency in public or private facilities of a more restrictive educational setting than the local school corporation could provide. This cite also designates financial responsibility for transportation in a variety of circumstances. (Refer to section 403.114 regarding placement in State Institutions.)

404.34 Discipline Policy

Discipline is training that develops self-control, character, orderliness, and efficiency. Through the application of effective discipline, the foster parent will teach the child responsible behavior; and the child will learn behaviors that will assist the child to develop into a responsible adult. Discipline is an ongoing process of teaching children responsible behavior through example as well as through various other activities and techniques. It helps to enable a child to develop a conscience, which is necessary to become a responsible, self-directing individual. Punishment differs from discipline in that punishment controls a child's behavior through the use of force or

authority and deals more with a child's present or past behavior than with future behavior.

The most important factor regarding discipline is the child/caregiver relationship. Ongoing communication between the child and the foster parent provides both with information as to how their behavior affects the way others see and relate to them. Since foster parents have not had the benefit of having a long-term relationship with a foster child, the trust and bond that foster parents probably have with their own children is not necessarily present with a foster child. Therefore, techniques that might be very effective with one's own children might be ineffective or lead to mistrust between foster child and foster parent. Many children who have been severely physically abused will not react to a "typical" spanking, while others may be traumatized due to their memories of their past experiences. In addition, it has been found that the parents of many of the children who have been physically abused were abused themselves as children. Implementing different types of discipline other than physical punishment helps stop the generational cycle of abuse.

Discipline involves teaching children that their behavior results in certain consequences. An awareness of this will help children to control their own behavior. There are three (3) types of consequences: natural, logical, and artificial (Ryan, 1988).

Natural consequences are those that happen without any intervention by a foster parent. For example, if the child stays up too late at night, the child will be tired the next day.

Logical consequences are those that are put into effect by the foster parent when the behavior and consequences are directly related. For example, if the child stretches a curfew to come home, the curfew will be set for an earlier time.

Artificial consequences are those that are put into effect by the foster parent, but there is no clear relationship between the behavior and the consequences. For example, if the child stays out later than the curfew, the child is not allowed to watch television the next day.

These three types of consequences can be seen as a continuum with natural being the most effective and artificial being the least effective. All have some effect depending upon the situation and how the foster parent interprets the situation to the child.

Corporal punishment, which includes physical hitting or any type of physical punishment inflicted in any manner upon the body is not to be used on children in foster care. The following punishments are prohibited also:

(1) Physical exercises such as running laps or performing push-ups shall not be used.

(2) Requiring or using force to make the child take an uncomfortable position such as squatting, bending, or repeated physical movements shall not be used.

(3) Children shall not be:

(a) subjected to verbal remarks that belittle or ridicule them or their families.
(b) denied emotional response as punishment.

(c) denied essential program services as punishment.
(d) denied meals, clothing, bedding, sleep, mail, or visits with their families as punishment.
(e) threatened with loss of their placement as punishment.
(f) bodily shaken.
(g) placed in a locked room.
(h) held with mechanical or chemical restraints.

These prohibited forms of discipline are listed in ICWIS. Allegations regarding foster parents' use of corporal punishment on foster children are to be entered into the intake module of ICWIS. If legal sufficiency is not met, the complaint is to be investigated by the licensing unit as an infraction of the licensing agreement or noncompliance with the case plan; and appropriate action is to be taken in accordance with Section 6 of this manual. If legal sufficiency is met, the complaint is to be investigated immediately following the requirements of any other abuse or neglect complaint. In either case, the intake is to be linked to the child's case; and the foster home worker is to be notified. Questions or concerns regarding the discipline policy are to be discussed with the foster family home worker during the home study process. At any time following placement, both the foster family home case manager and the child's family case manager need to be available and accessible to the foster family to discuss concerns related to a specific child.

404.341 Techniques

Throughout the teaching/learning process of helping the child develop into a responsible adult, the foster parent is to employ four (4) basic principles as follows:

(1) Identifying positive behavior

(2) Rewarding positive behavior

(3) Identifying unacceptable behavior

(4) Learning to deal with unacceptable behavior

There are several methods for encouraging internal control and responsibilities in children including contracts, behavior management, and corrective action.

404.3411 Contracts

Contracts are statements, either verbal or written, by which the foster parents and the children negotiate a mutually acceptable agreement. Contracts can be a simple and convenient method of helping children to acquire self-discipline because contracts:

(1) involve the children in making their own decisions and taking responsibility for their own actions.

(2) are flexible and can be negotiated to meet the requirements of the situation.

(3) are individual and can be tailored to meet the individual child's needs.

(4) provide opportunities for success which are visible to children.

(5) are tools that require the children to examine themselves in terms of their capacity for self-direction. (Contracts can increase in complexity as the children assume greater responsibility for themselves and their behavior.)

(6) provide opportunities for interaction between children and foster parents. (The parties are required to make an investment in their relationship. Great patience is required with the children, though, as it will take time for them to succeed.)

(7) provide practice for adult life. (For example, the time children return home from outside activities varies according to the child's age. Older children may wish to negotiate times that seem reasonable to themselves but not to the foster parents. The foster parents may sit down with the children and develop contracts (oral or written) which would be satisfactory for both. The negotiations may stall, so it is important to remain flexible but firm.)

(8) represents an investment on the part of both contracting parties.

404.3412 Behavior Management

A second form of discipline available to foster parents is behavior management. If a child is not able to handle the responsibility for self-discipline, the foster parent may need to impose structure and then gradually turn responsibility over to the child. This is usually done through a system of incentives or through a level system. The child receives rewards (privileges or tokens) for approved behavior and can usually work up to a level of increased self-responsibility.

Any behavior management program is to be developed by a professional (social worker, psychologist, family case manager) in consultation with the foster parent as a team member. Any such program is to be reviewed, approved, monitored and modified as necessary by the team.

When developing a behavior management plan, it is good to bear in mind that the system will work best if the rewards are established through mutual agreement of the child, the child's family, foster parent, and family case manager. All must follow the plan consistently.

The child is to be rewarded when the child behaves appropriately. If the child does not perform these behaviors, the child is not rewarded. Under no conditions is the child to be asked to return a reward.

EXAMPLE: Behavior wanted: Brushing teeth before bedtime.

Behavior management: Offer the child a token (penny, poker chip, etc.) each time the child brushes teeth before bedtime.

Reward: After the child has earned 10 tokens, the child will receive the reward (extra TV time, extra bonus in allowance, choice of toothpaste, money, etc.)

404.3413 Corrective Action

The third technique for discipline is corrective action. Before deciding to take corrective action, the foster parents must decide whether the behavior in question can be permitted or tolerated for a time or ignored in keeping with the needs and progress of the child, the needs of the foster parents, and the seriousness of the behavior. Children must be given opportunities to recognize that their behavior is inappropriate and to control it themselves.

The following presents types of corrective action:

(1) Clarification. In order for disciplinary action to be effective and helpful, it is necessary to make clear exactly what the offense was, when it occurred, the identity of the person(s) who provoked it, the identity of the offender(s), and under what circumstances it took place.

(2) Persuasion. Following clarification, foster parents can attempt to persuade the children to correct mistakes. Foster parents can show the children that there are other ways of achieving goals and that they have the ability to control their impulses. The foster parents' tone must be supportive and dispassionate, emphasizing the real consequences of the offense and suggesting how it can be corrected. The children may be able to suggest ways of correcting their mistakes.

(3) Distraction. Sometimes the simplest way of correcting children is to draw their attention to a substitute activity. The choice of the substitute activity should be guided by some criteria such as your best understanding of the children's intent, their interests, the social acceptability and age appropriateness of the substitute activity and its capacity to diminish the self-defeating aspects of the original activity.

(4) Interference. There are times when foster parents must stop unacceptable behavior immediately. Verbal interference tells the child "since you cannot control yourself, I will help you control yourself". Interference can be social, in the form of accompanying the child to prevent a social act. Physical restraint is to be used to prevent injury to another child or damage to property. Physical restraint is to be used for protection rather than punishment. The Division of Family and Children does not oppose the use of force that is reasonable and necessary to:

(a) stop a child who is threatening physical injury to persons or property;
(b) remove a child causing a disturbance who refuses to cease the behavior or to leave; or
(c) obtain possession of weapons within control of the child in self-defense or in defense of others <u>if</u> the child is actually attacking. If the child is <u>not</u> attacking, a confrontation is to be avoided, if possible, by giving the child room, removing others from the area, and obtaining appropriate assistance to disarm the child.

(5) Time-out. Time-out involves removal of children from situations until they can calm down. Children are isolated by having them sit on chairs or stay in parts of occupied rooms or in other unoccupied unlocked rooms under careful supervision. Under no circumstances are closets to be used for time-out. In some situations, it may be more appropriate for foster parents to "take time-out", removing themselves from situations as long as the children's safety is not in question.

(a) Time-out is to be used sparingly, after other techniques have failed to bring children under control.
(b) Time-out is to be short. A rule of thumb for the length of time-out is one minute per year

of the child's age; e.g., a maximum of 10 minutes for a 10 year old child.

(c) Once time-outs are over and the children have calmed down, they can return to other activities. It is helpful to bring the children back to something constructive that will redirect their energy.

(6) Withholding privileges. At times, it may become necessary to withhold privileges as a means of changing children's behavior. Privileges are benefits or favors that have been granted to children. Privileges have to be given to children before they can be withheld. Examples of privileges that could be withheld include use of the telephone, walks to the store, television time, etc. Food, shelter, and visits with parents are rights, not privileges; therefore, the child is not to be deprived of these.

(7) Restitution. Restitution is a realistic and simple form of discipline in cases of property damage or theft. Children can pay for repair of the property within reason in relation to the amount of money they have or receive through such sources as an allowance or a part-time job. Children who steal can either return the stolen goods or pay for them.

In the field of foster care, many professionals such as social workers, foster parents and family case managers have long stressed the importance of developing each foster child's potential. Discipline is one method of helping foster children reach their potential.

404.342 Guidelines for Use of Discipline

When any form of discipline is used on a foster child, these general guidelines are encouraged:

(1) Use encouragement and praise whenever possible to reinforce behavior.

(2) Don't take any type of corrective action while you are angry. Wait until your anger subsides before implementing discipline.

(3) There will usually be several discipline options to deal with a specific behavior or set of behaviors.

(4) Set clear limits, rules, and expectations; and communicate these to the children.

(5) If it is possible, have the children take responsibility for their actions and correct the behavior or situation.

(6) Give children choices and involve them in decision-making. This helps children to develop internal controls.

(7) As a general rule, the younger the child, the more immediate the consequences should be.

(8) Some children have physical, emotional, or mental disabilities or limitations that impede their ability to understand what is expected of them and to behave accordingly.

404.4 Independent Living

Under title IV-E of the Social Security Act, the federal government allocated funds to any state to receive funds for the implementation of Foster Care Independence Act of 1999, Public Law 106-169. The law amended Section 477 of the Social Security Act (42 U.S.C. 677) and replaced the former Independent Living Initiative with the John H. Chafee Foster Care Independence Program (CFCIP). CFCIP requires a 20% match for the states to secure its total allotment. CFCIP increases from $1,000 to $10,000 the assets that a youth in foster can have and still maintain their eligibility for Title IV-E funded foster care. CFCIP increases funding for independent living activities, offers increased assistance including room and board for youth ages 18 to 21, expands the opportunity for states to offer Medicaid to youth transitioning from care, and increases state accountability for outcomes for youth transitioning from foster care.

The purpose of the CFCIP program is to design and implement programs that will:

(1) Identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services such as assistance in obtaining a high school diploma, career exploration, secondary education, vocational training, job placement and retention, training in daily life skills, training in budgeting and financial management, substance abuse prevention, and preventative health activities (including smoking avoidance, nutrition education, and pregnancy prevention);

(2) Provide personal and emotional support to youth aging out of foster care, through mentors and the promotion of interactions with committed adults;

(3) To provide assessment, financial, housing, counseling, employment, education, and other support services to youth formerly in foster care between 18-21 years of age to assist them in achieving self-sufficiency while accepting personal responsibility for their future; and

(4) To assist eligible youth in substitute care and those returning home from substitute care while continuing under court supervision to prepare for emancipation by enhancing their skills and ability to live independently.

The Division of Family and Children (DFC) administers funds allocated to the Chafee Foster Care Independence Program. The DFC distributes the funds through regional contracts to the Regional Child Welfare Executive Committees based on the amount each region is entitled to receive. Allocations are based on the number of youth in substitute care, 14-21 years of age, in each respective region. Chafee funds pays 80% of the cost of all IL services provided to the target population named in 404.44 of this manual with a 20% match from the Family and Children's Fund being provided by the local office of family and children. For eligible youth ages 18 to 21 that are no longer wards of the court, the 20% match to cover IL skill services and room and board payments will be covered by funds available to the state from the ProLiance settlement until the settlement funds are exhausted. The counties will be notified at that time and will then resume responsibility for

the 20% match.

Expenditures for specific Independent Living services may be paid in whole or in part, either by direct vendor payments or as reimbursement, through CFCIP. Payment cannot be made prior to delivery of an approved service. Therefore, claims may be submitted only after a service unit has been completed. CFCIP funds are to be used to supplement, rather than replace, current state efforts.

404.41 Permanency Planning

The LOFC must document to the court a compelling reason for determining that it would not be in the best interest of the youth to return home, be referred for termination of parental rights, or be placed for adoption, with a fit and willing relative or with a legal guardian. After this has occurred, emancipation may then be established as a other planned permanent living arrangement that must be approved by the court with independent living as a service.

404.42 Definitions

Foster care refers to a youth's status with the state as opposed to a particular placement. Foster care means 24 hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. The youth placement could be in a family foster home, group home, child caring institution, kinship care home, pre-adoptive home, emergency shelter, Independent Living Placement orother state sanctioned voluntary placement. Pursuant to the definition of foster care, facilities that are outside the scope of foster care include, but are not limited to: detention facilities psychiatric hospitals; forestry camps; or facilities that are primarily for the detention for children who are adjudicated delinquents. Children placed in such facilities are not in foster care and may not be considered candidates for foster care because they have already been removed from the home.

Case Plan is a document required for children in need of services who are under the supervision of the COFC and is to be completed on specific forms as generated in ICWIS. State Form 2956, Case Plan Needs Assessment/Service for Child/Family is to be completed for every child under COFC supervision, including IV-E eligible probation youth in foster care. For youth beginning at age 14, Family Case Managers and Probation Officers are required to refer all youths for independent living services. Probation Officers must have IV-E eligibility
determined for any youth that is referred for IL services and request that the Family Case Manager forward the referral to the appropriate service provider. In the appropriate areas of the Case Plan, the Family Case Manager or Probation Officer must include the independent living plan that is developed for the youth. The Case Plan must also document information relating to the youth who refuses Independent living services and include all efforts to encourage the youth to participate. Youth with developmental disabilities should participate in
IL services that are geared to accommodate their special needs.

Independent Living Plan is a written plan that is developed between the youth, the youth's caregivers, Family Case Manager or Probation Officer, and other significant persons in the youth's life following a life skills assessment of the youth's independent living strengths and deficits. When the life skills assessment is completed with the youth, the independent living plan should incorporate the results of the life skills assessment and identify the programs and services which are needed to prepare the youth for self sufficiency. This plan must clearly identify the

goals and objectives for becoming self-sufficient and how the goals and objectives will be met. The youth must be an active participant in developing their own independent living plan. At ages 14 and 15, independent living services will focus on building basic life skills, at age 16 on independent living skills and program opportunities, and at age 17 on developing a transition plan as they prepare for independence. If the youth is in special education, a transition plan should be completed in connection with Vocational Rehabilitation and is appropriate for the youth aging out of foster care. The transition plan should include details of how the youth will obtain housing, food, clothing, transportation, healthcare, and other necessary services after dismissal.

The Independent Living plan can be entered in the Case Plan in section F under details below the IL need type and sub type. The plan must be updated every 180 days with progress and continuing needs reported in the same section. Objectives and activities are to be entered in section H that follow the plan.

Independent Living Services are services provided with Chafee Foster Care Independence Program (CFCIP) funds statewide through contracted service providers. Independent living services are available to assist youth toward developing self-sufficiency, regardless of their permanency goal. All services teach independent living skills designed to increase the youth's level of personal responsibility and to acquire appropriate decision-making skills. Service standards for IL services available can be located in Appendix M, Room and Board services in Appendix O, and Youth Advisory Boards in Appendix P. Services are provided through regionally contracted service providers and are available to the target population as named later in this document.

Room and Board is financial assistance available to youth ages 18 to 21 that "age out" of foster care, which means they are in foster care as defined above on their 18th birthday and no longer a CHINS. Room and board expenses may be considered as rent payments, deposits (i.e. apartment or house rental deposits, utility deposits), utilities, dormitory housing (includes food if part of the structure of dormitory expenses). No furniture may be purchased with these funds. Room and board funding is provided to prevent youth from leaving care and being in a "homeless" or "transient" living situation while being particularly careful not to create financial hardship or stress for the youth. The youth will be expected to gradually assume some of the financial responsibility of their living costs. Once the youth voluntarily agrees to receive room and board services, the Independent Living Plan must address a plan for the youth to continue their independence when the assistance ends.

These services are contingent upon funding availability and a referral from the DFC. Youth may access this assistance as long as they continue to meet eligibility requirements and until the lifetime cap of $3000 (not including match) is exhausted or until the youth's 21st birthday. During the 18 to 21 year old time period, youth may access this service more than once, pending availability of funds and the amount of designated room and board funds available for that youth. Youth leaving foster care or re-entering the system to receive CFCIP room and board services must do so on a voluntary basis and sign an agreement (see Appendix Z) for voluntary case management services with the IL service provider.

Youth Advisory Boards are located in eleven sites throughout the state and are designed to provide a forum for youth 14 to 21 to develop their own agenda related to services and areas of interest. The youth will be involved in design and implementation of independent living services

and programs they believe would be beneficial in assisting youth in care in reaching their full potential as they move into adulthood. Service standards and meeting sites can be located in Appendix P. Agencies contracted to oversee and manage the Youth Advisory Boards are listed in the contracted IL service provider list for each region in Appendix Q through V.

404.43 Independent Living Services

Independent Living Programs are designed to assist youth by advocating, teaching, training, demonstrating, monitoring and/or role modeling new appropriate skills in order to enhance self-sufficiency. Services will be provided according to the developmental needs and differing stages of independence of the youth. As such, independent living services should not be seen as a single event or as being provided in a substitute care setting but rather as a series of activities designed over time to support the youth in attaining a level of independence that allows for a productive adult life. Services should recognize the evolving and changing developmental needs of the adolescent and address all of the preparatory requirements for independent adulthood. The CFCIP clarifies that IL activities should not be seen as an alternative to permanence for children and can be provided concurrently with adoption and other permanency activities. Independent living is a set of services to assist a youth in reaching the goal of their permanent plan. IL service providers should link with the local Workforce Investment Boards, Vocational Rehabilitation offices, Bureau of Developmental Disabilities, Community Action Agencies, Housing and Community Services, Department of Mental Health, and IMPACT for youth eligible for their services.

Consistent with the case plan, individual, group and family counseling services should be provided for youth to help them better understand their past and present, and prepare for their future, including the possibility of reconnection with significant persons from the past. Social services are essential to the well-being and psychosocial development of all youth.

Service providers will provide social services either directly or by referral that include a comprehensive independent living assessment and written independent living plan, which is strengths-based, developmentally appropriate, and involves the youth, caregiver, and other significant persons in its development. Services will build on the youth's positive behaviors, personal strengths, and recognize the need for advocacy by case managers, social workers, counselors, and foster parents/ caregivers. Service components must include the assessment and can include one or more of the following:

Service components must include all of the following based on the youth's needs as identified through the Independent Living assessment and documentation in the case plan:

<u>Assessment</u>

The independent living assessment must include a comprehensive, written assessment of the youth's strengths as well as areas needing improvement. The assessment must include youth self-assessment in addition to assessment(s) of caregiver(s). The following assessment tools are approved for use: Daniel Memorial Assessment and Ansell-Casey Life Skills Assessment (ACLSA).

The ACLSA can be accessed online at www.caseylifeskills.org with separate assessments completed by the youth and caregiver. When entering information use the region and county number as the organizational ID (i.e. INNW58; INNC50; INNE44; INWC86; INC06; INEC33; INSW87; INSE59). The youth ID should be something that will identify the youth for the county. If the caregiver and youth complete the assessment within 30 days of each other using the same organizational and youth ID, a report will be generated that includes both assessments together. This document will identify the youth's strengths and areas in which the youth needs

assistance. The Independent Living Plan should be developed building upon the strengths of the youth and addressing the areas of improvement identified in the assessment.

Educational Services

As indicated by the youth's Assessment and Independent Living Plan, service providers will provide and /or monitor that the youth receives targeted educational services consistent with the goals of the plan, either directly or by referral that may include:

(1) An assessment of the youth's skills, learning styles, and aptitudes;
(2) An educational plan or IEP/ITP consistent with the youth's case plan;
(3) Assistance with obtaining access to appropriate resources, such as a public or private school, college or university, as well as specialized vocational training programs. Including receiving academic support (HS/GED/Vocational Certificate);
(4) Advocating with the public school system for the youth's right to an education as provided in federal law;
(5) Assistance with receiving financial support related to educational support;
(6) Receiving planned driver's education services (if over the age of 16 and there is an adult willing to take legal responsibility for the youth regarding insurance and liability); and
(7) Assistance with career preparation to reinforce preparedness and possession of a marketable skill set. Such services may include assessment of a skilled occupation competency based on the youth's interest and aptitudes.

Vocational and Employment Services

As indicated by the youth's Assessment and Independent Living Plan, service providers will provide and /or assist the youth in accessing vocational and employment services consistent with the goals of the plan, either directly or by referral that may include:

(1) An assessment of interests, abilities, and aptitudes as well as strengths and weaknesses in obtaining and maintaining employment;
(2) Assistance in developing habits, skills, and self-awareness essential to employability;
(3) Making use of all available community employment and training resources including on the job training, a job coach if eligible for service, and helping the youth access them, as appropriate;
(4) Assistance with receiving career planning/job placement/job retention services; and
(5) Developing job leads in the private sector and working with employers who may employ youth, including internships, job mentoring, apprenticeship, summer employment programs and other supportive services.

Health Services

As indicated by the youth's Assessment and Independent Living Plan, service providers will provide and /or assist the youth in advocating for physical and mental health services consistent with the goals of the plan, either directly or by referral that may include:

(1) Documentation of his/her physical health status, and referral for services as needed
(2) A written summary or Medical Passport of his/her known medical history, including family health history, that includes immunizations, operations, and childhood illnesses
(3) Assessment and documentation of special needs, if any
(4) Age-appropriate education regarding basic hygiene and nutrition, medical and dental care, sex education and HIV prevention, substance abuse prevention/intervention, teen parenting education
(5) Assistance with accessing formal individual and group counseling, including crisis counseling and family therapy.
(6) Receiving Medicaid coverage, State alternative, or other insurance coverage for self and children.
(7) Education regarding safety skills (personal safety, fire, etc).

Housing Services

Youths seeking independence should be assisted in their efforts to locate suitable living arrangements, an essential step in making a successful transition to independence. As indicated by the youth's Assessment and Independent Living Plan, service providers will provide and /or assist the youth in locating, obtaining, and maintaining housing consistent with the goals of the plan, either directly or by referral that may include:

(1) Education regarding the range of housing options;
(2) Budgeting for consistent payments of rent to assure a positive rental history;
(3) Education on tenant rights and responsibilities;
(4) Education to develop understanding of the importance of following Apartment Communities rules and regulation policies;
(5) Advocacy on behalf of particular youth for affordable, appropriate housing;
(6) Assistance with obtaining a safe, growth-enhancing living environment suitable to the needs of the youth and his/her level of maturity and functioning;
(7) Receiving formal supervised independent living services where the youth is under the supervision of an agency and receiving agency financial support, but without 24-hour adult supervision, as appropriate and outlined in the case plan; and
(8) Receiving room and board payment (for youth 18 years or older only) as appropriate.

Life Skills and Social Skills Services

As indicated by the youth's assessment and Independent Living Plan, service providers will provide life and social skills training that may include:

(1) Access to legal services and training on exercising legal rights and responsibilities;
(2) Information and referral regarding public assistance from the state and local township trustee;
(3) Opportunity to meet and interact with others in small and large groups and to develop a consistent, ongoing mentoring relationship with an appropriate caring adult;
(4) Participation in peer support and community service programs;
(5) Specific education and training in the areas of problem-solving, conflict resolution, resource management, stress management, communication skills, interpersonal skills, community resources, support systems, and goal-setting;
(6) Training in life skills, self-care, and the activities of daily living as necessary, including budget and financial management services;
(7) Referral to and advocacy within the community for services that are not provided directly by the agency; and
(8) Obtaining and maintaining written documentation of all physicians, dentists, social workers, schools, mental health providers, social security, court records, etc., related to their case, including name, address, and phone number.

Youth Development

As indicated by the youth's assessment and Independent Living Plan, service providers will provide opportunities for social, cultural, recreational, and/or spiritual activities that:

(1) Are designed to expand the range of life experiences;
(2) Are sensitive to the cultural needs of youth;
(3) Are sensitive to youth with special needs;
(4) Form meaningful and growth-producing adult relationships with families, peers, and other persons;
(5) Assist the youth in managing relationships with family, peers, and significant others;
(6) Provide regular feedback from service provider on observations of the relationships;
(7) Introduce various available recreational and social activities for leisure time;
(8) Offer experiential learning in communication skills and conflict resolution management;

Allow for participation in youth conferences and other developmental opportunities, which include leadership activities and mentoring services (mentoring services include group pairings of youth with adult role models to provide a support system to guide and advise youth); and provide mentoring in the school, workplace and/or community.

404.44 Eligibility for IL Services

Any youth to be eligible for IL services through CFCIP must be:

(1) Youth ages 14-21, up to the 21st birthday, who are in foster care under the supervision of the local office of the Division of Family and Children, with a case plan establishing the need for independent living services.
(2) Youth ages 14-18 who were formerly in foster care as a CHINS between the ages of 14-18 who have been adopted and were receiving independent living services prior to their adoption.
(3) Youth ages 14-21 who were formerly in foster care as a CHINS between the ages of 14-18 that were returned to their own homes and remain a CHINS with a case plan establishing the need for independent living services.
(4) Youth ages 18-21 who were formerly in foster care as a CHINS between the ages of 14-18 under the supervision of the local office of the Division of Family and Children.
(5) Young people who are 18-21 who would otherwise meet the eligibility criteria above and who were in the custody of another state or were a "ward of another state" will be eligible if through the Interstate Compact for the Placement of Children there is a verification of wardship and all eligibility criteria from the state of jurisdiction.
(6) Probation youth 14-21 who are IV-E eligible and in a IV-E eligible foster placement, adjudicated a delinquent and meets the criteria of 1 or 2 above and their county of residence has an interagency agreement between the court and the local DFC relating responsibilities of each party for meeting all state and federal mandates.

Probation youth that do not meet the criteria above can be provided IL services with the contracted IL service providers with the billing made directly to the referring DFC and the cost being paid from the Family and Children's Fund.

404.441 Referral Process for Youth ages 14 to 18

ICWIS provides a tickler to inform the Family Case Manager when a youth currently in care turns 14 to remind them to make a referral for IL services. Lists of agencies providing IL services in each region is located in Q as well as referral forms that are required for services. Youth that come into care after their 14th birthday should be referred for IL services within 30 days.

Youth that should be referred for IL services are youth that are placed in local foster care homes, relative/kinship homes, and those placed in LCPA foster homes that do not include IL services in their per-diem. Youth previously placed in out of home placement that have been reunified with their families should also be referred for IL services while they remain a CHINS. IL services should be provided to youth placed in residential facilities and group homes as a part of ongoing services and included in the per-diem for that placement. It is the responsibility of the FCM to ensure that an IL assessment and services are being provided to all youth ages 14 to 21 that are placed out of the home.

404.442 Referral process for continuing services for youth 18 to 21 upon dismissal of wardship

Youth currently provided with IL services that are "aging out of foster care" are to be provided with a voluntary services agreement (see Appendix Z) at least 60 days prior to their 18th birthday if the youth chooses to continue with IL services, Youth Advisory Boards, and/or request room and board services. A referral should be made to a contracted IL service provider that is capable of meeting the needs of the youth and is contracted to provide the needed services. Not all IL service providers have the provision of room and board assistance in their contracts.

If the youth is already working with an IL service provider and has chosen to continue voluntarily, the referral form for youth's 18 to 21 must be completed and submitted to the service provider for continuing services along with the voluntary services agreement that will then be signed by the agency as well as the youth and FCM. The offer of a voluntary service agreement must be entered into ICWIS contact logs for all youth turning 18 or upon dismissal of wardship whether the youth chooses to participate or not. There must be clear documentation regarding the offer of continuing IL services and the youth's decision regarding acceptance of services as the decision is voluntary.

404.443 Providing services for youth re-entering the system for assistance from other states or counties

A youth's eligibility for IL services ages 18 to 21 is not determined by placement or geography, but by their legal status with a state. A youth, who moves from one state to another, does not lose eligibility for independent living services. The state of that youth's current residence bears responsibility for providing and paying for those services. Youth who are 18-21 who would otherwise meet the eligibility criteria and who were in the custody of another state, or were a "ward of another state" must have verification of wardship in that state through the Interstate Compact. The county where the youth currently resides will be responsible for making referrals for all eligible youth requesting services through Interstate Compact.

Services are available through the independent living service provider contracted in the county of residence of the youth based on a referral from the local DFC. If the youth is applying for services in a county other than the county in which they were placed in foster care, the county where the youth is applying must contact the previous county to verify eligibility prior to making the referral for services. The current county of residence is responsible for making referrals for all eligible youth regardless of previous CHINS involvement or out-of-state youth.

404.45 Youth Advisory Boards

The Youth Advisory Boards are designed to provide a forum for youth 14 to 21 to develop their own agenda related to services and areas of interest that they believe would be beneficial in assisting them in reaching their full potential as they move into adulthood. The youth will develop topics of interest, develop research and interpersonal skills, and seek adult guidance in bringing their ideas to fruition. This program will prepare youth as they transition from adolescence to adulthood by recognizing and accepting personal responsibility.

The Youth Advisory Boards will meet six times annually, approximately every other month. The board members will design their mission statement, develop group guidelines, and develop meeting agendas. The regional boards will collaborate quarterly by teleconference to review and discuss direction of the program and exchange information regarding their agendas, research, and projects.

The youth will be involved in design and implementation of independent living services and programs. They will be involved in decision making, shaping policy and monitoring implementation of services for youth as well as serving as advisors to provide feedback to program administrators, legislators and other involved in providing youth services. The youth will provide broad consultation to state child welfare administrators in the long-term implementation of the state independent living plan and represent the voices of foster youth across Indiana.

Youth chosen to serve on the advisory boards will be provided transportation to all activities related to their duties by the contracted IL service provider. Contracted IL service providers are developing this program with the assistance of the Ball State University Independent Living Initiative that is contracted with the State.

The Youth Advisory Board meeting sites are in the following counties:

YAB Seat: St. Joseph County
Serving counties: St. Joseph, LaPorte, Marshall, Elkhart, Koscuisko, Fulton,

YAB Seat: Lake County
Serving counties: Lake, Porter, Newton, Jasper, Starke, Pulaski

YAB Seat: Allen County
Serving counties: LaGrange, Steuben, Noble, Dekalb, Whitley, Allen, Huntington, Wells, Adams

YAB Seat: Howard
Serving counties: Cass, Miami, Wabash, Howard, Tipton

YAB Seat: Tippecanoe:
Serving counties: Benton, White, Carroll, Clinton, Tippecanoe, Warren, Fountain and Montgomery

YAB Seat: Johnson
Serving counties: Marion, Johnson, Morgan, Shelby, Hendricks, Hancock, Hamilton, and Boone

YAB Seat: Delaware
Serving counties: Madison, Delaware, Jay, Randolph, Grant, Henry, Blackford

YAB Seat: Wayne County
Serving counties: Wayne, Rush, Fayette, Union, Franklin

YAB Seat: Ripley
Serving counties: Jennings, Jefferson, Switzerland, Decatur, Bartholomew, Ripley, Dearborn, Ohio

YAB Seat: Vigo
Counties served: Vigo, Clay, Owen, Monroe, Sullivan, Vermillion, Parke, Putnam

YAB Seat: Daviess
Counties served: Daviess, Greene, Knox, Martin, Dubois, Perry

YAB Seat: Vanderburgh
Counties served: Gibson, Pike, Posey, Vanderburgh, Warrick, Spencer

YAB Seat: Washington
Counties served: Brown, Lawrence, Jackson, Orange, Washington, Scott, Crawford, Harrison, Floyd, Clark

404.451 Eligibility for Youth Advisory Boards

Youth Advisory Board (YAB) members, ages 14 to 21, are current participants in independent living programs or have successfully completed an independent living program. Membership will also include youth involved with the juvenile justice system, adopted teens, parenting teens, teens involved with drug and alcohol rehabilitation programs, homeless youth, unattached youth, and youth that represent ethnic and cultural diversity that were previously placed in foster care between the ages of 14 and 18. Youth returning for assistance from previous service providers, private foster home agencies, or residential facilities also may be chosen to participate.

404.452 Referral Process for Youth Advisory Boards

Service providers and/or placement agencies may submit potential member names of youth that return to request assistance following wardship dismissal to the local office of the Division of Family and Children. Each office of the Division of Family and
Children will identify potential members in conjunction with the contracted IL service providers and provide referrals to the Independent Living Program Assistant at Ball State University on the YAB referral form (see Appendix Y). The local DFC FCM must sign the referral form for each youth referred. Youth over 18 interested in serving on a YAB who are no longer CHINS must sign the referral form as well as the
FCM. Ball State will assign the location of the YAB in which they will participate and notify the YAB Coordinator of their acceptance. The YAB Coordinator will then notify the youth of their acceptance to the board and provide them with information regarding their involvement and responsibility to the YAB.

404.46 Procedure for youth ages 18 to 21 re-entering the system for assistance

Youth re-entering the system to receive CFCIP funds must do so on a voluntary basis. The youth desiring services must contact the local DFC or request that a former foster parent, service provider, or other community agency personnel contact the DFC for the youth to determine eligibility. Eligibility for services will be determined based on the eligibility standards listed in the service standards for the service the youth is requesting. (See Appendix N for service standards.) Once eligibility is established, a referral should be made to an IL service provider contracted to provide the appropriate services needed by the youth. (See Appendix Q through V for a list of IL services providers for all regions and Appendix W for the referral form.)

404.47 Procedure for initiating refused services/re-initiating terminated services for youth 18-21

The FCM shall make a referral to the IL service provider prior to the youth's dismissal of wardship to allow the youth the option of participating voluntarily following dismissal of wardship. For youth refusing the offer of voluntary services, their referral will remain open for a 90-day grace period, beginning on the youth's 18th birthday to allow for the youth to change their mind. The FCM or Probation Officer will advise the youth in writing of the 90-day grace period when completing their discharge summary with contact information for the IL service provider.

Youth who have been previously discharged from IL services either voluntarily or involuntarily may contact their previous IL service provider or the DFC to reinitiate services. The DFC must make a new referral to the IL service provider if the grace period has ended with eligibility being re-established. If the youth moves to a different county and chooses to re-enter services, the youth must contact their current county of residence DFC and request that a referral be made. The county of residence must check ICWIS to determine eligibility and contact the original county of residence for verification of eligibility.

For youth who are already on a voluntary agreement for services and are not meeting the terms of their agreement or wish to voluntarily terminate the agreement, the IL service provider will inform the youth in writing that they have 90 days in which to come back into compliance with the terms of the agreement or to renegotiate the terms of the agreement. The youth will also be informed that they have the option of scheduling a meeting with their IL service provider to discuss the terms of the agreement.

For those youth who engage in violent or other serious criminal behavior, or are consistently non-compliant with the terms of the agreement, the IL service provider shall have the option of immediate termination of the agreement with notification to the referring DFC. The IL service provider should review the youth's agreement every three months to assess the youth's progress with regard to the terms of the agreement and the need for any revisions to the agreement.

404.48 Room and Board eligibility ages 18 to 21

Up to 30% of Indiana's federal CFCIP allocation can be used to provide room and board services to youth who leave foster care at the age of 18. This funding cannot be used for any youth under the age of 18. Eligibility for CFCIP Room and Board Services include only:

(1) Youth who have aged out at age 18 or older up to age 21 who move directly from foster care into independent living programs, as well as those who age out, lose touch with the Local Office of the Division of Family and Children, and then return for assistance before reaching the age of 21.
(2) Youth who leave care voluntarily at age 18 but find themselves in need of supportive services after leaving, but prior to turning age 21.
(3) Youth with child(ren) and those married or have a roommate must meet eligibility requirements for room and board assistance.

As the youth becomes increasingly self-sufficient, the amount of funds being provided should be reduced accordingly to allow for assistance at a later date if needed. Because stability of the youth can be unpredictable, it is possible that a youth may become homeless despite the fact that they were self-sufficient for a period of time. In the event that this occurs, they may request assistance again provided they have not used their $3000 cap (not including the match) and have not reached the age of 21.

404.481 Room and Board Assistance for youth ages 18 to 21 following dismissal of wardship

Room and board expenses may be considered as rent payments, deposits (i.e. apartment or house rental deposits, utility deposits), utilities, dormitory housing (includes food if part of the structure of dormitory expenses). No furniture can be purchased with these funds. These services are contingent on funding availability and eligibility requirements of the youth. Eligible Youth for room and board payments may receive a maximum, lifetime cap of $3000 (excluding the match) for assistance, as established in the IL plan. All youth who access this service will be required to participate in an IL plan that includes a full time schedule of work or part time work schedule and school. The monthly room and board assistance will be based on need and will be determined on a Budget Worksheet (see Appendix AA for example). DFC central office staff only, based on availability of funds will consider all subsequent requests for emergencies on a case-by-case basis when amounts exceed the $3000 maximum.

Room and Board payments will only be made through a contracted IL service provider. The supervisor or FCM in the local office should make a referral using the referral form in Appendix X. Any youth receiving room and board payments must receive independent living case management services. Potential housing options may include host homes, family foster homes, youth shelters, shared houses, single room occupancy, boarding houses, semi-supervised apartments, subsidized housing, scattered site apartments, and transitional group homes. Room and board payments shall not be expended to allow a youth to reside with their biological family or legal parent.

404.482 Room and Board Assistance for Host Homes (see sample Host Home Agreement in Appendix HH)

A host home is where a youth rents a room in a family or single adult's home, sharing basic facilities and agreeing to basic rules while being largely responsible for their own life. Host homes are a great solution in rural areas where apartment buildings are scarce and house rentals may be cost prohibitive. Host homes are similar to foster homes, except the host is not necessarily a licensed foster parent and does not usually have to go through the process of having the home licensed and the parent trained.

A host home could be a former foster parent, teacher, coach, or church member with whom the youth has a positive relationship. In this environment, the youth would be able to come and go as they choose and be expected to manage their time, money, school, work, and appointments without oversight from the host home. They would be expected to follow the rules of the home as with any other renting situation.

If the host home is not a licensed foster parent, a State Limited Criminal History check and CPS check through the Central Client Index in ICWIS will be required on all adults in the home as required for foster parents. The host will be required to arrange for their own criminal background check with the assistance of the IL service provider or DFC. It will be the responsibility of the contracted IL service provider to ensure that the CPS check is completed and to collect the criminal background check from the potential host home, once the release of information is signed. Criminal
history that indicates that any adult in the host home has been convicted of crimes against a child, crimes of violence, or sex crimes and any substantiated

investigations of abuse or neglect will eliminate the person as a possible host home for the youth.

The youth and the host should mutually decide upon an amount of rent money the host should receive while the youth is living in the home, subject to approval of the DFC.

Factors to consider when determining financial compensation for a host home should include:

(1) The amount of time the youth will live in the home.
(2) The employment status of the youth.
(3) The financial status of the youth.
(4) The educational and vocational goals of the youth.
(5) The health and behavioral needs of the youth.

See Appendix HH for a sample host home agreement that may be used as a guide in developing a youth/host home specific agreement.

404.483 Referral process for IL services and Room and Board for youth ages 18 to 21 re-entering the system for assistance

Once eligibility is established, the supervisor or a family case manager in the local office should make a referral using the appropriate referral form in Appendix W to the independent living service provider in the area where the youth resides. Any youth receiving Room and Board services must also participate in IL case management services to maintain eligibility.

A service case must be opened in ICWIS to manage the case. The youth's IL plan must be entered along with the services being provided.

404.49 Termination of Independent Living Services for youth ages 18 to 21

The youth's participation in independent living services including room and board shall end upon the following conditions:
(1) The youth has achieved independence to the extent that financial support and social service support are no longer needed.
(2) The youth has made a voluntary decision not to participate in the program.
(3) The youth has been adopted and no longer desires to continue in services.
(4) The youth has consistently demonstrated unwillingness or inability to participate in services or follow the terms of the voluntary agreement.
(5) The youth turns 21 years of age.

404.50 Discharge Summary for youth ages 18 to 21 ending wardship (see Appendix BB for form)

When the youth's wardship case is ready to be dismissed, the Family Case Manager or probation officer, depending on jurisdiction, must meet with the youth to complete the discharge summary in ICWIS. The discharge summary can be competed on a paper copy and then entered into ICWIS in situations where it is impossible to meet

with the youth in the DFC office. Probation officers completing the discharge summary must have the youth sign the paper copy and provide the summary to the DFC for input into ICWIS. The discharge summary must be completed before the case can be closed in ICWIS.

The discharge summary will be completed with each youth leaving DFC care with the following exceptions:

(1) Youth refuses to meet with the FCM or Probation Officer.
(2) Youth's whereabouts are unknown.

Family case managers or probation officers must provide assistance with obtaining a copy of the youth's birth certificate, social security card, a State ID card if unable to obtain a valid driver's license, and other necessary documents prior to dismissal of wardship.

404.51 Post-Discharge Summary for youth ages 18 to 21 with continuing services following wardship or re-entering the system (see Appendix CC for form)

When the youth completes IL services or requests that IL services discontinue, the IL service provider must meet with the youth to complete the post-discharge summary prior to dismissal of the case. The post-discharge summary should be competed on the paper copy, signed by the youth and person completing the summary, and maintained in the youth's case file by the IL service provider with a copy provided to the Regional Voluntary Services Coordinator within 30 days for input into ICWIS.

The post-discharge summary will be conducted with each youth discontinuing extended IL services with the following exceptions:

(1) Youth refuses to meet with the IL service provider.
(2) Youth's whereabouts are unknown.

The State Independent Living Coordinator will keep this information in paper files at Central Office in order to obtain statistics for this population until such time that ICWIS is ready to accept this information.

404.52 Family Case Manager Role

Family case managers are to assist youths, ages 14 to 21, to develop and utilize available resources necessary to prepare for independent living. They are to utilize contracted independent living service providers, community resources, and other significant individuals in the youth's lives to assist in this preparation.

When placing youths in family foster homes, group homes, or residential child care facilities, family case managers are to ensure that an independent living assessment is completed as soon as possible following placement. The family case manager is to initiate the development of agreements with the contract personnel that incorporates informal independent living concepts into the youth's daily living arrangements. Informal independent living concepts include programs and activities that encourage youth to prepare for life in the community. These include:

(1) problem-solving;

(2) assisting in the planning and preparation of meals;
(3) using public transportation or finding their own transportation;
(4) doing their own laundry;
(5) budgeting money; and
(6) time management skills regarding completing homework assignments, completion of required chores, planning their own leisure activities, required amount of sleep, and getting themselves up in the morning.

These services must be provided for foster care youths to whom the goal of independent living is assigned. Many youths in out of home care are expected to return home to their families. In reality, all youths in care should be acquiring independent living skills regardless of the case plan goal assigned.

For younger adolescents, personal skills should receive primary focus while education in basic skills assumes a complementary role. The provision of independent living skills is an ongoing process with continued services being provided to maintain gains made by the youth as well as to continually increase and strengthen the youth's knowledge and skill base.

404.53 Driver's Training

Indiana statutes do not permit COFC employees to sign an authorization for a ward to take driver's training or obtain a driver's license. Signing such an authorization implies assumption of a liability. COFC employees are prohibited by law from guaranteeing payment of the personal bills of a consumer of agency services, and the COFC has no funds to assume the liability.

However, the child's legal parent or legal guardian may wish to sign such authorization and assume liability. If this is not feasible, the Central Office of the Division of Family and Children (DFC) supports, in principle, the willingness of foster parents to authorize a ward to take driver education and obtain a driver's license. Enabling a foster child to accomplish this goal at the time in a child's life when it is most important as a rite of passage promotes the development of a family environment. However, the foster family needs to understand that it is the family that must assume full responsibility both for authorizing the child to receive driver education and for providing full insurance coverage for the child. The DFC Central Office assumes no responsibility/liability for either authorization or insurance coverage. If the foster parent does sign, it must also be understood that the foster parent is responsible for retrieving the license if the child is moved. It should be noted that a child for whom a driver's license is being sought by foster parents is required to have completed, be attending or be registered for a bona fide driver education program (verification required). The COFC would need to establish a method for monitoring whether insurance coverage is always in place.

If a foster parent wishes to assume responsibility by signing an authorization for a ward to receive driver education or obtain a driver's license, the foster parent shall submit a written request to the COFC for permission prior to giving authorization. The COFC may grant or deny a written request from a foster parent for permission to sign an authorization for a ward to receive driver education or obtain a driver's license. Factors to consider in determining whether to permit or deny foster parents to give this authorization include the following:

(1) Whether the parent or guardian is willing to sign the authorization and provide full insurance coverage and, if not, the reason for it; e.g., the child's past history, or the inability of the parent or guardian to provide full insurance coverage.

(2) Whether the child's parent or guardian will give permission for the foster parent to sign a driver education authorization. This requirement may be waived if it is in the child's best interest to do so, but the COFC would be obligated to notify the parent or guardian of the intent to assist the child to obtain a driver's license.

(3) Whether the foster parent can assume full responsibility for the authorization and full insurance coverage.

(4) Whether it is in the child's best interest to pursue a driver's license while in out-of-home care. For example, is the child considered sufficiently mature to handle the responsibility of driving? Is the child expected to remain in substitute care long enough to warrant pursuing a driver's license while in care?

Using the criteria outlined above, COFCs need to evaluate each situation involving the pursuit of a driver's license for a ward on its own merits and make a decision concerning allowing foster parents to assist a foster child to obtain a driver's license on the basis of that evaluation.

404.54 DFC Liability for Property Damages Perpetrated by a Ward

The state has no funds available to pay for damages to property perpetrated by a ward. In such a situation, the injured party is required to file a standard tort claim in order to collect damages would necessarily go to court.

404.55 Life Books

The Independent Living LIFEBOOK (NN13) is available for IL youth and can be obtained by the local county office of the division of family and children through the forms distribution center at no cost. The LIFEBOOK is a spiral bound book that provides information to assist youth, as they become independent. The LIFEBOOK includes pockets to store important documents as well as other personal items that youth want to keep.

404.56 Independent Living Outcome Measures Report Procedure

In accordance with the requirements (Chafee Foster Care Independence Program) to identify outcome measures that can be used to "assess the performance of States in operating independent living programs" and to identify data elements for purposes of tracking performance, the National Youth in Transition (NYT) was developed. NYT is a comprehensive system that integrates information pertaining to the characteristics of the youth served, services delivered, and outcomes achieved into a unique data collection and data reporting process.

Independent Living Outcome Measures Report Procedure and Clarifications

The Indiana Family and Social Services Administration (IFSSA), has approved the Independent Living Outcome Measures Report which includes questions related to each of the outcome measures mandated by the Chafee Foster Care Independence Act of 1999 (CFCIP).

Every provider will complete an Independent Living Outcome Measures Report when a youth enters the independent living program. A report will be completed for each youth every six months following the initial interview until discharge. Each report must be completed to reflect the current reporting period. When filling out an initial report, the form is to be used as a background inventory for everything that happened to the youth prior to beginning the program.

The six-month report should include everything that happened with the youth between intake and 6 months. The one year report should show everything between 6-months and one year, etc.

Intake: Must be completed when a child enters an IL program
Six-Month Progress Report: Must be completed every six months for each child enrolled in the IL program (e.g., at six months, 12 months, 18 months, and so on), and include information from the six months prior to date of report.
Discharge: Must be completed when a child is discharged from an IL program. The information on a discharge report will be relevant from the last completed report to the date of discharge.

Copies of these reports will be submitted to the Indiana Independent Living Initiative and the State Independent Living Coordinator two times per year (March 30 and October 31).
In addition, providers will be required to submit a early mid-year (February 28) and an Annual evaluation report (October 31) o the Regional Child Welfare Services Coordinators, using the forms provided by the Division of Family and Children. To meet these reporting requirements, providers should be collecting data in the following areas on the individual youths served by the program.

404.57 Education and Training Voucher Program

The Education and Training Voucher Program (ETV) will allow Indiana the opportunity to strengthen its Chafee program by offering transitioning youth the financial and supportive assistance they need. Youth in the foster care system have varied capabilities and needs as they approach the age at which they are expected to become independent of the system. This program will allow those needs to be addressed in a manner that is conducive to their ability and wishes. Youth may choose to earn a bachelor's degree, a vocational certificate, or obtain training that will enable them to obtain employment to meet their financial needs. Youth receiving ETV assistance should retain the mentor services afforded them prior to the dismissal of their foster care case.

Youth in foster care must be referred for IL services at age 14 and are expected to participate in the case planning process. Case conferencing is a requirement of case planning which allows the youth and all parties working with the youth to meet at least every six months and more often if necessary to identify progress and future needs. The youth meets with the treatment team which includes the youth's family case manager, CASA/GAL, therapist, IL service provider, education partner, parents, and any other person significantly involved in the youth's life. Through this process the team will assist the youth as the youth determines their interests and then guide the youth into the most appropriate vocational or post secondary program.

As the youth determines their desire regarding their future, a plan will be developed to ensure that the youth is able to follow through. If a youth is within six months of their 18th birthday and will not be graduating from high school prior to turning 18, an alternative plan of obtaining a GED may be determined based on the youth's ability. If a youth is unable to complete a GED due to reasons beyond their control, an alternative training program may be sought out to allow them to develop skills that could lead to employment opportunities. This participation allows the youth to develop a program that best suits their future needs and ability to meet those needs with guidance of the treatment team. Developmental disabilities are to be taken into consideration as each youth makes plans for their future. Youths participating in a Individual Transition Plan (ITP) through special education will have a member of that program participate on their treatment team in the case conferencing process to ensure that the appropriate agencies are involved to ensure success. They may have involvement with Vocational Rehabilitation through

their ITP.

The youth will complete an IL assessment tool along with their caregiver when they are referred to IL services and at intervals deemed necessary as progress is made. Assistance will be provided as needs are determined by the assessment. Research into areas of interest will be done to help the youth try to determine what they would like to do when they become independent. When a youth turns 17, finalization of post secondary options will begin. This will ensure that all necessary steps are taken regarding applications, testing, financial aid, housing, and any other areas that need attention to ensure the youth is ready when they complete high school, receive a GED, or begin their future as an adult.

Youth eligible to receive CFCIP IL services will likely be eligible for the ETV program. All youth receiving ongoing IL services sign a voluntary contract indicating their plan for the future and their commitment to the plan. IL services are provided to all youth receiving room and board services to ensure that the youth is making progress to maintain independence and to provide support when needed. These services will also be provided to youth participating in the ETV program. The IL worker will serve as an advisor, mentor, or any other role that will be of assistance to ensue that the youth is successful in their post secondary endeavor.

Those intending to pursue post-secondary education and training will be assisted in completing the Free Application for Student Financial Aid (FASFA). Youth aging out of foster care are declared an independent student on the FASFA and do not need parent information which usually makes them eligible for full Pell grants. Youths attending post secondary education programs are required to maintain at least a 2.0 grade point average (GPA) on a 4.0 scale or the equivalent on another GPA scale. Youth attending training programs must meet the progress standards of the program they are enrolled in.

See the ETV Guidelines for complete eligibility requirements in Appendix FF. Indiana ETV forms are located in Appendix GG.

405 Documentation

While delivery of services to children and families in the best possible manner is the paramount objective of the division, the importance of properly documenting case activity cannot be overstated. The reasons include, but are not limited to:

(1) continuity of service provision.

(2) verification of timeliness with regard to meeting legal requirements.

(3) assuring receipt of all federal monies to maintain and improve services to Indiana's families and children.

405.1 Child Welfare Data Collection

Federal regulations at 45 CFR 1355.40, which implement section 479 of the Social Security Act (the Act), set forth the Adoption and Foster Care Analysis and Reporting System (AFCARS) requirements for the collection of uniform, reliable information on the children who are under the responsibility of the state Title IV-B/IV-E agency for placement and care. Effective October 1, 1994, states were required to collect and submit data on children in foster care and children adopted under the auspices of the state's public child welfare agency. The AFCARS penalty

structure for failure to meet the regulatory requirements was not applicable until the beginning of the fourth year of AFCARS reporting, starting with data submitted for the seventh report period (October 1, 1997 through March 31, 1998).

Federal regulations at Section 479; 45 CFR 1355.40 through 45 CFR 1355.57, which implement section 474 (a) (3) (C) of the Act, set forth the requirements states must meet to receive funding for the planning, design, development, and installation of a statewide automated child welfare information system (SACWIS). Such systems must be comprehensive in that they must meet the requirements for AFCARS, required by section 479 (b) (2) of the Act and implementing the regulations.

405.2 Required Case Record Information

Documentation of information regarding a child in out-of-home care that is required to be in the electronic ICWIS case is delineated in the ICWIS Student Handbook and Bulletin Board, and in the ICWIS information included in the sections of this manual. Information required to be in the paper case record is outlined in the revised Section 11.

405.3 Retention of Case Information

The date when a paper case record would be eligible for transfer to the State Archives is the January following the year in which the youngest child in the case reaches 23 years of age. For example, if the youngest child turns 23 in 1998, January 1999 is when the case will be transferred. In ICWIS, identifying information is purged after the victim child reaches 24 years of age and before the case is archived.

406 Permanency Planning

Federal Title IV-E legislation is designed to eliminate unplanned extended out-of-home placements for children. This legislation is based on the premise that every child requires a permanent home for healthy development. Case planning and review form the procedural structure to ensure that a child does not drift in out-of-home care, but rather that there is continued movement toward the goal of creating a sense of permanency in the child's living situation as rapidly as is conducive to the child's well-being. Refer to subsections 306 and 307 relative to case planning and review.

406.1 Reunification and Case Closure

The decision to return a child home or to seek alternate permanent placement, such as termination of parental rights and subsequent change in placement through kinship care, change of custody, adoption, establishing a guardianship or institutionalization, is critical. It must be based upon a thorough assessment of the child's needs and desires, and a reassessment of the strengths and needs of the legal family and the risk to the child if returned home. Factors to be considered in making such a decision include, but are not limited to whether:

(1) the circumstances that led to the child's initial removal from home have been alleviated.

(2) the child wishes to return home.

(3) the parents want the child to return home.

(4) the goals of the service plan have been met.

(5) sufficiently regular and meaningful visitation has occurred.

Best practice dictates that the strengths and needs of a family and the risk to the child are always to be the focus of agency involvement. Engagement of the family allows the family case manager (FCM) to assist the family in discovering what their strengths and needs are, and the assessment tool allows child welfare staff to measure where the family is in relation to where it needs to be in that process of discovery. These assessments also focus the FCM on factors to be addressed in order to lower risk. The assessments are to be the core of the case plan and the basis for any recommendations for services and any decisions to return a child to the child's own home or to close a case.

Best practice also dictates that decision-making is best served by a team approach, which includes parents, foster parents, service providers, attorneys and CASA/GAL workers (when assigned to a case). The FCM has the responsibility for reassessing risks and needs and initiating permanency planning conferences at appropriate stages of a child's out-of-home placement. Any recommendations for returning the child to the child's home will then need to be presented to the court; and the court, in all cases, will make the final decision.

The following process is recommended for reunification and case closure:

(1) Assess the risk, strength/needs of the family and the risk to the child of a return to the home. Family case managers are to refer back to the safety assessment to make sure that factors causing the removal of a child have been addressed. An override of risk level must address the findings of the FCM on the safety assessment.

(2) Set up a case planning/reunification conference with providers, foster parents, parents, children (when appropriate), and any CASA/GAL assigned to the case. If providers cannot attend the conference, a written report is to be requested from them which addresses any service needs of the family before reunification as well as post-reunification.

(3) A consensus of the team that reunification is to take place before making a recommendation to the court is always a goal of a case planning reunification conference. If there is a difference of opinion and consensus cannot be reached, a child welfare supervisor is to be asked to mediate. If this does not result in a consensus, a written report to the court is to be submitted with a request for a hearing and finding by the court.

(4) A trial home visit (THV) for up to six (6) months is required for all children in the process of reunification, and the THV can be extended an additional 12 months by order of the court. Some exceptions to providing the opportunity for a THV include the following:

   (a) All assessed needs have been addressed through services.
   (b) The court orders the case closed.
   (c) The child is 18 and wants to be released from agency supervision.
   (d) The rights of the child's parent(s) have been terminated (TPR).
   (e) An assisted guardianship (AG) has been established.
   (f) The child transitions to the Division of Disability, Aging and Rehabilitative Services (DDARS or the Department of Corrections (DOC).

(5) Trial home visits are to meet contact standards for assessment of critical case decisions, which is a weekly contact with parent and child for up to a month (1106.441). Collateral

contacts and face-to-face contacts with the child(ren) and family are to take place based upon the service level of the most recent assessments after the first month and up to a month prior to case closure.

(6) Services that address the needs of the family are to be in place including supportive services.

(7) Prior to closure of the case, assessments of strengths/needs of the family and risk to the child are to be completed and a case planning/case closure conference called.

(8) During the case planning/case closure conference, a safety plan must be developed and put in place for the child and family. The assessed needs of child and family are to be addressed in the safety plan, and referrals are be made to agencies that can assist the family without the involvement of the county office.

(9) The recommendation to the court is to reflect the consensus of this case planning/case closure conference. If consensus is not possible, the county office is to petition the court for a hearing to make a finding on the best interest of the family with regards to case closure.

406.2 Recidivism

Data gathered in Indiana and throughout the nation indicates a high recidivism rate for families involved with child welfare. Although recidivism occurs for many reasons over which agencies have no control (i.e., maturity of parent(s), low motivation level of parents, etc.), there are some agency factors that may contribute to recidivism that agency staff may be able to change. They include the following:

(1) The family is not engaged and therefore is not invested in making changes.

(2) When the family is not engaged, case planning becomes a task rather than a process for change. Families will do what they are "told" while the agency is involved, but they return to behaviors causing our intervention when we withdraw from the case.

(3) The assessment of the families' strengths and needs and the level of risk to the child is inappropriate.

(4) Assessed risks are not reduced because of a lack of services or the provision of services that are inappropriate for reducing the identified risks.

(5) Assessment and/or documentation from providers and other significant persons involved in the family/case do not support the recommendations made to the court.

(6) Simultaneous reunification of children and case closure can result in lack of much needed supportive services to the family post-closure.

(7) Assessed needs that cause risk to the child(ren) at case closure are not addressed by referrals to support services or other agencies which might be able to help the family.

407 Funding

It is essential that the family case manager have a working knowledge of child welfare funding systems and budget allocations to promote maximum utilization of available resources for the benefit of the children and families served. Limited funds require the family case manager to review all available resources for each child. The family case manager and accounting personnel must communicate on a regular basis.

407.1 Primary Funding Sources

The first resource to be reviewed is the child's own family. The family case manager must request parents to supply information regarding any benefits the child is receiving or is eligible to receive and information regarding the parents' ability to make voluntary support payments.

407.11 Voluntary Support/Reimbursement Payments

Under Indiana law, birth parents are liable for the support of their children. In determining the amount to be contributed by parents, the following factors should be considered:

(1) the costs incurred for providing care for the child;

(2) the financial circumstances of the parents.

The support/reimbursement arrangements agreed upon must be in writing, and each party is to have a copy. The voluntary payments are made directly to the COFC.

407.12 Court-Ordered Support/Reimbursement Payments

When voluntary contributions cannot be obtained from parents who are financially able to make payments, the COFC can make a referral to the court for a determination under the provisions of IC 31-40-1-2. For accounting information regarding these funds, see subsection 407.421. Court judgments may order support/reimbursement payments to be made directly to the COFC, to persons caring for the child, or to the court clerk for appropriate distribution. Payments must be made in accordance with the judgment.

407.13 Social Security (RSDI) and Other Benefits

When the COFC takes wardship of a child who is eligible for or is receiving Social Security in the form of Retirement, Survivor's, and Disability Insurance, (RSDI), or other benefits paid for the care of dependent, minor children, the COFC may apply for, and act as the recipient of these benefits. Social security benefits follow a child even when the child is adopted. If at the time wardship is dismissed or a child is emancipated there are excess Social Security or Supplemental Security Income funds in the child's Trust Clearance Fund, the moneys must be returned to the child or the child's family.

Benefits other than Social Security include:

(1) military allotments;

(2) Railroad Employees' Insurance;

(3) Unemployment Insurance;

(4) Veterans' Benefits;

(5) Workers Compensation.

In addition, a child might be the beneficiary of a will, a trust fund, or a life insurance policy. The child may also be covered for medical costs under a parent's health insurance policy.

407.14 Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federally funded aid program for "the needy aged, blind and disabled". A blind or disabled child may qualify for benefits under this program that is administered by the Social Security Administration. A representative from that agency should be contacted for further information.

407.2 Family and Children Fund

Having explored what financial resources are available through the child's family as well as what other community resources might be available to meet the needs of the child, the family case manager may then investigate the use of appropriations from the Family and Children Fund.

The Family and Children Fund provides services to children who are adjudicated CHINS or delinquent, recipients eligible for an informal adjustment (IA) agreement or a services referral agreement (SRA), or children who are receiving adoption assistance.

The following further defines the accounts in this fund:

407.21 #32500 Care of Children in Foster Homes – Includes expenditures for all dependent children placed in foster homes, homes of parent, or homes of relatives. This includes IV-E and IV-A eligible children. See Appendix II for the ICWIS Special Needs Checklist.

407.22 #32510 Care of Children in Therapeutic Foster Homes – Includes expenditures to an organization (company or institution) that recruits and trains therapeutic foster parents and monitors placements in the foster home. This includes IV-E and IV-A-eligible children.

407.23 #32520 Care of Children in Institutions - Includes expenditures for placement in a residential facility, group home, and secure detention, regardless of whether it is an in-state facility or out-of-state facility. This includes IV-E and IV-A-eligible children.

407.24 #32530 Independent Living for Children - Services provided to older teenagers who are adjudicated CHINS or delinquent to enable them to become self-sufficient and prepared for adulthood. NOTE: If funds are paid directly to a child for the child to manage, the funds cannot be reimbursed through Title IVE-FC funds.

407.25 #32540 Preservation Services - Provides services to either prevent children from being removed from the home or to reunite families after removal has occurred. This includes IV-A children. Services include but are not necessarily limited to the following:

(1) Respite Care - Child care for abused, neglected, and delinquent children provided to give parents or foster families a break from the child or children.

(2) Home Based Services - Services provided within the home to the child and/or family.

(3) Counseling - Provided to the child and/or the family.

(4) Other Family Services - Provides for other family preservation services, family education and training, alcohol and drug testing and treatment, medical exams and treatment for non-wards (family members), and other expenses as necessary to avoid removal of children from the home.

407.26 #32550 Miscellaneous Cost of Children - This includes IV-E and IV-A-eligible children and provides for the following services:

(1) Medical, Dental and Burial - Pays for medical and/or dental exams and treatment for wards not otherwise covered by Medicaid. The suggested guideline for burial of a ward is the TANF allowance of $1000 per burial.

(2) Clothing and Other - Pays for clothing, supplies, including school supplies; reimbursement to family case managers for entertainment of wards during visitations, and transportation costs to visit relatives. NOTE: Some of these costs can be reimbursed through Title IVE-FC.

(3) Transfer Tuition and Capital Costs - Pays for:

(a) out-of-state transfer tuition if a ward is attending public school in another state;
(b) education programs to a non-public school; e.g., a school on the grounds of an institution when the educational cost is not included in the institutional per diem; and
(c) capital costs, which are charges for the use of special equipment by a child with disabilities. The equipment must be necessary for the education of that child. This funding source cannot be used for or by any child who is not a child with disabilities.

(4) Monitoring Device - Pays for the use of electronic devices to monitor activities of a delinquent child.

407.27 #32560 Medicaid Rehabilitative Option (MRO) – Provides matching funds for federal participation in the Medicaid Rehabilitative Option. Services for MRO are available only through a community mental health center. A list of services eligible for MRO reimbursement are as follows: diagnostic assessment, pre-hospital screening, individual treatment, conjoint treatment, family treatment, group treatment, med/somatic treatment, crisis intervention, train/active daily living, partial hospitalization, and case management.

Offices are required to budget only the required Medicaid match, and only this match will be paid from the Family and Children Fund.

407.28 #32600 Adoption Services - Includes the IV-E Adoption Assistance Program (AAP) as well as the Indiana Adoption Subsidy for Hard to Place Children.

The Indiana Adoption Subsidy for Hard to Place Children - Pays for non-IV-E-eligible children who are disadvantaged due to ethnic background, race, color, language; physical, mental, or medical disability; age, or membership in a sibling group that should not be separated. (IC 31-9-2-51) See Section 3 of this manual for detailed information regarding the availability of Indiana Adoption Subsidy Program-only (IASP-only) Medicaid for these children.

Under this program, if:

(1) federal payments for adoption assistance are not equal to the total monthly cost of care in a foster home, or

(2) the child is not eligible for the federal IVE-AAP,

the court may order the support of the adoptive child in an amount not to exceed the monthly cost of care of the child in a foster home under this program.

This program is also a subsidy to IVE-AAP, which limits payments to 75% of the per diem amount. The remaining 25% could be paid under this program.

Also, the court is authorized to order a subsidy to continue until the adoptive child becomes twenty-one (21) years of age if:

(1) the adoptive child files a petition for the order; and

(2) the court determines that the child is enrolled in a:

(a) secondary school;
(b) college or university; or
(c) course of vocational training leading to gainful employment.

Adoption Assistance - Provides a subsidy for adoptive families with IV-E-eligible children with special needs. The amounts to be paid under this program are the greater of $13.50 per day, or 75% of the per diem amount which is being paid by the county having wardship of the child for foster home care.

407.29 #32700 Foster Parent Insurance - Provides payment for the insurance available through the Indiana Foster Care and Adoption Association (IFCAA). Title IV-B-Part I funds can be used to pay for this insurance. If these funds are used for this purpose, the intent to do so must be included in the Title IV-B-Part I Plan; and the funds must come from the capped foster care maintenance portion of the allocation.

The following account is located in the Family and Children Fund.

407.210 #30090 Child Welfare Services - Payment to develop, establish, extend and strengthen child welfare services for the protection and care of dependent and delinquent children and children in need of services as referred to in the Early Intervention Plan. This includes, but is not limited to:

(1) Information/education, including general parent health, prenatal education, and information on child care;

(2) Community Awareness Programs

(3) camping for underprivileged children;

(4) Foster Parent Training and Recognition and Family Support Services.

407.3 Other Sources of Funding

The following is a list of additional sources of funding for child welfare:

407.31 Title IV-A: Temporary Assistance to Needy Families (TANF)

Assistance for dependent children in the custody of relatives can be paid with Title IV-A federal funds through the Temporary Assistance to Needy Families (TANF) entitlement program. Refer to the Indiana TANF Manual for eligibility requirements of the program.

407.32 Title IV-A: Emergency Assistance (EA) - Provides federal matching funds. Services can be provided through this program on an emergency basis for 180 days in a 12-month period. Eligible services include out-of-home placement, counseling, home-based services, other family services, some medical expenses, and clothing. Refer to Divisional Policy Directive #5-A-002 under "Community Based Services and Programs: Public Assistance".

407.33 Title IV-B: Child Welfare Services (CWS)

Under Title IV-B of the Social Security Act, federal funds are made available to the states in the form of annual grants for Child Welfare Services. The funds are divided into subparts to be used for different purposes as described below. In Indiana, the Central Office of the Division of Family and Children administers these funds.

407.331 Subpart I

Title IV-B-Subpart I funds are used for administrative expenses, statewide contracts such as those for family case manager training, and for regional services. The regional services are planned and contracted through a regional committee. Title IV-B may be used to benefit individual children or groups of children, but must be related to child abuse or neglect issues or services. See Section 10 for further information.

407.332 Subpart II

Title IV-B-Subpart II funds are used for preservation and support services (family support), crisis intervention (family preservation), time-limited reunification services and adoption promotion and support services.

407.333 Title IV-E: Foster Care (FC)

Provides federal matching funds calculated using the federal medical assistance percentage rate. Funds can be used for the care of eligible children who have been removed from their homes pursuant to a judicial determination.

407.334 Title IVE-FC: Waiver Demonstration

In 1995, the federal government announced a demonstration project in which 10 states would be allowed to request waivers of select sections of the Title IV-E program. Indiana filed a proposal to waive five (5) specific selections with the goal of making it possible, through increased funding flexibility, for more children to be served in their local communities rather than being placed in restrictive settings. Restrictive care, in this context, includes foster family home, group home, and institutional settings.

Indiana received approval for four of the five waiver requests on July 18, 1997. Detailed information concerning the project can be found in an administrative letter dated December 15, 1997, entitled "IV-E-FC Waiver Demonstration Project". The savings produced as a result of a reduced number of placements in restrictive settings can then be used to develop new, or pay for already existing home-based, intensive services. These wraparound services are intended to prevent out-of-home placements and further abuse and neglect.

75% of waiver slots are designated for children who are eligible for traditional Title IV-E benefits or who can meet IV-E eligibility requirements under the waiver. 25% of the waiver slots are designated for children who cannot meet the requirements for traditional IV-E benefits or benefits under the waiver.

407.335 Title IV-E: Adoption Assistance Program (AAP) Provides federal matching funds to adoptive parents calculated using the federal medical assistance percentage rate. These funds are provided to assist adoptive parents in covering expenses associated with meeting the special needs of the adoptive child.

407.336 Refugee Act of 1980 Funds

The Refugee Act of 1980 provides federal reimbursement to the states for costs in the settlement of refugees. Subsection 1005 of this manual describes this program relating to unaccompanied minor refugee children.

407.337 Health Facilities

IC 12-15-2-9 enables eligible persons who are under age 21 and in Medicaid-certified psychiatric facilities to receive medical assistance. It also extends eligibility to persons in Medicaid-certified intermediate care facilities for the mentally retarded (ICF/MR). In both categories, the child must be receiving active treatment in a Medicaid-certified facility and must meet Medicaid

eligibility requirements. For further details, refer to the Indiana Medical Assistance Manual.

407.338 Medicaid

IC 12-15-2-16, IC 12-13-8 and IC 12-13-9 make available medical assistance (Medicaid) to children who are adjudicated to be in need of services (CHINS) or are under the custody or supervision of a county office of family and children as ordered by the court. There are several Medicaid categories that are available to benefit children. For example, children who are eligible for Title IVE-FC and Title IVE-AAP benefits receive Medicaid coverage through those programs. See Sections 9 and 8 respectively for detailed information regarding these programs.

407.3381 Medicaid for Wards

The intent of this program is to provide for costs of medical care for children who meet financial eligibility requirements but do not qualify to receive Medicaid benefits under any other category of medical assistance. Due to the special funding mechanism that includes county financial participation, children are to be covered under this category only if they do not qualify under any other category of medical assistance. For more specific procedures regarding this program, refer to Section 3 of this manual.

407.3382 Medicaid for Indiana Adoption Subsidy Program (IASP)

Effective 7/1/99, this program extends Medicaid coverage to non-IV-E-eligible special needs children who receive only a court-ordered adoption subsidy under Indiana's program for adoption of hard to place children. (IC 31-19-27) This Indiana Adoption Subsidy Program-only (IASP-only) Medicaid applies to adoptive children who are not eligible for the Title IVE-Adoption Assistance Program (AAP) but who are disadvantaged due to ethnic background, race, color, language; physical, mental, or medical disability, age, or membership in a sibling group that should not be separated. (IC 31-9-2-51) See Section 3 of this manual for detailed information regarding this Medicaid program.

407.339 Hoosier Healthwise for Children

Hoosier Healthwise is a health insurance program for children, pregnant women and low-income families that is offered through the Family and Social Services Association. In operation since 1994, the program was expanded in 1998 to provide coverage to all children below the age of 19 who live in Indiana and who live in a family that earns at or below 150% of the federal poverty level. Benefits include primary and preventive care, doctor visits, hospital stays, prescription drugs, vision and dental care, mental health care, and other important benefits for children. The program also has benefits for children with special health care needs such as asthma and diabetes. To apply, families may go to an enrollment center in a hospital, mental health center or other location frequented by families with uninsured children who may be

eligible for this program. A separate health insurance plan for children above 150% of poverty, with premiums and co-pays, is available.

407.3310 Hoosier Assurance Plan for Seriously Emotionally Disturbed Children and Adolescents

The Division of Mental Health's Hoosier Assurance Plan (HAP) is designed to equalize the availability and quality of community-based mental health and addictions services for seriously emotionally disturbed (SED) children and adolescents across the state. To accomplish this goal, the Division of Mental Health contracts with managed care providers to provide an array of services to this population.

In order to be eligible for this program these children must:

(1) be at or below 200% of the poverty level;

(2) have a mental illness diagnosed under DSM III-R or DSM IV after 1/1/95;

(3) have experienced significant functional impairments in at least one (1) of the following areas:

(a) activities of daily living;
(b) interpersonal functioning;
(c) concentration, persistence, and pace; or
(d) adaptation to change; and

(4) have a mental illness, the duration of which has been, or is expected to be in excess of 12 months. However, children who have experienced a situational trauma and who are receiving services in two (2) or more community agencies do not have to meet the durational requirement of this clause.

Services in the array of care include:

(1) individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed below.

(2) 24-hour a day crisis intervention.

(3) case management to fulfill individual patient needs, including assertive case management when indicated.

(4) outpatient services, including intensive outpatient services, substance abuse services, counseling and treatment.

(5) acute stabilization services.

(6) residential services.

(7) day treatment.

(8) family support services.

(9) medication evaluation and monitoring.

(10) services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

407.3311 County Welfare Trust Clearance Fund

This fund is established by the Welfare Act and is used for purposes as provided in IC 12-19-1-14 through IC 12-19-1-16. There are no public monies in this fund. Sources of revenue for this fund are as follows:

(1) Money available to or for the benefit of a person receiving services from a COFC, such as parental support payments, SSI, or inheritance received for a particular child receiving child welfare services may be deposited in the county welfare trust clearance fund. Money that is received for the purpose of reimbursing the county for expenditures for services for a child may not be deposited in the trust clearance fund. Payments for services provided to a child should not be made from this fund. Payments are to be made from the appropriate account in the Family and Children Fund, or from the Welfare Fund while there are child welfare-related accounts remaining in it. See subsections 407.210-212. Those accounts can then be reimbursed from the child's trust clearance fund.

(2) Gifts, devises or bequests of personal property and voluntary contributions may be used for the benefit of:

(a) any home or institution for dependent or neglected children who are under supervision of the county office of family and children (COFC); or
(b) any children who are committed to the care and supervision of the COFC.

These monies may not be commingled with other funds and shall be spent only with the approval of the COFC and the probate court.

407.3312 Adoption Trust Clearance Fund

Placement fees from adoptive parents as described in subsection 718 of this manual are entered into this fund. Monies may be used for the care of children whose adoption is contemplated and for the improvement of adoption services provided by the COFC. Services may include, but are not limited to:

(1) the care of children whose adoption is contemplated. This includes per diem for placement in a pre-adoptive home.

(2) maternity care for mothers considering adoptive placement.
adoption training.

(3) purchase of training materials for prospective adoptive parents.

APPENDIX – SECTION 4

A. Family and Social Services Administration Service Entry Points

B. FY 2000 Hoosier Assurance Plan: Managed Care Providers, CMHC's with MRO, and Populations

C. Integrated Field Service Offices (DDARS)

D. First Steps Local Council

E. Local Coordinating Committee Forms and Instructions

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G. Indiana Parenting Guidelines

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I. General Information About AIDS and HIV Infection/Preamble and Rationale: HIV Policy for Foster Care

J Indiana Code: Communicable Diseases

K. Blue Book and ICWIS Medical Passport

L Sample Consent to Release Mental Health Records Form

M. Mental health Screening Tool

N. Service Standards for Available IL Services

O. Service Standards for Room and Board

P. Service Standards for Youth Advisory Boards

Q. Northwest Contracted IL Service Providers List

R. Northeast Contracted IL Service Providers List

S. West Central Contracted IL Service Providers List

T. East Central IL Service Provider List

U. Southwest Contracted IL Service Providers List

V. Southeast Contracted IL Service Providers List

W. Title IV-B Referral Form for Youth Age 14 and up who are CHINS

X. Referral Form for Youth age 18 to 21 who are no longer CHINS

Y. Youth Advisory Board Referral Form

Z. Agreement for Voluntary Services

AA. Room and Board Assistance Budget Worksheet

BB. IL Discharge summary

CC. IL Post-Discharge Summary

DD. IL Outcome Measures Report

EE. Education and Training Voucher (ETV) Program Guidelines

FF. Education and Training Voucher Program Forms

GG. Sample Host Home agreement

HH. ICWIS Special Needs Checklist

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DIVISION OF MENTAL HEALTH
Providers Certifications
MCPs and CMHCs SFY 2005

Provider Name && Number / DBA (if different) / Location / Mailing Address	Type	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO / Phone / Fax
Addiction Resource Network of Indiana, Inc. (996)				A	Yes	No	Ms
Cheryl DeVol-Glowinski				(317) 955-2764			
					CARF-NET		233
McCrea Street, Suite 200 ~ Indianapolis IN 46225					(317) 955-9710		
	CA	Cert/Lic		06/30/05			
	GAM	Cert/Lic		06/30/05			
Adult and Child Mental Health Center, Inc. (429)				A	No	Yes	Mr.
A. Robert Dunbar				(317) 882-5122			
					JCAHO		8320
Madison Avenue ~ Indianapolis IN 46227					(317) 888-8642		
	CMHC	Cert/Lic	Regular	08/31/06			
Affiliated Service Providers of Indiana, Inc. (998)				A	Yes	No	Mr.
Larry Ulrich				(574) 722-5151			
ASPIN					JC-NET		1015
Michigan Avenue ~ Logansport IN 46947					(574) 722-9523		
	CA	Cert/Lic		06/30/05			3600
Woodview Trace Suite 103 ~ Indianapolis IN 46268							
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Amethyst House, Inc. (1279)				A	Yes	No	Mr.
Tom Cox				(812) 336-3570			
					CARF		645
N. Walnut ~ Bloomington IN 47402					(812) 336-9010		
	CA	Cert/Lic		06/30/05			P O
Box 11 ~ Bloomington IN 47402							
	GAM	Cert/Lic		06/30/05			
BehaviorCorp, Inc. (430)				A	No	Yes	Mr.
Larry Burch				(317) 587-0500			
					JCAHO		697
Pro-Med Lane ~ Carmel IN 46032-5323					(317) 574-1234		
	CMHC	Cert/Lic	Regular	04/30/05			
Center for Mental Health, Inc., The (425)				A	Yes	Yes	Mr.
Richard DeHaven				(765) 649-8161			
Center for Mental Health, Inc.					JCAHO		1100
Broadway ~ Anderson IN 46012					(765) 641-8238		
	CA	Cert/Lic		06/30/05			P O
Box 1258 ~ Anderson IN 46015							
	CMHC	Cert/Lic		06/30/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Providers Certifications
MCPs and CMHCs SFY 2005

Provider Name && Number DBA (if different) / Location / Mailing Address	Type Phone / Fax	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
Children's Bureau of Indianapolis, Inc. (1009) Ron Duke Carpenter North Alabama Street #426 ~ Indianapolis IN 46204				A (317) 264-2700 (317) 264-2714	Yes COA	No 615	Mr.
	SED	Cert/Lic		06/30/05			
Community Hospitals of Indiana, Inc. (416) Eric Crouse PHD Gallahue Mental Health Center Hillsdale Court ~ Indianapolis IN 46250				A (317) 621-7600 (317) 621-7608	No JCAHO	Yes 6950	Dr.
	CMHC	Cert/Lic	Regular	04/30/06			
Community Mental Health Center, Inc. (413) Joseph D. Stephens Bielby Road ~ Lawrenceburg IN 47025				A (812) 537-1302 (812) 537-0194	Yes JCAHO	Yes 285	Mr.
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		02/28/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Comprehensive Mental Health Services, Inc. (422) Hank Milius N. Tillotson Avenue ~ Muncie IN 47304				A (765) 288-1928 (765) 741-0310	Yes JCAHO	Yes 240	Mr.
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		08/31/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Cummins Mental Health Center, Inc. (428) Ann Borders East U.S. 36 ~ Avon IN 46123				A (317) 272-3330 (317) 272-3331	Yes JCAHO	Yes 6655	Ms
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic	Regular	08/31/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Provider Name && Number / DBA (if different) / Location / Mailing Address	Type	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
Dunn Mental Health Center, Inc. (417)				A	Yes	Yes	Dr.
Kathryn Whittington PHD				(765) 983-8005			
					CARF		630
East Main Street, 2nd Fl ~ Richmond IN 47374					(765) 983-8019		
	CA	Cert/Lic		06/30/05			PO
Box 487 ~ Richmond IN 47375							
	CMHC	Cert/Lic		08/31/04			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Edgewater Systems For Balanced Living, Inc. (421)				A	Yes	Yes	Dr.
Danita Johnson-Hughes PHD				(219) 885-4264			
					CARF		1100
West 6th Avenue ~ Gary IN 46402-1711					(219) 882-7517		
	CMHC	Cert/Lic		Regular	08/31/06		
	GAM	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Four County Comprehensive Mental Health Center, Inc. (427)				A	No	Yes	Mr.
Lawrence R. Ulrich				(574) 722-5151			
Four County Counseling Center					JCAHO		1015
Michigan Avenue ~ Logansport IN 46947					(574) 722-9523		
	CMHC	Cert/Lic	Regular	05/31/06			
Grant Blackford Mental Health, Inc. (414)				A	Yes	Yes	Mr.
Paul G. Kuczora				(765) 662-3971			
					JCAHO		505
Wabash Avenue ~ Marion IN 46952					(765) 662-7480		
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		09/30/05			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Provider Name && Number DBA (if different) / Location / Mailing Address	Type Phone / Fax	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
Hamilton Center, Inc. (405) Galen Goode				A (812) 231-8323	Yes	Yes	Mr.
8th Avenue ~ Terre Haute IN 47804					JCAHO (812) 231-8411		620
Box 4323 ~ Terre Haute IN 47804	CA	Cert/Lic		06/30/05			P O
	CMHC	Cert/Lic		07/31/06			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Health & Hospital Corporation of Marion County, Indiana (401) Margaret Payne				A (317) 554-2701	No	Yes	Ms
Midtown Community Mental Health Center West Tenth Street ~ Indianapolis IN 46202					JCAHO (317) 554-2721		1001
N Meridian Street ~ Indianapolis IN 46204-1098	CMHC	Cert/Lic	Regular	01/31/06			850
Howard Community Hospital (407) James Alender				A (765) 453-8555	Yes	Yes	Mr.
Howard Regional Health System South LaFountain ~ Kokomo IN 46902					JCAHO (765) 453-8114		3500
Box 9011 ~ Kokomo IN 46904-9011							P O
	CMHC	Cert/Lic		07/31/04			
	SMI	Cert/Lic		06/30/05			
InteCare, Inc. (1018) Geoffrey E. Buck				A (317) 237-5770	Yes	No	Mr.
S. Capitol Avenue Suite 610 ~ Indianapolis IN 46225					URAC (317) 237-5777		201
	CA	Cert/Lic		06/30/05			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Knox County Hospital (403) James A. Koontz MD				A (812) 886-6800	Yes	Yes	Dr.
Samaritan Center Bayou Street ~ Vincennes IN 47591					JCAHO (812) 886-6809		515
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		11/30/04			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Provider Name && Number / DBA (if different) / Location / Mailing Address	Type	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
LaPorte County Comprehensive Mental Health Council, Inc. (410)				A	Yes	Yes	Ms
Elizabeth Kuhn				(219) 879-4621			
Swanson Center						CARF	450
St. John Rd. Suite 501 ~ Michigan City IN 46360						(219) 873-2388	
	CMHC	Cert/Lic		08/31/06			
	GAM	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Lifespring Inc. (402)				A	Yes	Yes	Dr.
Terry Stawar EDD				(812) 280-2080			
						JCAHO	460
Spring Street ~ Jeffersonville IN 47130						(812) 206-1229	
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		02/28/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Madison Center, Inc. (406)				A	Yes	Yes	Mr.
Jack Roberts				(574) 234-0061			
						JCAHO	403
E Madison Street ~ South Bend IN 46617						(574) 288-5047	
	CA	Cert/Lic		06/30/05			P O
Box 80 ~ South Bend IN 46624							
	CMHC	Cert/Lic		06/30/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Northeastern Center, Inc. (426)				A	Yes	Yes	Mr.
Jeryl Hollister				(260) 347-2453			
Northeastern Center						CARF	220
S Main ~ Kendallville IN 46755						(260) 347-2456	
	CA	Cert/Lic		06/30/05			P O
Box 817 ~ Kendallville IN 46755							
	CMHC	Cert/Lic	Regular	08/31/05			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Oaklawn Psychiatric Center, Inc. (409)				A	No	Yes	Mr.
Harold Loewen				(574) 533-1234			
						JCAHO	330
Lakeview Drive ~ Goshen IN 46528						(574) 537-2605	
	CMHC	Cert/Lic		03/31/05			PO
Box 809 ~ Goshen IN 46527-0809							

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Otis R. Bowen Center for Human Services, Inc., The (423)				A	No	Yes	Mr.
Kurt Carlson				(574) 267-7169			
Otis R. Bowen Center for Human Services, Inc.						JCAHO	850
North Harrison Street ~ Warsaw IN 46581						(574) 269-3995	
	CMHC	Cert/Lic	Regular	12/31/06			P O
Box 497 ~ Warsaw IN 46581							
Park Center, Inc. (419)				A	Yes	Yes	Mr.
Paul D. Wilson				(260) 481-2721			
						CARF	909
East State Boulevard ~ Fort Wayne IN 46805						(260) 481-2717	
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		07/31/06			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Porter-Starke Services, Inc. (418)				A	Yes	Yes	Mr.
David Lomaka				(219) 531-3500			
						JCAHO	601
Wall Street ~ Valparaiso IN 46383						(219) 462-3975	
	CMHC	Cert/Lic		09/30/05			
	GAM	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
PSI Services III, Inc. (1468)				A	Yes	No	Dr.
Sheila Pandit				(219) 884-0185			
PSI Family Services of Indiana							3229
Broadway Suite 207 ~ Gary IN 46408							(219)
884-4403							
	SED	Cert/Lic		Temp 2	06/30/05		
Quinco Consulting Center, Inc. (408)				A	Yes	Yes	Dr.
Robert J. Williams PHD				(812) 379-2341			
Quinco Behavioral Health Systems						JCAHO	720
North Marr Road ~ Columbus IN 47201						(812) 376-4875	
	CA	Cert/Lic		06/30/05			720
North Marr Road ~ Columbus IN 47202-0628							
	CMHC	Cert/Lic		02/28/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Salvation Army, The (826)				A	Yes	No	Major
Douglas Stearns				(317) 972-1450			
Harbor Light Center					CARF		2400
N. Tibbs Avenue ~ Indianapolis IN 46222					(317) 972-1075		
	CA	Cert/Lic		06/30/05			
Sisters of St. Francis Health Services, Inc. (1001)				A	Yes	No	Mr.
Gene Diamond				(219) 865-2141			
Saint Margaret Mercy Healthcare Centers, Inc.					AOA		5454
Hohman Avenue ~ Hammond IN 46320					(219) 864-2157		
Joliet Street ~ Dyer IN 46311							24
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
South Central Community Mental Health Centers, Inc. (411)				A	Yes	Yes	Dr.
Dennis P. Morrison PHD				(812) 339-1691			
Center for Behavioral Health					JCAHO		645
South Rogers ~ Bloomington IN 47403					(812) 337-2438		
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		01/31/07			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Southern Hills Counseling Center Incorporated, The (420)				A	Yes	Yes	Mr.
Don Aronoff				(812) 482-3020			
Southern Hills Counseling Center					CARF		480
Eversman Drive ~ Jasper IN 47547-0769					(812) 482-6409		
	CA	Cert/Lic		06/30/05			P O
Box 769 ~ Jasper IN 47547-0769							
	CMHC	Cert/Lic		08/31/06			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
Southlake Community Mental Health Center, Inc. (424)				A	No	Yes	Mr.
Lee C. Strawhun				(219) 769-4005			
Southlake Center for Mental Health, Inc.					JCAHO		8555
Taft Street ~ Merrillville IN 46410					(219) 769-2508		
	CMHC	Cert/Lic		10/31/06			
Southlake/Tri-City Management Corp. (999)				A	Yes	No	Mr.
Sanford Kauffman				(219) 757-1905			
Geminus					JC-NET		8400
Louisiana Street ~ Merrillville IN 46410					(219) 757-1950		
	CA	Cert/Lic		06/30/05			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			

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Provider Name && Number / DBA (if different) / Location / Mailing Address	Type	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
Southwestern Indiana Mental Health Center, Inc. (404)				A	Yes	Yes	Mr.
John K. Browning				(812) 423-7791			
					JCAHO		415
Mulberry Street ~ Evansville IN 47713					(812) 422-7558		
	CA	Cert/Lic		06/30/05			
	CMHC	Cert/Lic		07/30/05			
	GAM	Cert/Lic		06/30/05			
	SED	Cert/Lic		06/30/05			
	SMI	Cert/Lic		06/30/05			
St. Joseph Hospital & Health Center, Inc. (994)				A	Yes	No	Mr.
James Full				(765) 456-5900			
St. Joseph Hospital & Health Center of Kokomo					JCAHO		1907
West Sycamore ~ Kokomo IN 46904-9010					(765) 456-5387		
	CA	Cert/Lic		06/30/05			
	GAM	Cert/Lic		06/30/05			
St. Vincent Hospital and Health Care Center, Inc. (1007)				A	Yes	No	Ms
Patty McCauley				(317) 338-4600			
St. Vincent Stress Centers					JCAHO		8401
Harcourt Road ~ Indianapolis IN 46260					(317) 338-4750		
							PO
Box 80160 ~ Indianapolis IN 46280-0160							
	SED	Cert/Lic		06/30/05			
Tara Treatment Center, Inc. (809)				A	Yes	No	Ms
Ann Daugherty				(812) 526-2611			
					JCAHO		6231
South U.S. 31 ~ Franklin IN 46131					(812) 526-9949		
	CA	Cert/Lic		06/30/05			
Tri-City Comprehensive Community Mental Health Center, Inc.				A	No	Yes	Mr.
Robert Krumwied				(219) 398-7050			
					JCAHO		3903
Indianapolis Boulevard ~ East Chicago IN 46312					(219) 392-6998		
	CMHC	Cert/Lic		03/31/05			

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Provider Name && Number DBA (if different) / Location / Mailing Address	Type Phone / Fax	Cert Status	Sub-Stat	Expires	MCP Accred	CMH Accred	CEO
Universal Behavioral Services Community Mental Health Center Therome Buford Universal Behavioral Services - Indianapolis Fort Wayne Avenue ~ Indianapolis IN 46204	A (317) 684-0442 (317) 684-0679				Yes JCAHO	Yes	Mr. 820
	CMHC SED SMI	Cert/Lic Cert/Lic Cert/Lic		12/31/04 06/30/05 06/30/05			
Villages of Indiana, Inc., The (1006) Sharon E. Pierce The Villages of Indiana, Inc. N Girls School Rd Suite 240 ~ Indianapolis IN 4621 4-3662	A (317) 273-7575 (317) 273-7565				Yes COA	No	Ms 652
	SED	Cert/Lic		06/30/05			
Volunteers of America of Indiana, Inc. (1017) Timothy Campbell Indianapolis Canal Walk ~ Indianapolis IN 46202	A (317) 686-5800 (317) 686-5810				Yes CARF	No	Mr. 549
	CA	Cert/Lic		06/30/05			
Wabash Valley Hospital, Inc. (415) R. Craig Lysinger North River Road ~ West Lafayette IN 47906	A (765) 463-2555 (765) 497-3960				Yes JCAHO	Yes	Mr. 2900
	CMHC SMI	Cert/Lic Cert/Lic		06/30/06 06/30/05			

MCP Count : 36 CMHC Count : 31

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WORKSHEET 1

Worksheet 1 is designed to assist the referring agency with the case preparation which should be sent to members five (5) days prior to the Local Coordinating Committee scheduled meeting. This worksheet should be the first page on all materials sent prior to the case presentation at the Local Coordinating Committee meeting. The information should provide an overview of the child and the child's needs for programs and placement.

INSTRUCTIONS

County—Name of county having wardship or jurisdiction for wardship

I. Child—Refers to child being referred to Local Coordinating Committee for placement considerations.

- Custody Status—Parent, ward, temporary ward, foster child, other.
- Living at or with—Please name and described those adults the child is currently living with (i.e. mother, mother's boyfriend).

II. Referring Agency—Current agency personnel working with case.

III. School—Check with appropriate school personnel.

- All information of the child's current school status.

IV. Tests Administered
Current tests given that assist in describing child's current placement needs. (Check with school, mental health professionals, etc.)

V. Medical—Describe health problems that affect current placement needs.

VI. Professional referring the case should provide necessary case history data that would give a clear picture of the child's prior service history and how current placement needs should be met.

VII. Synopsis of current problems and current needs that must be addressed in future placement plans.

VIII. Describe how agencies have worked together with meeting child's psychological, educational, and social needs.

WORKSHEET 1

REFERRAL CASE SUMMARY FOR LOCAL COORDINATING COMMITTEE

(Completed by Referring Agency)

Date Summary Completed: _____

County: _____

I. Child

Full Name _____ Date of Birth ___/___/___ Age ____

Custody Status _____

Address _____

Living at or with _____

Relationship _____

Legal Custodian _____ Address _____ Phone _____

Natural or Adoptive Parents: _____

Name—Father _____ Name—Mother _____

Address _____ Address _____

Phone _____ Phone _____

II. Referring Agency

Case Worker/Probation Officer/Referring Agent

Name _____ Case # _____

Title _____ Cause # _____

Agency _____ Date of Court Hearing If Set _____

III. School

Name of School _____ School, Special Ed _____

School Corporation _____ School, Regular _____

Program Type
(Check appropriate program)

- ☐ Special Class in Regular Public School Facility
- ☐ Special Class in Public Separate Special Education Facility
- ☐ Instructional Resource Service
- ☐ Special Consultation
- ☐ Multi-Categorical Resource Service
- ☐ Special Class in a Department of Mental Health Residential Facility
- ☐ Special Class in a Private Nursing Home

WORKSHEET 1

REFERRAL CASE SUMMARY FOR LOCAL COORDINATING COMMITTEE

(Completed by Referring Agency)

Date Summary Completed: _____

County: _____

I. Child

Full Name _____ Date of Birth ___/___/___ Age ____

Custody Status _____

Address _____

Living at or with _____

Relationship _____

Legal Custodian _____ Address _____ Phone _____

Natural or Adoptive Parents: _____

Name—Father _____ Name—Mother _____

Address _____ Address _____

Phone _____ Phone _____

II. Referring Agency

Case Worker/Probation Officer/Referring Agent

Name _____ Case # _____

Title _____ Cause # _____

Agency _____ Date of Court Hearing If Set _____

III. School

Name of School _____ School, Special Ed _____

School Corporation _____ School, Regular _____

Program Type
(Check appropriate program)

- ☐ Special Class in Regular Public School Facility
- ☐ Special Class in Public Separate Special Education Facility
- ☐ Instructional Resource Service
- ☐ Special Consultation
- ☐ Multi-Categorical Resource Service
- ☐ Special Class in a Department of Mental Health Residential Facility
- ☐ Special Class in a Private Nursing Home

WORKSHEET 1
PAGE 2

IV. Tests Administered (If Available)

- I.Q. Date ___/___/___ - Full Scale _____ Performance _____ Verbal _____
- WRAT Date ___/___/___ Math _____ Spelling _____ Reading _____ Adaptive _____
- Mental Health/Diagnosis Treatment (List Specific Agencies Involved)
  Psychological Data (attached)

V. Medical

Height _____ Weight _____

Medications _____ Other Pertinent Information _____

_____

VI. Materials Available

— Other relevant descriptive material (attached)

VII. Summary of unresolved problems and unmet needs.

VIII. Summary of this agency's involvement with other agencies for purposes of meeting child's needs.

RETAIN COPY IN
REFERRING AGENCY FILE

WORKSHEET 4

Worksheet 4 is to be prepared by the referring agency. This informs the parent of the child's case review by the Local Coordinating Committee.

WORKSHEET 4

ADVISEMENT TO PARENT/GUARDIAN/CUSTODIAN

1. I understand that my child's case will be presented to the Local Coordinating Committee for case review. This presentation may include all information obtained by those agencies working with my child.

2. I understand that the purpose of the Local Coordinating Committee is to explore alternatives and make recommendations regarding services for my child, as well as possible placement resources for my child.

3. I understand that I have the right to attend the Local Coordinating Committee meeting while my child's case is being presented.

4. I understand that I will be invited to have input to the Local Coordinating Committee regarding appropriate services and/or placement for my child.

5. I understand that the Local Coordinating Committee will make a recommendation regarding appropriate services and/or placement for my child.

6. I understand that I have the right to present my view points (in writing) on any recommendations made for my child.

Date	Parent's Signature
Date	Guardian's Signature
Date	Witness

WORKSHEET 5

Worksheet 5 is prepared by the referring agency. This secures approval from the child's legal guardian to collect prior case history. This information will be shared with the Local Coordinating Committee.

WORKSHEET 5

RELEASE OF INFORMATION TO THE LOCAL COORDINATING COMMITTEE

I, _____ address _____

Parent, Guardian, or Custodian of _____.

Child's Date of Birth _____

Authorize the following Agencies/Organizations: (Please Name all Agencies)

Schools _____

Regular _____

Special Ed _____

Private _____

County Welfare Department _____

Court/Probation Department _____

Community Mental Health Center _____

Other (Specify) _____

_____

_____

_____

to disclose to:

Schools _____

Regular _____

Special Ed _____

Private _____

County Welfare Department _____

Court/Probation Department _____

Community Mental Health Center _____

Other (Specify) _____

_____

_____

_____

All necessary information for a thorough case history.

Specify necessary reports to be released.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WORKSHEET 5
PAGE 2

I understand that the purpose for disclosure of the information is to ensure that the child service agencies/organizations listed develop a service plan which will meet the individual needs of my child, and to ensure that appropriate follow-up will occur.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken.

I hereby release the Local Coordinating Committee and related personnel from any and all liability for damages which may result because of compliance with this release of information.

I understand that this consent will expire in 60 days from date of signature.

Signature of Legal Guardian	Date Signed
Signature of Witness	Date Signed

WORKSHEET 2

Worksheet 2 is designed to assist the Local Coordinating Committee with documentation of the committee's recommended Action Plan.

This worksheet should be completed at the Local Coordinating Committee meeting during discussion of each individual case.

This information should be included in Worksheet 7: Reporting to the judge.

Recommended Action Description of Services: Service plan(s) to meet the child's current needs.

Agency Responsible: Who will follow through with the case recommendation.

Services Provided by Whom: Who will pay for recommended services.

WORKSHEET 2

INDIANA LOCAL COORDINATING COMMITTEE ACTION PLAN

Child's Name: _____

Date: _____

Referral Agency: _____ Signature of Referring Agent _____

RECOMMENDED ACTION DESCRIPTION OF SERVICES	AGENCY RESPONSIBLE	SERVICES PROVIDED BY WHOM

Long-Range Treatment Plan

_____

_____

_____

_____

Names of Local Coordinating Committee Members Present:

Vote Total For Plan

YES NO

_____ Name/Agency _____ Name/Agency

_____ Name/Agency _____ Name/Agency

RETAIN COPY IN REFERRING AGENCY FILE

APPENDIX E

Appendix F

Family Case Manager Contact Standards as Determined by Risk and Needs Assessments

FAMILY CASE MANAGER CONTACT STANDARDS		
Service Level	**Family Contacts**	**Location**
Low	**One** Face-to-Face per Month with Parent & Child **One** Collateral Contact	Must be in the Parent's Residence
Moderate	**Two** Face-to-Face per month with Parent & Child **Two** Collateral Contacts	**One** must be in Parent's Residence
High	**Three** Face-to-Face per month with Parent & Child **Three** Collateral Contacts	**One** must be in Parent's Residence
Very High	**Four** Face-to-Face per month with Parent & Child **Four** Collateral Contacts	**Two** must be in Parent's Residence

Contact Standards Additional Considerations

Children In Placement	**One** Face-to-Face with Child Every 60 Days **One** Face-to-Face with Caregiver Every 60 Days **One** Face-to-Face with Parent, Guardian, or Custodian
Children with In-Home Placement	Per above chart. If contacts are designated to a provider, FCM must see child(ren) and parent, guardian or custodian prior to case closure.
Crisis Intervention Contacts	Face-to-face contact with the child by the FCM is required within 24-hours of receiving the knowledge that a crisis has occurred and should continue weekly until the crisis has subsided and appropriate services are in place. If a crisis occurs when the child is in placement with a birth parent, face-to-face contact with the parent by the FCM is required within 24-hours of receiving the knowledge that a crisis has occurred and should continue weekly until the crisis subsides and appropriate services are in place. If the child is in placement outside the home when the crisis occurs, the FCM should make every effort to inform the birth parent(s) in a timely manner. Contact with the birth parent(s) may be required at this time, depending on the circumstances; and the FCM should consult with the supervisor to determine the necessity for immediate FCM contact with the birth parent(s). If a crisis occurs when the child is in a foster home, an adoptive home, a relative home, or a child care facility, contact by the FCM is required within 24-hours of receiving the knowledge that a crisis has occurred and should continue weekly until the crisis subsides and services are in place. If the crisis is a placement crisis, the FCM may need to see the child and caregiver together for mediation after seeing them separately. If the child is placed in an out-of-county child care facility, the follow-up weekly contacts may be telephone contacts if supervisory approval is obtained.
Critical Case Decisions Contacts	Critical case decisions refer to those events that seriously impact the child and the permanency plan. Critical case decisions include, but are not limited to the following events: (1) removal of a child from home; (2) a change from supervised to unsupervised visits; (3) reunification preparation; (4) reunification follow-up; (5) any placement change; (6) termination of parental rights; and (7) case closure. When a critical case decision needs to be made, the child and parent, guardian or custodian needs to be seen weekly by the FCM or a service provider designated by the FCM for the purpose of assessing risk and determining the continued need for services. In order to assess risk, the child should be interviewed alone. In the event that this weekly contact has been designated to a service provider, feedback should be provided to the FCM on a regular basis.

Contact Standards Additional Considerations

Stable Placement Contacts	If a child's placement is stable, the FCM must make a contact with the child, caregiver, parent, guardian, or custodian every 60 days. These contacts may not be delegated to a service provider.
Designated Contacts when case management is contracted out	The FCM may designate required Parent and collateral contacts to a service provider through a written contract, it is recommended that the contract include the following: (1) purpose of the contacts; (2) frequency of the contacts; (3) starting date of the service; (4) duration of the agreement; (5) parties to be contacted; (6) procedure for feedback; and (7) a plan of action if risk is perceived. In these cases, the service provider should participate in the case planning process and the terms of the agreement specified in the case plan. When contact is designated to a service provider, the FCM functions as a case manager by pulling together resources and information from the service provider as well as from the child(ren), birth parent(s), and caregiver. While the service provider assists the child and family and provides information, the responsibility of risk assessment and formulating recommendations remains with the county department. In the cases which an agency is contracted to provide case management, the collateral contacts, crisis intervention contacts, and critical case decision contacts can be assigned to the agency, but the face-to-face contact with the child, caregiver, and parent, guardian or custodian, every 60 days remains the obligation of the supervising OFC FCM.

IN THE

SUPREME COURT OF INDIANA

ORDER ADOPTING PARENTING TIME GUIDELINES

Under the authority vested in this Court to provide by rule for the procedure employed in all courts of this state and this Court's inherent authority to supervise the administrative procedures of all courts and to direct trial courts in implementing and applying applicable statues, this Court now adopts the ***Indiana Parenting Time Guidelines*** *set forth as follows:*

Indiana Parenting Time Guidelines

Table of Contents

PREAMBLE

The Indiana Parenting Time Guidelines are based on the premise that it is usually in a child's best interest to have frequent, meaningful and continuing contact with each parent. It is assumed tha both parents nurture their child in important ways, significant to the development and well being of the child.

The Guidelines also acknowledge that scheduling parenting time is more difficult when separate households are involved and requires persistent effort and communication between parents to promote the best interest of the children involved. The purpose of these guidelines is to provide a model which may be adjusted depending upon the unique needs and circumstances of each family. These guidelines are based upon the developmental stages of children. The members of the Domestic Relations Committee of the Judicial Conference of Indiana developed the guidelines after reviewing the current and relevant literature concerning visitation, the visitation guidelines of other geographic areas, and the input of child development experts and family law practitioners. Committee members also relied upon data from surveys of judges, attorneys, and mental health professionals who work with children, reviews of court files, and a public hearing.

A child whose parents live apart has special needs related to the parent-child relationship. A child's needs and ability to cope with the parent's situation change as the child matures. Parents should consider these needs as they negotiate parenting time. They should be flexible and create a parenting time agreement which addresses the unique needs of the child and their circumstances.

The Indiana Parenting Time Guidelines are designed to assist parents and courts in the development of plans and represent the minimum time a parent should have to maintain frequent, meaningful, and continuing contact with a child.

Commentary

1. Use of Term "Parenting Time." *Throughout these Guidelines the words "parenting time" have been used instead of the word "visitation" so as to emphasize the importance of the time a parent spend with a child. The concept that a non-custodial parent "visits" with a child does not convey the reality of the continuing parent-child relationship.*

2. Minimum Time Concept. *The concept that these Guidelines represent the minimum time a non-custodial parent should spend with a child should not be interpreted as a limitation of time imposed by the court. They are not meant to foreclose the parents from agreeing to, or the court from granting, such additional or reduced parenting time as may be reasonable in any given case. In addressing all parenting time issues, both parents should exercise sensibility, flexibility and reasonableness.*

3. Purpose of Commentary Following Rule. *Throughout these Guidelines many of the rules are followed by a commentary further explaining the rule or setting forth the child centered philosophy behind the rule. The commentary is not an enforceable rule but provides guidance in applying the rule.*

SCOPE OF APPLICATION

1. <u>Generally</u>. These Guidelines are applicable to all child custody situations, including paternity cases and cases involving joint legal custody where one person has primary physical custody. However, they are not applicable to situations involving family violence, substance abuse, risk of flight with a child, or any other circumstances the court reasonably believes endanger the child's physical health or safety, or significantly impair the child's emotional development.

Commentary

Variance from the Indiana Parenting Time Guidelines does not alone constitute good cause for amendment of an existing visitation order; however, a court or parties to a proceeding may refer to these guidelines in making changes to a parenting time order after the effective date of the guidelines.

2. <u>Presumption</u>. There is a presumption that the Indiana Parenting Time Guidelines are applicable in all cases covered by these guidelines. Any deviation from these Guidelines by either the parties or the court must be accompanied by a written explanation indicating why the deviation is necessary or appropriate in the case.

Commentary

The written explanation need not be as formal as Findings of Fact and Conclusions of Law; however, it must state the reason(s) for the deviation.

A CHILD'S BASIC NEEDS

To insure more responsible parenting and to promote the healthy adjustment and growth of a child each parent should recognize and address a child's basic needs:

1. To know that the parents' decision to live apart is not the child's fault.

2. To develop and maintain an independent relationship with each parent and to have the continuing care and guidance from each parent.

3. To be free from having to side with either parent and to be free from conflict between the parents.

4. To have a relaxed, secure relationship with each parent without being placed in a position to manipulate one parent against the other.

5. To enjoy regular and consistent time with each parent.

6. To be financially supported by each parent, regardless of how much time each parent spends with the child.

7. To be physically safe and adequately supervised when in the care of each parent and to have a stable, consistent and responsible child care arrangement when not supervised by a parent.

8. To develop and maintain meaningful relationships with other significant adults (grandparents, stepparents and other relatives) as long as these relationships do not interfere with or replace the child's primary relationship with the parents.

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SECTION I. GENERAL RULES APPLICABLE TO PARENTING TIME

A. COMMUNICATIONS

1. <u>Between Parents</u>. Parents shall at all times keep each other advised of their home and work addresses and telephone numbers. Notice of any change in this information shall be given to the other parent in writing. All communications concerning a child shall be conducted between the parents. Any communication shall occur at reasonable times and places unless circumstances require otherwise. A child shall not be used to exchange documents or financial information between parents.

2. <u>With A Child Generally</u>. A child and a parent shall be entitled to private communications without interference from the other parent. A child shall never be used by one parent to spy or report on the other. Each parent shall encourage the child to respect and love the other parent. Parents shall at all times avoid speaking negatively about each other in or near the presence of the child, and they shall firmly discourage such conduct by relatives or friends.

3. <u>With A Child By Telephone</u>. Both parents shall have reasonable phone access to their child at all times. Telephone communication with the child by either parent to the residence where the child is located shall be conducted at reasonable hours, shall be of reasonable duration, and at reasonable intervals, without interference from the other parent. If a parent uses an answering machine, voice mail or a pager, messages left for a child shall be promptly communicated to the child and the call returned.

Commentary

Parents should agree on a specified time for telephone calls so that a child will be available to receive the call. The parent initiating the call should bear the expense of the call. A child may, of course, call either parent, though at reasonable hours, frequencies, and at the cost of the parent called if it is a long distance call.
Examples of unacceptable interference with communication include a parent refusing to answer a phone or refusing to allow the child or others to answer; a parent recording phone conversations between the other parent and the child; turning off the phone or using a call blocking mechanism or otherwise denying the other parent telephone contact with the child.

4. <u>With A Child By Mail</u>. A parent and a child shall have a right to communicate privately by e-mail and faxes, and by cards, letters, and packages, without interference by the other parent.

Commentary

A parent should not impose obstacles to mail communications. For example, if a custodial parent has a rural address, the parent should maintain a mailbox to receive mail at that address. A parent who receives a communication for a child shall promptly deliver it to the child.

5. Emergency Notification. For emergency notification purposes, whenever a child travels out of the area with either parent, one of the following shall be provided to the other parent: An itinerary of travel dates, destinations, and places where the child or the traveling parent can be reached, or the name and telephone number of an available third person who knows where the child or parent may be located.

B. IMPLEMENTING PARENTING TIME

1. Transportation Responsibilities. Unless otherwise agreed between the parents, the non-custodial parent shall provide transportation for the child at the start of the scheduled parenting time and the custodial parent shall provide transportation for the child at the end of the scheduled parenting time.

Commentary

1. Presence Of Both Parents. *Both parents should be present at the time of the exchange and should make every reasonable effort to personally transport the child. On those occasions when a parent is unable to be present at the time of the exchange or it becomes necessary for the child to be transported by someone other than a parent, this should be communicated to the other parent in advance if possible. In such cases, the person present at the exchange, or transporting the child, should be a responsible adult with whom the child is familiar and comfortable.*

2. Distance/Cost As Factors. *Where the distance between the parents' residences is such that extended driving time is necessary, the parents should agree on a location for the exchange of the child. The cost of transportation should be shared based on consideration of various factors, including the distance involved, the financial resources of the parents, the reason why the distances exist, and the family situation of each parent at that time.*

3. Parental Hostility. *In a situation where hostility between parents makes it impracticable to exchange a child at the parents' residences, the exchange of the child should take place at a neutral site.*

2. Punctuality. Each parent shall have the child ready for exchange at the beginning and at the end of the scheduled parenting time and shall be on time in picking up and returning the child. The parents shall communicate as early as possible regarding any situation that would interfere with the timely exchange of the child.

Commentary

Punctuality is a matter of courtesy. Parents should make every effort to pick up and return a child at the agreed time, and not substantially earlier or later. Parents should recognize, however, that circumstances occur that require leeway in the scheduled times. Phone calls are always appropriate when there will be a delay.

3. Clothing. The custodial parent shall send an appropriate and adequate supply of clean clothing with the child and the non-custodial parent shall return such clothing in a clean condition. Each parent shall advise the other, as far in advance as possible, of any special activities so that the appropriate clothing may be available to the child.

Commentary

It is the responsibility of both parents to ensure their child is properly clothed. The non-custodial parent may wish to have a basic supply of clothing available for the child at his or her home.

4. Privacy of Residence. A parent may not enter the residence of the other, except by express invitation, regardless of whether a parent retains a property interest in the residence of the other. Accordingly, the child shall be picked up at the front entrance of the appropriate residence unless the parents agree otherwise. The person delivering the child shall not leave until the child is safely inside.

C. CHANGES IN SCHEDULED PARENTING TIME

Introduction

Parents should recognize there will be occasions when modification of the existing parenting schedule will be necessary. Parents should exercise reasonable judgment in their dealings with each other and with their child. Parents should be flexible in scheduling parenting time and should consider the benefits to the child of frequent, meaningful and regular contact with each parent and the schedules of the child and each parent.

1. Scheduled Parenting Time To Occur As Planned. Parenting time is both a right and a responsibility, and scheduled parenting time shall occur as planned. If a parent is unable to provide personal care for the child during scheduled parenting time, then that parent shall provide alternate child care or pay the reasonable costs of child care caused by the failure to exercise the scheduled parenting time.

Commentary

Parents should understand it is important for a child to experience consistent and ongoing parenting time. A child is entitled to rely on spending time with each parent in a predictable way and adjusts better after a routine has been established and followed. A parent who consistently cancels scheduled parenting time sends a very harmful message to the child that the child is not a priority in that parent's life. In addition to disappointing a child, the voluntary cancellation of scheduled parenting time by one parent may interfere with the plans of the other parent or cause the other parent to incur child care and other costs.

2. Adjustments to Schedule / "Make Up" Time. Whenever there is a need to adjust the established parenting schedules because of events outside the normal family routine, the parent who becomes aware of the circumstance shall notify the other parent as far in advance as possible. Both parents shall then attempt to reach a mutually acceptable adjustment to the parenting schedule.

If an adjustment results in one parent losing scheduled parenting time with the child, "make-up" time should be exercised as soon as possible. If the parents cannot agree on "make-up" time, the parent who lost the time shall select the "make-up" time within one month of the missed time.

Commentary

There will be occasions when scheduled parenting times may need to be adjusted because of illnesses or special family events such as weddings, funerals, reunions, and the like. Each parent should accommodate the other in making the adjustment so that the child may attend the family event. After considering the child's best interests, the parent who lost parenting time may decide to forego the "make-up" time.

3. Opportunity for Additional Parenting Time. When it becomes necessary that a child be cared for by a person other than a parent or a family member, the parent needing the child care shall first offer the other parent the opportunity for additional parenting time. The other parent is under no obligation to provide the child care. If the other parent elects to provide this care, it shall be done at no cost.

Commentary

The rule providing for opportunities for additional parenting time promotes the concept that a child receives greater benefit from being with a parent rather than a child care provider. It is also intended to be practical. When a parent's work schedule or other regular recurring activities require hiring a child care provider, the other parent should be given the opportunity to provide the care. Distance, transportation or time may make the rule impractical. Parents should agree on the amount of child care time and the circumstances that require the offer be made.

D. EXCHANGE OF INFORMATION

Commentary

A child may suffer inconvenience, embarrassment, and physical or emotional harm when parents fail to actively obtain and share information. Parents should take the initiative to obtain information about their child from the various providers of services.

1. School Records. Each parent shall promptly provide the other with copies of a child's grade reports and notices from school as they are received. A parent shall not interfere with the right of the other parent to communicate directly with school personnel concerning a child.

Commentary

Under Indiana law, both parents are entitled to direct access to their child's school records, Indiana Code ' 20-10.1-22.4-2.

2. School Activities. Each parent shall promptly notify the other parent of all school activities. A parent shall not interfere with the right of the other parent to communicate directly with school personnel concerning a child's school activities. The parent exercising parenting time shall be responsible to transport the child to school related activities.

Commentary

The opportunity for a child to attend a school function should not be denied solely because a parent is not able to attend the function. In such instance, the child should be permitted to attend the function with the available parent. Scheduled parenting time should not be used as an excuse to deny the child's participation in school related activities, including practices and rehearsals.

3. Other Activities. Each parent shall promptly notify the other parent of all organized events in a child's life which permit parental and family participation. A parent shall not interfere with the opportunity of the other parent to volunteer for or participate in a child's activities.

Commentary

A child is more likely to enjoy these experiences when supported by both parents. Each parent should have the opportunity to participate in other activities involving the child even if that activity does not occur during his or her parenting time. This includes activities like church functions, athletic events, scouting, school photographs, etc.

4. Health Information. If a child is undergoing evaluation or treatment, the custodial parent shall communicate that fact to the non-custodial parent.
Each parent shall immediately notify the other of any medical emergencies or illness of the child that requires medical attention.

If a child is taking prescription or nonprescription medication, the custodial parent shall provide the noncustodial parent with a sufficient amount of medication with instructions whenever the noncustodial parent is exercising parenting time.
The custodial parent shall give written authorization to the child's health care providers, permitting an ongoing release of all information regarding the child to the non-custodial parent including the right of the provider to discuss the child's situation with the non-custodial parent.

407 *Commentary*

Each parent has the responsibility to become informed and participate in ongoing therapies and treatments prescribed for a child and to ensure that medications are administered as prescribed. An evaluation or treatment for a child includes medical, dental, educational, and mental health services.

Under Indiana law, both parents are entitled to direct access to their child's medical records, Indiana Code ' 16-39-1-7; and mental health records, Indiana Code ' 16-39-2-9.

4. Insurance. A parent who has insurance coverage on the child shall supply the other parent with current insurance cards, an explanation of benefits, and a list of insurer-approved or HMO-qualified health care providers in the area where each parent lives. If the insurance company requires specific forms, the insured parent shall provide those forms to the other parent.

Commentary

Qualified health care orders may permit the parent to communicate with the medical health care insurance provider.

E. RESOLUTION OF PROBLEMS

1. Disagreements Generally. When a disagreement occurs regarding parenting time and the requirements of these Guidelines, both parents shall make every effort to discuss options, including mediation, in an attempt to resolve the dispute before going to court.
2. Mediation. If court action is initiated, the parents shall enter into mediation unless otherwise ordered by the court.

3. Child Hesitation. If a child is reluctant to participate in parenting time, each parent shall be responsible to ensure the child complies with the scheduled parenting time. In no event shall a child be allowed to make the decision on whether scheduled parenting time takes place.

Commentary

In most cases, when a child hesitates to spend time with a parent, it is the result of naturally occurring changes in the life of a child. The child can be helped to overcome hesitation if the parents listen to the child, speak to each other and practically address the child's needs.

Parents should inquire why a child is reluctant to spend time with a parent. If a parent believes that a child's safety is compromised in the care of the other parent, that parent should take steps to protect the child, but must recognize the rights of the other parent. This situation must be promptly resolved by both parents. Family counseling may be appropriate. If the parents cannot resolve the situation, either parent may seek the assistance of the court.

4. Relocation. When either parent considers a change of residence, reasonable advance notice of the intent to move shall be provided to the other parent so they can discuss necessary changes in the parenting schedule as well as the allocation of transportation costs in exercising parenting time which may result from the move.

Commentary

1. Impact Of Move. *Parents should recognize the impact that a change of residence may have on a child and on the established parenting time. The welfare of the child should be a priority in making the decision to move.*

2. Indiana Law. *Indiana law (Ind. Code § 31-14-13-10 and Ind. Code § 31-17-2-23) require that if a custodial parent intends to move outside Indiana, or more than one hundred (100) miles from the individual's county of residence, a notice of intent to move must be filed with the clerk of the court that issued the custody order, and a copy of the notice must be sent to the other parent.*

5. Withholding Support or Parenting Time. Neither parenting time nor child support shall be withheld because of either parent's failure to comply with a court order. Only the court may enter sanctions for noncompliance. A child has the right both to support and parenting time, neither of which is dependent upon the other. If there is a violation of either requirement, the remedy is to apply to the court for appropriate sanctions.

6. Enforcement of Parenting Time

A. Contempt Sanctions. Court orders regarding parenting time must be followed by both parents. Unjustified violations of any of the provisions contained in the order may subject the offender to contempt sanctions. These sanctions may include fine, imprisonment, and/or community service.

B. Injunctive Relief. Under Indiana law, a noncustodial parent who regularly pays support and is barred from parenting time by the custodial parent may file an application for an injunction to enforce parenting time under Ind. Code § 31-17-4-4.

C. Criminal Penalties. Interference with custody or visitation rights may be a crime. Ind. Code § 35-42-3-4.

D. Attorney Fees. In any court action to enforce an order granting or denying parenting time, a court may award reasonable attorney fees and expenses of litigation. A court may consider whether the parent seeking attorney fees substantially prevailed and whether the parent violating the order did so knowingly or intentionally. A court can also award attorney fees and expenses against a parent who pursues a frivolous or vexatious court action.

SECTION II. SPECIFIC PARENTING TIME PROVISIONS

INTRODUCTION

The best parenting plan is one created by parents which fulfills the unique needs of the child and the parents. The specific provisions which follow are designed to assist parents and the court in the development of a parenting plan. They represent the minimum recommended time a parent should have to maintain frequent, meaningful, and continuing contact with a child.

Commentary

1. Assumptions. *The provisions identify parenting time for the non-custodial parent and assume that one parent has sole custody or primary physical custody of a child, that both parents are fit and proper, that both parents have adequately bonded with the child, and that both parents are willing to parent the child. They further assume that the parents are respectful of each other and will cooperate with each other to promote the best interests of the child. Finally, the provisions assume that each parent is responsible for the nurturing and care of the child. Parenting time is both a right and a trust and parents are expected to assume full responsibility for the child during their individual parenting time.*

2. Lack of Contact. *Where there is a significant lack of contact between a parent and a child, there may be no bond, or emotional connection, between the parent and the child. It is recommended that scheduled parenting time be "phased in" to permit the parent and child to adjust to their situation. It may be necessary for an expert to evaluate the current relationship (or lack thereof) between the parent and the child and recommend a schedule.*

3. Age Categories. *The chronological age ranges set forth in the specific provisions are estimates of the developmental stages of children since children mature at different times.*

4. Multiple Children of Different Ages. *When a family has children of different ages, the presumption is that all the children should remain together*

during the exercise of parenting time. However, the standards set for a young child should not be ignored, and there will be situations where not all of the children participate in parenting time together. On the other hand, when there are younger and older children, it will generally be appropriate to accelerate, to some extent, the time when the younger children move into overnight or weekend parenting time, to keep sibling relationships intact.

5. Non-traditional Work Schedules. *For parents with non-traditional work schedules, who may regularly work weekends, weekday parenting time should be substituted for the weekend time designated in these rules. Similar consideration should also be given to parents with other kinds of non-traditional work hours.*

A. INFANTS AND TODDLERS

Introduction

The first few years of a child's life are recognized as being critical to that child's ultimate development. Infants (under eighteen months) and toddlers (eighteen months to three years) have a great need for continuous contact with the primary care giver who provides a sense of security, nurturing and predictability. It is thought best if scheduled parenting time in infancy be minimally disruptive to the infant's schedule.

Commentary

1. Both Parents Necessary. *It is critical that a child be afforded ample opportunity to bond with both parents. A young child thrives when both parents take an active role in parenting. There is a positive relationship between the degree of involvement of mothers and fathers and the social, emotional, and cognitive growth of a child. Both parents can care for their child with equal effectiveness and their parenting styles may make significant contributions to the development of the child. Parents, therefore, must be flexible in creating for each other opportunities to share both the routine and special events of their child's early development.*

2. Frequency Versus Duration. *Infants and young children have a limited but evolving sense of time. These children also have a limited ability to recall persons not directly in front of them. For infants, short frequent visits are much better than longer visits spaced farther apart. From the vantage point of the young child, daily contact with each parent is ideal. If workable, it is recommended that no more than two days go by without contact with the noncustodial parent. A parent who cannot visit often may desire to increase the duration of visits but this practice is not recommended for infants. Frequent and predictable parenting time is best.*

1. <u>Overnight Parenting Time</u>. Unless it can be demonstrated that the non-custodial parent has not had regular care responsibilities for the child, parenting time shall include overnights. If the non-custodial parent has not previously exercised regular care responsibilities for the child, then parenting time shall not include overnights prior to the child's third birthday, except as provided below.

Commentary

Overnight contact between parents and very young children can provide opportunities for them to grow as a family. At the same time, when very young children experience sudden changes in their night time care routines, especially when these changes include separation from the usual caretaker, they can become frightened and unhappy. Under these circumstances, they may find it difficult to relax and thrive, even when offered excellent care.

When a very young child is accustomed to receiving regular, hands-on care from both parents, the child should continue to receive this care when the parents separate. Regardless of custodial status, a parent who has regularly cared for the child prior to separation should be encouraged to exercise overnight parenting time. When a parent has not provided regular hands-on care for the child prior to separation, overnight parenting time is not recommended until the parent and the child have developed a predictable and comfortable daytime care taking routine.

2. <u>Parenting Time In Early Infancy</u> (Birth through Age 9 Months)

(A) <u>Birth through Age 4 Months</u>:

(1) Three (3) non-consecutive "days" per week of two (2) hours in length.

(2) All scheduled holidays of two (2) hours in length.

(3) Overnight if appropriate under Rule 1 above but not to exceed one (1) 24 hour period per week.

Commentary

The custodial home is the preferred place for this parenting time to occur. However, in some cases this may not be practical. Parenting time should occur in a stable place and without disruption of an infant's established routine.

(B) <u>Age 5 Months through Age 9 Months</u>:

(1) Three (3) non-consecutive "days" per week of three (3) hours per day. The child is to be returned at least one (1) hour before evening bedtime.

(2) All scheduled holidays of three (3) hours in length**.** The child is to be returned at least one (1) hour before evening bedtime.

(3) Overnight if appropriate under Rule 1 above but not to exceed one (1) 24 hour period per week.

3. Parenting Time In Later Infancy (Age 10 Months through Age 18 Months)

(A) Age 10 Months through Age 12 Months:

(1) Three (3) non-consecutive "days" per week, with one day on a "non-work" day for eight (8) hours. The other days shall be for three (3) hours each day. The child is to be returned at least one (1) hour before evening bedtime.

(2) All scheduled holidays for eight (8) hours. The child is to be returned at least one (1) hour before evening bedtime.

(3) Overnight if appropriate under Rule 1 above but not to exceed one (1) 24 hour period per week.

(B) Age 13 Months through Age 18 Months:

(1) Three (3) non-consecutive "days" per week, with one day on a "non-work" day for ten (10) hours. The other days shall be for three (3) hours each day. The child is to be returned at least one (1) hour before evening bedtime.

(2) All scheduled holidays for eight (8) hours. The child is to be returned at least (1) hour before evening bedtime.

(3) Overnight if appropriate under Rule 1 above but not to exceed one (1) 24 hour period per week.

(C) Age 19 Months through 36 Months:

(1) Alternate weekends on Saturdays for ten (10) hours and on Sundays for ten (10) hours. The child is to be returned at least one hour before bedtime, unless overnight is appropriate under Rule 1.

(2) One (1) "day" preferably in mid-week for three (3) hours, the child to be returned at least one (1) hour before evening bedtime, unless overnight during the week is appropriate under Rule 1.

(3) All scheduled holidays for ten (10) hours. The child is to be returned one hour before bedtime.

(4) If the non-custodial parent who did not initially have substantial care responsibilities has exercised the scheduled parenting time under these guidelines for at least nine (9) continuous months, overnight parenting time may take place.

B. CHILD 3 YEARS OF AGE AND OLDER

1. Regular Parenting Time

(1) On alternating weekends from Friday at 6:00 P.M. until Sunday at 6:00 P.M. (the times may change to fit the parents' schedules).

(2) One (1) evening per week, preferably in mid-week, for a period of up to four hours but the child shall be returned no later than 9:00 p.m.

(3) On all scheduled holidays.

Commentary

Where the distance from the non-custodial parent's residence makes it reasonable, the weekday period may be extended to an overnight stay. In such circumstances, the responsibility of feeding the child the next morning, getting the child to school or day care, or returning the child to the residence of the custodial parent, if the child is not in school, shall be on the non-custodial parent.

2. Extended Parenting Time (Child 3 through 4 Years Old)

Up to four (4) non-consecutive weeks during the year beginning at 4:00 P.M. on Sunday until 4:00 P.M. on the following Sunday, the non-custodial parent to give sixty (60) days advance notice of the use of a particular week.

3. Extended Parenting Time (Child 5 and older)

One-half of the summer vacation. The time may be either consecutive or split into two (2) segments. The noncustodial parent shall give notice to the custodial parent of the selection by April 1 of each year. If such notice is not given, the custodial parent shall make the selection.

If a child attends year-round school, the periodic breaks should be divided equally between the parents.

If a child attends summer school, the parent exercising parenting time shall be responsible for the child's transportation to and attendance at school.

During any extended summer period of more than two (2) consecutive weeks with the non-custodial parent, the custodial parent shall have the benefit of the regular parenting time schedule set forth above, unless impracticable because of distance created by out of town vacations.

Similarly, during the summer period when the children are with the custodial parent for more than two (2) consecutive weeks, the non-custodial parent's regular parenting time continues, unless impracticable because of distance created by out of town vacations.

Notice of an employer's restrictions on the vacation time of either parent shall be delivered to the other parent as soon as that information is available. In scheduling parenting time the employer imposed restrictions on either parent's time shall be considered by the parents in arranging their time with their child.

C. PARENTING TIME FOR THE ADOLESCENT AND TEENAGER

1. Regular Parenting Time. Regular parenting time by the noncustodial parent on alternating weekends, during holidays, and for an extended time during the summer months as set forth in the Parenting Time Guidelines (Section II. B.) shall apply to the adolescent and teenager.

Commentary

1. A Teenager Needs Both Parents. *Adolescence is a stage of child development in which parents play an extremely important role. The single most important factor in keeping a teenager safe is a strong connection to the family. The responsibility to help a teenager maintain this connection to the family rests with the parents, regardless of their relationship. The parents must help the teenager balance the need for independence with the need to be an active part of the family. To accomplish this, they must spend time with the teenager. Parents must help the adolescent become a responsible adult. A teenager should safely learn life's lessons if the parents provide the rules which prevent dangerous mistakes.*

2. Anchors of Adolescence. *Regardless of whether the parents live together or apart, an adolescent can be made to feel part of a supportive, helpful family. Things that can help this occur include:* ***Regular time spent in the company of each parent****. Parents need to be available for conversation and recreation. They need to teach a teenager skills that will help the teen in adult life.*

Regular time spent in the company of siblings. *Regardless of personalty and age differences, siblings who spend time together can form a family community that can be a tremendous support in adult life. If the children do not create natural opportunities for them to want to do things together, the parents will need to create reasons for this to occur.*

Emphasis on worthwhile values. *Parent and teens together should invest time in wholesome activities that teach a teenager important lessons. If a teenager identifies with worthwhile values, the teen is more likely to have a positive self-image.*

Time spent with good friends. *A parent's expectations can influence a teenager's choice of friends. Meet your teenager's friends and their parents and interact with them as guests in your home. This will increase the likelihood that your teenager's friends will be people who are comfortable in the environment that is good for the teen.*

Clear rules that are agreed upon by both parents. *As a child matures, it is very important that the teen knows rules of acceptable behavior. The chances of this occurring are much better if both parents agree in these important areas. When parents jointly set the standard of behavior for their teen, the chances of the child accepting those values are greatly increased.*

Good decisions/greater freedoms. *A teenager who does what is expected should be offered more freedom and a wider range of choices. It is helpful if a teenager is reminded of the good decisions that have caused the teen to be given more privileges. If a teen is helped to see that privileges are earned and not natural "rights" he or she will be more likely to realize that the key to getting more freedom is to behave well. If rules are not followed, appropriate consequences should result. A teenager who does not make good use of independence should have less of it.*

3. Decision Making In Parenting A Teenager. *The rearing of a teenager requires parents to make decisions about what their teen should be allowed to do, when, and with whom. At the same time, parents who live apart may have difficulty communicating with each other.*

If parents are not able to agree, the teenager, who very much wants freedom from adult authority, should never be used as the "tie breaker." When parents live apart, it is more likely that a child will be required to make decisions, not as a healthy part of development, but simply to resolve disagreements between the parents.

As a general rule, a teenager should be involved in making important decisions if the parents agree the opportunity to make the decision is valuable, and the value

of that opportunity outweighs any possible harm of a poor decision. If the parents feel the welfare of the child is dependent on the decision made, and if they allow the child to make a decision simply because they cannot agree, the parents are in danger of failing the child.

Example #1
Mary Jones and John Jones disagree as to whether or not their daughter, Sally, should study a foreign language in middle school. Mary feels that this early exposure to a foreign language will offer Sally an advantage when she continues this study in high school. John would like Sally to have the opportunity to develop her artistic talents through electives in drawing and painting. The Jones agree that Sally's success and happiness will in large part be determined by her motivation. They agree that Sally should decide between a foreign language and art, and that they will support whatever decision she makes.

> *Comment: Mary and John feel that Sally is mature enough to think about what interests her and makes her happy. They feel that an opportunity to do this in choosing an elective will be an important experience for Mary - more important than the relative merits of foreign language or art study to Sally's academic career. This is a good example of parents agreeing to involve the adolescent in making a decision that resolves their own disagreement.*

Example #2
Tom Smith and Sue Smith cannot come to a visitation agreement. Tom believes their 17 year old son, Pete, should have visitation at a time to be determined by Pete. Tom feels that, if Pete is given a visitation schedule, he will feel that he is being forced to see his father. Tom further believes this will weaken his relationship with his son. Sue believes a clear plan regarding the time Tom and Pete spend together should be established. She says if Pete is not given a firm expectation of when he will be with Tom, it will be too easy for other activities in Pete's life to crowd out this priority. Unable to resolve this question, Tom and Sue give Pete the option of deciding if he would like a visitation schedule or if he would like to be free to see his father whenever he pleases.

> *Comment: Tom and Sue each feel the quality of Pete's relationship with Tom will depend on the way that visitation is structured. Each believes that, if Pete makes the wrong choice, the problems that follow could impact him throughout his adult life. They have placed the responsibility for the decision on Pete, not because the chance to make such a decision will help him, but because they cannot resolve the matter between themselves. This is a poor reason for entrusting an adolescent with such an important decision.*

2. Special Considerations. In exercising parenting time with a teenager, the non-custodial parent shall make reasonable efforts to accommodate a teenager's participation in his or her regular academic, extracurricular and social activities.

Commentary

Making Regular Parenting Time Workable. *Parents must develop a parenting plan that evolves or changes as the teen matures. The needs of the child at age thirteen will be very different from the needs of that same child at age seventeen. Parents also must develop a parenting plan that assures regular involvement of both parents. This can be a particular challenge when the teen is involved with school, activities, and friends, and becomes even more difficult when the parents live some distance apart.*

When parents differ in their views of which freedoms should be given and which should be withheld, the parents must be sufficiently united to keep the teenager from assuming responsibilities when the child is not ready. At the same time, the parents must respect that they will run their homes differently because they are living apart.

Living apart challenges parents to teach their child that different ways of doing things can work for different parents. They must see that their child needs to work especially hard to adapt to two distinct ways of doing things. Not all differences mean that one parent is right and one parent is wrong. The key is for parents to realize different homes can produce a well-adjusted teen.

<u>Example: The Student Athlete</u>
Jim Doe and Jane Doe have been divorced for 3 years. Their oldest child, Jeremy, is beginning high school. Throughout his middle school years, Jeremy was active in football. Practices were held after school and games took place on weekends. Jeremy had spent alternating weekends and one night each week with his noncustodial parent. The parent who had Jeremy took him to practices and games during the time they were together. On week nights with the noncustodial parent, this usually consisted of dinner and conversation. Weekends with both parents included homework, chores, play, and family outings.

Jeremy's high school coach is serious about football. Jeremy loves the sport. Coach expects Jeremy to work out with teammates throughout the early summer. In August, practice occurs three times a day. Once school begins, Jeremy will practice after school for several hours each day. In addition, he is taking some difficult courses and expects that several hours of study will be needed each night. Jeremy will have games on Friday nights. Because of his busy weekend schedule, he expects that Saturdays will be his only time to be with friends.

<u>Discussion</u>

On the surface, a traditional parenting plan, placing Jeremy with his noncustodial parent on alternating weekends and one night each week, would not seem to work. Jeremy's athletic and academic demands will require him to work hard on weeknight evenings. Jeremy's parents agree he needs time to be with friends and he should be allowed to make social plans on Saturdays. They recognize Sundays will often need to be devoted to homework projects which do not fit into the busy weekday schedule.

A Possible Solution
Jeremy's parents want him to enjoy sports and have friends. Yet, they also want him to have the benefits of being actively raised by two parents. They want him to grow to become an adult who sees that balancing family, work, and play is important. They want to teach him how to do this.

Jeremy's parents have agreed to maintain their previous supervision plan. However, they have also agreed on some changes. Jeremy's noncustodial parent will come to the community of the custodial parent for midweek visitation. Regardless of how busy he is, Jeremy needs to eat. The noncustodial parent plans to take Jeremy to dinner at a restaurant that offers quick but healthy meals. They will spend the rest of the time at a local library where Jeremy can study. The noncustodial parent can offer help as needed or simply enjoy a good book. Jeremy's parents plan to purchase an inexpensive laptop computer to assist him when he works at the library.

Jeremy's parents plan that alternating weekends will continue to be spent with the noncustodial parent. They, like many parents of adolescents, understand Jeremy wants to be with his friends more than he wants to be with them. They recognize that, on weekends, they are offering more supervision and Jeremy's friends are getting more time. Yet, they also see the need to help Jeremy establish active family membership as one of his priorities.

D. HOLIDAY PARENTING TIME SCHEDULE

1. Conflicts Between Regular and Holiday Weekends.
The Holiday Parenting Time Schedule shall take precedence over regularly scheduled and extended parenting time. Extended parenting time takes precedence over regular parenting time unless otherwise indicated in these Guidelines.

If the non-custodial parent misses a regular weekend because it is the custodial parent's holiday, the regular alternating parenting time schedule will resume following the holiday. If the non-custodial parent receives two consecutive weekends because of a holiday, the regular alternating parenting time schedule will resume the following weekend with the custodial parent.

2. <u>Holiday Schedule</u>. The following parenting times are applicable in all situations referenced in these Guidelines as "scheduled holidays" with the limitations applied as indicated for children under the age of three (3) years.

A. Special Days.

[1] <u>Mother's Day</u>. With the child's mother from Friday at 6:00 P.M. until Sunday at 6:00 P.M.

[2] <u>Father's Day</u>. With the child's father from Friday at 6:00 P.M. until Sunday at 6:00 P.M.

[3] <u>Child's Birthday</u>. In even numbered years the non-custodial parent shall have all of the children on each child's birthday from 9:00 A.M. until 9:00 P.M. However, if the birthday falls on a school day, then from 5:00 P.M. until 8:00 P.M.

In odd numbered years the non-custodial parent shall have all of the children on each child's birthday on the day before the child's birthday from 9:00 A.M. until 9:00 P.M., however, if such day falls on a school day, then from 5:00 P.M. until 8:00 P.M.

[4] <u>Parent's Birthday</u>. From 9:00 A.M. until 9:00 P.M. with that parent, however, if the parent's birthday falls on a school day, then from 5:00 P.M. until 8:00 P.M.

B. Christmas Vacation.

One-half of the period which will begin at 8:00 P.M. on the evening the child is released from school and continues to December 30 at 7:00 P.M. If the parents cannot agree on the division of this period, the custodial parent shall have the first half in even-numbered years. In those years when Christmas does not fall in a parent's week, that parent shall have the child from Noon to 9:00 P.M. on Christmas Day. The winter vacation period shall apply to pre-school children and shall be determined by the vacation period of the public grade school in the custodial parent's school district.

C. Holidays.

In years ending with an even number, the non-custodial parent shall exercise the following parenting time:

[1] <u>New Year's Eve and New Year's Day</u>. (The date of the new year will determine odd or even year). From December 30th at 7:00 P.M to 7:00 P.M. of the evening before school resumes.

[2] Memorial Day. From Friday at 6:00 P.M. until Monday at 7:00 P.M.

[3] Labor Day. From Friday at 6:00 P.M. until Monday at 7:00 P.M.

[4] Thanksgiving. From 6:00 P.M. on Wednesday until 7:00 P.M. on Sunday.

In years ending with an odd number, the non-custodial parent shall exercise the following parenting time:

[1] Spring Break. From Friday at 6:00 P.M. through Sunday of the

following weekend at 7:00 P.M.

[2] Easter. From Friday at 6:00 P.M. until Sunday at 7:00 P.M.

[3] Fourth of July. From 6:00 P.M. on July 3rd until 10:00 A.M. on July 5th.

[4] Halloween. On Halloween evening from 6:00 P.M. until 9:00 P.M. or at such time as coincides with the scheduled time for trick or treating in the community where the non-custodial parent resides.

3. Religious Holidays. Religious based holidays shall be considered by the parties and added to the foregoing holiday schedule when appropriate. The addition of such holidays shall not affect the Christmas vacation parenting time, however, they may affect the Christmas day and Easter parenting time

Commentary

Recognizing there are individuals of varying faiths who celebrate holidays other than those set out in the guidelines, the parties should try to work out a holiday visitation schedule that fairly divides the holidays which they celebrate over a two-year period in as equal a manner as possible.

SECTION III. PARENTING TIME WHEN DISTANCE IS A MAJOR FACTOR

Where there is a significant geographical distance between the parents, scheduling parenting time is fact sensitive and requires consideration of many factors which include: employment schedules, the costs and time of travel, the financial situation of each parent, the frequency of the parenting time and others.

1. General Rules Applicable. The general rules regarding parenting time as set forth in Section 1 of these guidelines shall apply.

2. Parenting Time Schedule. The parents shall make every effort to establish a reasonable parenting time schedule.

Commentary

When distance is a major factor, the following parenting time schedule may be helpful:

***(A) Child Under 3 Years Of Age**. For a child under 3 years of age, the noncustodial parent shall have the option to exercise parenting time, in the community of the custodial parent, up to two five hour periods each week. The five hour period may occur on Saturday and Sunday on alternate weekends only.*

***(B) Child 3 and 4 Years of Age.** For a child 3 and 4 years of age, up to six (6) one week segments annually, each separated by at least (6) weeks. Including the pickup and return of the child, no segment shall exceed eight (8) days.*

(C) Child 5 Years of Age and Older. *For a child 5 years of age and older, seven (7) weeks of the school summer vacation period and seven (7) days of the school winter vacation plus the entire spring break, including both weekends if applicable. Such parenting time, however, shall be arranged so that the custodial parent shall have religious holidays, if celebrated, in alternate years.*

3. Priority of Summer Visitation. Summer parenting time with the non-custodial parent shall take precedence over summer activities (such as Little League) when parenting time cannot be reasonably scheduled around such events. Under such circumstances, the non-custodial parent shall attempt to enroll the child in a similar activity in his or her community.

4. Extended Parenting Time Notice. The noncustodial parent shall give notice to the custodial parent of the selection by April 1 of each year. If such notice is not given, the custodial parent shall make the selection.

5. Special Notice of Availability. When the non-custodial parent is in the area where the child resides, or when the child is in the area where the non-custodial parent resides, liberal parenting time shall be allowed. The parents shall provide notice to each other, as far in advance as possible**,** of such parenting opportunities.

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INDEX TO PARENTING TIME GUIDELINES

no entries

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These Guidelines shall be effective on March 31, 2001.

The Clerk of this Court is directed to forward a copy of this order to the Clerk of each Circuit Court in the State of Indiana; Attorney General of Indiana; Legislative Services Agency and its Office of Code Revision; Administrator, Supreme Court of Indiana; Administrator, Indiana Court of Appeals; Administrator, Indiana Tax Court; Public Defender of Indiana; Indiana Supreme Court Disciplinary Commission; Indiana Supreme Court Commission for Continuing Legal Education; Indiana Board of Law Examiners; Indiana Judicial Center; and Division of State Court Administration.

In addition, the Clerk is directed to forward a copy to Judge Daniel F. Donahue, Clark Circuit Court; the Indiana Family and Social Services Administration, Division of Family and Children and IV-D Support Divisions; Indiana State Bar Association, Family Law Section; Indiana Child Custody and Support Advisory Committee created under Ind. Code 33-2.1-10-1; the libraries of all law schools in the state; the Michie Company, and West Publishing Company.

West Publishing Company is directed to publish this order in the advance sheets of this Court.
The Clerks of the Circuit Courts are directed to bring this order to the attention of all judges within their respective counties and to post this order for examination by the Bar and general public.

Done at Indianapolis, Indiana this _____ day of _____ , 2000.

FOR THE COURT

_____

II. Randall T. Shepard

Chief Justice of Indiana

All Justices concur.

VISITATION PLAN

Visits

Begin Date	Supervision

Persons Who May Visit	Persons Who Cannot Visit

Plan Schedules

Day of Week	Contact Type	Visit Time	Length	Frequency	Appropriate Location

Activities to Promote Interaction/Growth

Protection Plan

Transportation

GENERAL INFORMATION ABOUT AIDS AND HIV INFECTION

What is AIDS?

The acquired immunodeficiency syndrome (AIDS) is the final stage of infection with the human immunodeficiency virus (HIV). This virus infects and, over time, destroys certain white blood cells (CD4 cells) in humans. These cells control an important part of the body's immune system (cell-mediated immunity). As CD4 cells are destroyed, the immune system becomes impaired, ultimately making HIV-infected persons susceptible to infections with certain "opportunistic" organisms and cancers. These infections and cancers are considered "opportunistic because they either do not occur at all or occur in much milder forms in persons with normal immunity. It is important to realize that the destruction of the immune system by HIV is a slow process and occurs over the years. A majority of HIV-infected adults looks and feels healthy for eight to ten years or more before developing AIDS.

Children, particularly those born with HIV infection, may become sick sooner and fare worse overall than adults and older children. Advances in diagnosis and treatment have lead to prolonged life; and HIV infection in children is now a chronic, not an acute or a short-term, illness.

The infections and cancers associated with AIDS do not usually cause serious disease in persons with normal immune systems, and most are not contagious to other persons. The Centers for Disease Control (CDC) has a list of the infections and cancers that indicate that an HIV-infected person has AIDS.

How is HIV transmitted?

HIV is transmitted through sexual intercourse and through contact with infected blood or specific infective body fluids. This is because blood, semen, and vaginal secretions contain large amounts of HIV. Other body fluids, such as saliva, nasal secretions, urine, feces, and tears, do not contain virus in large enough amounts to be infectious. If these "safe" body fluids are visibly contaminated with blood, however, they must be considered infectious because of the potential for blood to transmit HIV.

Other body fluids, such as cerebral spinal fluid (CSF), amniotic fluid, and pericardial fluid, contain HIV in significant amounts and are potentially infectious. These fluids are usually handled only in special settings (hospitals, emergency rooms, operating rooms, etc.) and with special precautions. Breast milk can be infectious, and HIV-infected women or women at risk for HIV infection should not breastfeed their babies.

Another route of transmission is called perinatal transmission in which a pregnant HIV-infected woman can infect the infant she is carrying in utero during pregnancy or delivery. Children born to a woman before she became HIV-infected are not at risk. Many studies have shown that family members of HIV-infected persons are not at risk of acquiring HIV from normal household contacts and activities unless they are the sexual or needle-sharing partners of the infected persons.

Not all exposures to infected fluids cause infection with HIV. While some persons have become infected from a single episode of sexual intercourse, or even from artificial

APPENDIX I

insemination with infected semen, others have had many episodes of intercourse with an infected partner without becoming infected. The chance of becoming infected from a single needle stick exposure is about 0.3%. The risk from a contact of a mucous membrane (eye, mouth) with infected blood is 0.mea. Research shows that without prenatal HIV treatment, there is a 22.6% chance of perinatal (mother to infant) HIV transmission. Research has proven that a three-part regimen of antiretroviral medications decreases perinatal transmission to less than 8%. The three-part regimen consists of the mother taking antiretroviral medications beginning after the twelfth week of gestation, and then during labor and delivery, followed by giving the newborn medications for the first six weeks of life.

What are risk factors for HIV infections?

Persons are at risk for HIV infection primarily because of the following activities:

(1) **Sexual intercourse**

All forms of intercourse-oral, vaginal, or anal, are capable of transmitting HIV. Anal intercourse is considered particularly risky because the rectal mucosa is easily broken, and tiny breaks in the skin allow HIV to enter the blood stream. As in other sexually transmitted diseases, men are more efficient transmitters than women. However, since cervical cells and secretions contain HIV, men are a risk of acquiring HIV from infected female sexual partners. The presence of genital ulcers also increases the risk of HIV transmission because the skin is broken in the area of the ulcer.

It is important to realize that the risk of HIV infection comes from repeated exposures to infected partners and is not related to sexual orientation or practices. Two uninfected persons may have any sort of intercourse they choose with each other without becoming infected with HIV.

By creating a barrier, condoms help prevent transmission of HIV during all forms of sexual intercourse. The use of condoms is strongly recommended for all forms of sexual intercourse when the HIV status of one or both partners is unknown.

(2) **Intravenous drug use (IVDU)**

In many parts of the country, the incidence of HIV infection among drug users is very high due to the practice of sharing needles containing HIV-infected blood. In addition, a drug user infected with HIV from sharing needles may transmit HIV to sexual partners. Consequently, the sexual partners of injection drug users are at high-risk of HIV infection whether or not they use drugs themselves. Over seventy percent (70%) of children with HIV infection acquire the disease in utero or at birth from women who use drugs or are sexual partners of intravenous drug users.

(3) **Accidental exposure to infected blood**

Health care workers may be exposed to contaminated needles and other sharps in the line of duty. Although such occupational exposures are fairly common, the risk of developing HIV from a needle from an infected person is about 0.3%; and health care workers, even those providing care for persons with AIDS (PWAs), are not a high-risk

group for HIV because of their occupation. Universal precautions; i.e., the use of appropriate barrier precautions in handling all blood or other potentially infective body fluids, are mandated by Indiana state law to further reduce the risk of occupational HIV infection.

HIV may also be transmitted through the use of infected blood or blood products as a therapeutic infusion. The screening test of HIV became available in 1985. However, hemophiliacs and others who required blood products prior to March, 1985, were at high-risk for HIV infection. Screening the blood supply and heat-treating clotting factors have made the use of blood products much safer; and today, HIV is rarely transmitted by therapeutic transfusions.

Is there a test to see if someone is infected with HIV?

There are simple blood tests that detect antibodies made by the body in response to the presence of HIV. While most infected persons make antibodies within three (3) months of infection, some persons may take six (6) months or more. Because of the time it takes to make antibodies after infection with HIV, antibody tests may be falsely negative early in the course of infection. Infected persons who test negatively early in the course of their infection are still infectious and

should take precautions to prevent transmission until their status is clearly determined. Test results are usually reliable six (6) months after initial infection with HIV.

The most widely used antibody test is the Enzyme Linked Immunosorbent Assay, referred to as the ELISA. This test is relatively inexpensive, quick, and easy to run and is used as a screening test for HIV infection. No test is perfect; and although the ELISA is over 99% sensitive and specific, it is possible to have false positive as well as false negative tests. A false positive test means that a person is not infected with HIV but has a positive ELISA.

If an ELISA is positive, it is to be repeated. If the repeat test is also positive, a second, confirmatory test is to be run. The most common confirming test is called a Western Blot. This test is more difficult and expensive to perform and is used to confirm repeatedly positive ELISAs.

It is possible, desirable, and usually less expensive to perform all necessary tests; i.e., the first ELISA and, if necessary, the repeat ELISA and Western Blot, from one (1) sample of blood. If ordered in this manner, it is not necessary to recall a person for further blood draws if the first ELISA is positive.

To be identified as HIV seropositive, which means that a person is HIV-infected, a person must have a repeatedly positive ELISA and a positive Western Blot. No one is to be told that they are HIV-infected on the basis of a positive ELISA alone.

To determine whether infants up to 18 months of age are HIV-infected, the viral load test (RNA PCN or DNA PCN) is used as a diagnostic tool. It is a more accurate test for infants of this age than HIV antibody testing. HIV antibody testing is used for children more than 18 months of age because it is not reliable in infants for the first 15-18 months of life. HIV seropositive (infected) mothers may pass their maternal antibodies to their babies causing the newborns to test positively for HIV whether or not they are actually infected. Some infants of infected mothers may not have these passively acquired maternal antibodies at birth but may be HIV-

infected. Babies normally begin to produce antibodies of their own by 15 to 18 months, and antibody tests may be considered reliable at that time.

What are the stages of HIV infection?

HIV infection is a long-term, chronic disease. The Centers for Disease Control (CDC) has developed four (4) stages of HIV disease in adults and adolescents (over 13 years old):

(1) **Acute**

Persons with acute (new) HIV infection often develop fever, malaise, enlarged lymph nodes, and rash several weeks after infection. These symptoms are not specific for HIV and are indistinguishable from other viral illnesses. This acute illness resolves on its own after several weeks. The HIV-infected person apparently regains normal good health and gives no sign of being infected. Since this stage is not specific for HIV, persons with no known risk or exposure should not be alarmed if they develop a typical viral-type illness. Persons with a known exposure to HIV, however, should be alerted to see their physician if such an illness develops soon after their exposure. HIV antibody tests are often negative during acute infections, and repeated testing over time is necessary.

(2) **Asymptomatic**

Persons with HIV-infection may be without signs or symptoms of disease for 10 years or more. A study done in San Francisco showed that eight (8) years after infection with HIV, 48% of persons developed AIDS, others had some symptoms of HIV infection, but about 20% still looked and felt well. Asymptomatic persons may still pass HIV to their sexual and needle-sharing partners, or in the case of pregnant women, to the infants they are carrying in utero.

(3) **Generalized lymphadenopathy**

Some HIV-infected persons feel entirely well but have multiple enlarged lymph nodes (glands). It is unclear whether or not enlarged nodes without other health problems indicate advancing HIV infection.

(4) **Symptomatic HIV infection**

This stage of infection includes all persons with symptoms of HIV disease whether or not they have AIDS. Thrush (Candida), appearing as painless white patches in the esophagus, bronchia, trachea or lungs, is considered to be an opportunistic infection and an indicator disease for AIDS. Other symptoms commonly associated with HIV infection, such as night sweats, unexplained fevers, loss of appetite, weight loss, rashes, diarrhea, fatigue and enlarged lymph nodes, are not specific to HIV. No matter how sick a person may be, CDC requires an indicator disease to be present before the diagnosis of AIDS can be made.

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Is HIV infection the same in children?

The CDC has developed a separate classification system for the pediatric age group (under 13 years of age).

(1) **Indeterminant infection**

Asymptomatic infants less than 15 months of age who have positive HIV antibody tests may not actually be infected. They may have "passively" acquired antibodies through the placenta from their HIV-infected mothers. Infants should be tested at one (1) month, two (2) months and six (6) months of age or greater with a viral load test. Two (2) consecutive negative tests confirm that an infant has not acquired HIV from the mother.

(2) **Asymptomatic infection**

These children are truly HIV-infected but are without signs or symptoms of HIV-related disease.

(3) **Symptomatic infection**

Similarly, HIV-infected infants and children of any age may have a variety of HIV-related infections and conditions, some meeting the diagnostic criteria for AIDS and some not.

What are the common AIDS-related infections and cancers?

Common opportunistic infections in the pediatric and adult/adolescent age groups that fill the diagnostic criteria for AIDS include:

(1) Pneumocystis carinii pneumonia - the most common AIDS-related infection, occurring in 70% of pediatric cases.

(2) Candida, esophageal or bronchopulmonary (thrush in the esophagus or airways). - NOTE: Thrush only in the mouth, while common, is not an indicator disease for AIDS. Many bottle-fed babies have thrush in their mouths and are not HIV-infected. In most of these cases, better cleaning of nipples eliminates the problem; and medication is rarely needed. Infants with HIV may have more severe or extensive thrush that requires medical treatment.

(3) Chronic herpes - Herpes simplex viruses (HSV) cause the common "cold sore" as well as genital herpes. While most children have cold sores that heal without medical treatment, herpes in adults and children with HIV

infection can cause severe, large spreading ulcers that do not heal without medical therapy. Perinatally acquired HSV disease must be excluded in infants suspected of having chronic herpes.

(4) Cytomegalovirus (CMV) - a common virus that causes self-limited illness in persons with normal immune systems but that can cause serious disease as well as blindness in HIV-infected adults and children. Congenital CMV disease may need to be excluded in some infants.

(5) Mycobacterium tuberculosis(TB) - TB that has spread throughout the body is associated with HIV infection. It is important for HIV-infected persons to be screened routinely for TB because when it is in the lungs (pulmonary TB) or throat, it is veryinfectious to other persons, even if they are not HIV-infected. In addition, TB in HIV-infected persons responds readily to treatment.

(6) Atypical mycobacteria - "cousins" of TB, these also cause disease in HIV-infected persons. Unlike TB, the atypical mycobacteria are not transmitted from person-to-person, even if in the lungs or throat.

Common cancers include:

(1) Kaposi's sarcoma - appears as multiple purplish nodules in the skin, and often involves lungs, intestines, and other viscera.

(2) Lymphoma - a cancer that can occur only in the brain but is also found outside the central nervous system. NOTE: All persons with lymphoma do not have AIDS, but HIV-infected persons with lymphoma have AIDS.

When tissue or microbiologic data are necessary to make the above diagnoses, two (2) other syndromes indicate AIDS:

(1) Wasting - unexplained weight loss and debilitation.

(2) Dementia - alterations of mental functioning not caused by any reason other than HIV infection.

Children with HIV infection are particularly prone to central nervous system dysfunction and may have loss of developmental milestones, developmental delays, as well as general failure to thrive.

In addition, pediatric AIDS includes the following:

(1) Pulmonary lymphoid hyperplasis (PLH)

(2) Lymphoid interstitial pneumonia (LIP).

(3) Recurrent serious bacterial infections - at lease two (2) episodes within a two (2) year period of septicemia, meningitis, or other serious infections (including otitis media).

How can I keep from getting HIV infection?

Most persons are infected from personal behaviors that are controllable. Since HIV is primarily a sexually transmitted disease, one way of preventing acquisition of infection is through sexual abstinence. If a person chooses to be sexually active, is not HIV-infected, and has only one sexual partner who is monogamous and uninfected, the risk of acquiring HIV from sexual intercourse is very small. It is not zero, however, because it is difficult to know a person's HIV status and even more difficult to know if that person is entirely monogomous. The use of condoms, with or without the spermicide nonoxynol-9, for every episode of sexual intercourse

will greatly reduce risk of HIV infection when a partner's HIV status is positive or uncertain, but it will not necessarily prevent it. The failure rate for condoms in preventing pregnancy is about 15%, and this may be true for prevention of HIV transmission where one partner is known to be infected.

In an ideal world, all persons using illicit injection drugs would stop using. Since such a scenario is unlikely, drug users who do not intend to alter their behavior or who are waiting to enter a detoxification program should avoid sharing needles. Another option, if needle sharing is expected to continue, is to cleanse needles and "works" before and after every use with a solution of bleach and water.

The risk of acquiring HIV from a blood transfusion is very small, about one (1) in 600,000. If this remains a concern, and if one's physician feels it is safe to donate blood, persons anticipating elective surgery may give their own blood for their own anticipated use (autologous donations). Hemophiliac and other clotting factors are now heat-treated and should not transmit HIV.

Health care professionals have a small but significant risk for occupational acquisition of HIV infection. This risk can be further reduced by careful technique during procedures and by the application of universal precautions.

Universal precautions are infection control measures taken by health care workers with all persons, regardless of HIV status. Numerous studies have shown that only 10-15% of HIV-infected persons is aware of their infection. In addition, it is impossible to determine who may or may not be HIV-infected from their age, race, sex, appearance or sexual orientation. Risk assessment may not be reliable unless skillfully done; and, on occasion, emergency situations prevent accurate gathering of medical history. Therefore, it is safest to assume that all persons requiring health care could be HIV-infected.

Universal precautions consist of the use of appropriate barrier precautions to prevent direct contact with blood, semen, vaginal secretions, visibly bloody body fluids, or other special fluids such as spinal fluid, which contain large amounts of HIV. In the family, school, or home setting, the main risk of HIV transmission occurs from exposure to infected blood. Body fluids such as tears, saliva, urine, feces, vomitus, sweat, and nasal secretions, if not visibly contaminated with blood are <u>not</u> infectious for HIV but may well be vectors for other infectious viruses and bacteria. However, gloves or other barrier precautions are <u>not</u> necessary for routine child care, including diapering/toileting, feeding, burping, etc. These same body fluids, if visibly contaminated with blood, should be considered potentially infectious; and universal precautions should be applied. All persons whose occupations make it likely that they will have contact with blood should be taught how to apply universal precautions. In most cases, this is very simple; e.g, putting on a pair of gloves when cleaning up after a bloody accident. Whether or not barrier precautions are used, hand washing should always be done following contact with body fluids to prevent the spread of any infection the fluids might contain.

In the home, HIV is readily killed by heat achievable in dish washers and clothes dryers. In addition, many common household agents such as Lysol or hypochlorite bleach will effectively eliminate HIV. A solution of one (1) part bleach to 10 parts water is inexpensive and effective on hard surfaces. If blood is on a rug or upholstery, most commercial cleaners or disinfectants will eradicate the virus. In any case, HIV does not survive for prolonged periods outside the body. Dried blood or other stains of uncertain origin need not be considered infectious for HIV.

Appendix I

PREAMBLE AND RATIONALE
HIV Policy for Foster Care

The increased prevalence of HIV infection in Indiana requires that state agencies serving children develop and adopt policies regarding the delivery of services to children with documented or suspected HIV infection.

Federal Anti-discrimination Law

The United States Supreme Court has ruled under Section 504 of the Federal Rehabilitation Act that a communicable disease may be a handicapping condition. Under this act, persons with contagious diseases cannot be discriminated against if they are "otherwise qualified" to be employed or to participate in programs covered by Section 504. Public, private, and voluntary agencies that receive federal funding to care for children; e.g., funds from Titles IV-A, IV-E, and XX of the Social Security Act, are covered by Section 504.

The Department of Health and Human Services has taken the position in its Notice to Recipients of Financial Assistance from the U.S. Department of Health and Human Services that federal civil rights laws apply to persons with HIV infection. In addition, the Supreme Court, in Bragdon vs. Abbott, ruled that the Americans with Disabilities Act (ADA) protects individuals with HIV from discrimination. Indiana's civil rights laws provide protection also.

Definitions

The Human Immunodeficiency Virus (HIV) is the causative agent of the acquired immunodeficiency syndrome (AIDS). HIV infection weakens the body's immune system until the affected person develops "opportunistic" infections and cancers not found in persons with normal immune systems. Morbidity and mortality in persons with advanced HIV infection or AIDS are caused by these infections and tumors and not by HIV itself.

The diagnosis of AIDS is based upon diagnostic criteria established by the Centers for Disease Control (CDC). For the purpose of this policy, a child is HIV-infected when the child:

(1) who is less than 18 months of age has a positive viral load after appropriate testing;

(2) who is at least 18 months of age has positive blood antibody tests; or

(3) has clinical signs and symptoms of immune deficiency conditions associated with HIV.

A child shall be considered as having AIDS when the child fulfills diagnostic criteria.

Transmission

Social workers and direct care providers can safely care for HIV-infected children by using simple hygiene practices. Such practices consist primarily of the appropriate use of disposable gloves and

disinfectant. Given the use of these hygiene practices as appropriate, it is safe for workers and caregivers to carry HIV-infected children in their arms, transport them in a car, hug them, hold their hands, dry their tears, or give them a kiss. These practices are also safe for the HIV-infected child.

Not one case of HIV infection is known to have been transmitted in a school, day care, or foster care setting. HIV infection is not spread through the kind of non-sexual contact persons normally have in the home, school, or office; e.g., touching, hugging, or

sharing meals, bathrooms, or telephones. This is
supported by long-term studies of family members of both adults and children with HIV infection. Not one household member has become infected through routine, non-sexual contact with a family member with AIDS. In addition, there is no evidence that siblings of an HIV-infected child are at risk for acquiring HIV infection from that child.

Confidentiality

Indiana Code IC 16-41-8 protects the confidentiality of positive HIV status. Agencies will establish clear policies and procedures to maintain the privacy and confidentiality of HIV-infected children, noting that the law protects the confidentiality of HIV status. Dissemination of information concerning an infected child's condition will occur only when necessary to assure proper care of the child and to protect others from increasing their risk of becoming HIV-infected. In general, caregivers and staff who work closely with an infected child have a right to know that the child is HIV-infected, although, unlike confidentiality, this right is not mandated by law. It is believed that clear and accurate information about HIV infection, a child's health status, and appropriate infection control measures must be given to parents, foster parents, guardians, or custodians to enable them to make an informed decision about their ability and willingness to provide care to the child. If possible, caregivers and staff will be informed of the child's condition in advance of an assignment involving the child. Agency requirements concerning client privacy and confidentiality of information will also be clearly communicated to those informed of a child's HIV infection.

Serving Children with HIV Infection

Based on the preceding information, agencies will provide or arrange services for any HIV-infected child under their care in a manner that protects the child's rights and well-being and minimizes the risk for further HIV transmission.

The decisions regarding the type of care setting for HIV-infected children will be based on:

(1) the presence of behaviors likely to transmit HIV infection (Based upon experience with other communicable diseases, a theoretical potential exists for transmission among children who are not in control of their body functions or behaviors, such as fighting or biting.);

(2) the age of the child;

(3) the child's medical status, history, and symptomatology;

(4) the need to protect the HIV-infected child from preventable exposures to additional infections;

(5) the appropriateness of existing services and structure; and

(6) whether another agency is better able to provide necessary services to a particular child.

Recommendations for the HIV-infected child's service plan must be based on a comprehensive review

by a multidisciplinary team that includes social and medical input to assure that the special needs of a handicapping condition can be met through creative programming or that such programming can be developed.

For most infected school-age children, the benefits of an unrestricted setting outweigh the risk of their acquiring potentially harmful infections in the school setting. The risk of transmission of HIV in the
school setting is so small as to be non-existent. Nevertheless, because many infections in addition to
HIV can be present in blood and body fluids, all schools and child care facilities are to adopt policies and procedures for handling all blood and body fluids that are in accordance with state law. In general then, HIV-infected children are to be allowed to attend school and child care and to be placed in a foster home in an unrestricted setting.

Regarding the infected preschool-age child, for some handicapped children who lack control of their body secretions or who display aggressive behavior, and for those children who have open lesions which cannot be covered, a more restricted environment is advisable.

NOTE: The hygienic practices of children with HIV infection may improve as the child matures but may deteriorate if the child's condition worsens. Therefore, ongoing evaluation is necessary to assess the need for a change of placement to an environment that is either more of less restricted.

The reason(s) for withholding any service to an HIV-infected child are to be documented, and a recommendation for a specific alternative care plan must be included in the documentation. Permanency planning for clients with HIV infection is to take place in the context of their medical condition and prognosis. Planning is to be based on knowledge of disease states, progression of the disease, and family support needs. Final decisions on disposition plans and acceptance into any specific agency service will be subject to administrative review and approval.

Education and Training

Agencies are to develop or arrange for the provision of programs designed to educate children and their families about HIV infection and transmission and about available psychosocial supports. Agencies will also conduct or arrange for ongoing training and education for employees and contract providers on diverse and appropriate topics surrounding HIV infection. In addition, employees and contract providers will be given a point of contact within their agency where they can call to obtain further

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IC16-41-6

Chapter 6. Communicable Disease: Mandatory Testing of Individuals With Communicable or Dangerous Diseases

IC 16-41-6-0.5

"Standard licensed diagnostic test for HIV"

Sec. 0.5. As used in this chapter, "standard licensed diagnostic test for HIV" means a test recognized by the state department as a standard licensed diagnostic test for the antibody or antigen to HIV.
As added by P.L.237-2003, SEC.5.

IC 16-41-6-1

HIV screening and testing

Sec. 1. (a) Except as provided in IC 16-41-10-2.5 and subsection (b), a person may not perform a screening or confirmatory test for the antibody or antigen to HIV without the consent of the individual to be tested or a representative as authorized under IC 16-36-1. A physician ordering the test or the physician's authorized representative shall document whether or not the individual has consented. The test for the antibody or antigen to HIV may not be performed on a woman under section 5 or 6 of this chapter if the woman refuses under section 7 of this chapter to consent to the test.

(b) The test for the antibody or antigen to HIV may be performed if one (1) of the following conditions exists:

(1) If ordered by a physician who has obtained a health care consent under IC 16-36-1 or an implied consent under emergency circumstances and the test is medically necessary to diagnose or treat the patient's condition.

(2) Under a court order based on clear and convincing evidence of a serious and present health threat to others posed by an individual. A hearing held under this subsection shall be held in camera at the request of the individual.

(3) If the test is done on blood collected or tested anonymously as part of an epidemiologic survey under IC 16-41-2-3 or IC 16-41-17-10(a)(5).

(4) The test is ordered under section 4 of this chapter.

(5) The test is required or authorized under IC 11-10-3-2.5.

(c) A court may order a person to undergo testing for HIV under IC 35-38-1-10.5(a) or IC 35-38-2-2.3(a)(16).
As added by P.L.2-1993, SEC.24. Amended by P.L.106-1998, SEC.1; P.L.293-2001, SEC.3; P.L.212-2003, SEC.4; P.L.237-2003, SEC.6; P.L.97-2004, SEC.67.

IC 16-41-6-2

Informed consent; court ordered examinations

Sec. 2. (a) As used in this section, "informed consent" means authorization for physical examination, made without undue inducement or any form of force, fraud, constraint, deceit, duress, or coercion after the following:

(1) A fair explanation of the examination, including the

purpose, potential uses, limitations, and the fair meaning of the examination results.

(2) A fair explanation of the procedures to be followed, including the following:

(A) The voluntary nature of the examination.

(B) The right to withdraw consent to the examination process at any time.

(C) The right to anonymity to the extent provided by law with respect to participation in the examination

and disclosure of examination results.

(D) The right to confidential treatment to the extent provided by law of information identifying the subject of the examination and the results of the examination.

(b) If the state health commissioner, the state health commissioner's legally authorized agent, or local health official has reasonable grounds to believe that an individual may have a communicable disease or other disease that is a danger to health, the state health commissioner, the state health commissioner's legally authorized agent, or local health officer may ask the individual for written informed consent to be examined to prevent the transmission of the disease to other individuals.

(c) If the individual, when requested, refuses such an examination, the state health commissioner, the state health commissioner's legally authorized agent, or local health officer may compel the examination only upon a court order based on clear and convincing evidence of a serious and present health threat to others posed by the individual.

(d) A hearing held under this section shall be held in camera at the request of the individual.

As added by P.L.2-1993, SEC.24.

IC 16-41-6-2.5 Repealed

(*Repealed by P.L.237-2003, SEC.18.)*

IC 16-41-6-3

Violations

Sec. 3. (a) Except as otherwise provided, a person who recklessly violates or fails to comply with this chapter commits a Class B misdemeanor.

(b) Each day a violation continues constitutes a separate offense.

As added by P.L.2-1993, SEC.24.

IC 16-41-6-4

Testing newborn infants; confidentiality; notice; information on treatment options; objecting; rules

Sec. 4. (a) Subject to subsection (f), if:

(1) the mother of a newborn infant has not had a test performed under section 5 or 6 of this chapter;

(2) the mother of a newborn infant has refused a test for the newborn infant to detect HIV or the antibody or antigen to HIV; and

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(3) a physician believes that testing the newborn infant is medically necessary;

the physician overseeing the care of the newborn infant may order a confidential test for the newborn infant in order to detect HIV or the antibody or antigen to HIV. The test must be ordered at the earliest feasible time not exceeding forty-eight (48) hours after the birth of the infant.

(b) If the physician orders a test under subsection (a), the physician must:

(1) notify the mother of the newborn infant of the test; and

(2) provide HIV information and counseling to the mother. The information and counseling must include the following:

(A) The purpose of the test.

(B) The risks and benefits of the test.

(C) A description of the methods of HIV transmission.

(D) A discussion of risk reduction behavior modifications, including methods to reduce the risk of perinatal HIV transmission and HIV transmission through breast milk.

(E) Referral information to other HIV prevention, health care, and psychosocial services.

(c) The confidentiality provisions of IC 16-41-2-3 apply to this section.

(d) The results of the confidential test ordered under subsection (a) must be released to the mother of the newborn infant.

(e) If a test ordered under subsection (a) is positive, the person who provides the results of the test shall inform the mother of the newborn infant of treatment options or referral options available to the newborn infant.

(f) If a parent of the newborn infant objects in writing for reasons pertaining to religious beliefs, the newborn infant is exempt from the test under subsection (a).

(g) The state department shall adopt rules under IC 4-22-2 to carry out this section.

(h) The results of a test performed under this section are confidential.

As added by P.L.106-1998, SEC.2. Amended by P.L.237-2003, SEC.7.

IC 16-41-6-5

Ordering and submitting a pregnant woman's blood sample for testing

Sec. 5. (a) This section applies to:

(1) a physician licensed under IC 25-22.5; or

(2) an advanced practice nurse licensed under IC 25-23;

who provides prenatal care within the scope of the provider's license.

(b) Subject to section 8 of this chapter, an individual described in subsection (a) who:

(1) diagnoses the pregnancy of a woman; or

(2) is primarily responsible for providing prenatal care to a pregnant woman;

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shall order to be taken a sample of the pregnant woman's blood and shall submit the sample to an approved laboratory for a standard licensed diagnostic test for HIV.

As added by P.L.237-2003, SEC.8.

IC 16-41-6-6

No written evidence of testing; ordering and submitting sample

Sec. 6. Subject to section 8 of this chapter, if, at the time of delivery, there is no written evidence that a standard licensed diagnostic test for HIV has been performed under section 5 of this chapter, the physician or advanced practice nurse in attendance at the delivery shall order to be taken a sample of the woman's blood at the time of the delivery and shall submit the sample to an approved laboratory for a standard licensed diagnostic test for HIV.

As added by P.L.237-2003, SEC.9.

IC 16-41-6-7

Right to refuse test

Sec. 7. A pregnant woman has a right to refuse a test under section 5 or 6 of this chapter.

As added by P.L.237-2003, SEC.10.

IC 16-41-6-8

Informing pregnant woman of information; documenting information given and a refusal of test; information if test results positive; confidentiality

Sec. 8. (a) This section applies to a physician or an advanced practice nurse who orders an HIV test under section 5 or 6 of this chapter or to the physician's or nurse's designee.

(b) An individual described in subsection (a) shall:

(1) inform the pregnant woman that:

(A) the individual is required by law to order an HIV test unless the pregnant woman refuses; and

(B) the pregnant woman has a right to refuse the test; and

(2) explain to the pregnant woman:

(A) the purpose of the test; and

(B) the risks and benefits of the test.

(c) An individual described in subsection (a) shall document in the pregnant woman's medical records that the pregnant woman received the information required under subsection (b).

(d) If a pregnant woman refuses to consent to an HIV test, the refusal must be noted in the pregnant woman's medical records.

(e) If a test ordered under section 5 or 6 of this chapter is positive, an individual described in subsection (a):

(1) shall inform the pregnant woman of the test results;

(2) shall inform the pregnant woman of the treatment options or referral options available to the pregnant woman; and

(3) shall:

(A) provide the pregnant woman with a description of the methods of HIV transmission;

(B) discuss risk reduction behavior modifications with the pregnant woman, including methods to reduce the risk of perinatal HIV transmission and HIV transmission through breast milk; and

(C) provide the pregnant woman with referral information to other HIV prevention, health care, and psychosocial services.

(f) The provisions of IC 16-41-2-3 apply to a positive HIV test under section 5 or 6 of this chapter.

(g) The results of a test performed under section 5 or 6 of this chapter are confidential.

(h) As a routine component of prenatal care, every individual described in subsection (a) is required to provide information and counseling regarding HIV and the standard licensed diagnostic test for HIV and to offer and recommend the standard licensed diagnostic test for HIV.

(i) An individual described in subsection (a) shall obtain a statement, signed by the pregnant woman, acknowledging that the pregnant woman was counseled and provided the required information set forth in subsection (b) to ensure that an informed decision has been made.

(j) A pregnant woman who refuses a test under this section must do so in writing.

As added by P.L.237-2003, SEC.11. Amended by P.L.97-2004, SEC.68.

IC 16-41-6-9

Information on confidential part of birth certificate

Sec. 9. The state department shall require, on the confidential part of each birth certificate and stillbirth certificate retained by the state department, in addition to the information otherwise required to be included on the certificate, the following information:

(1) Whether a standard licensed diagnostic test for HIV was performed on the woman who bore the child.

(2) If a standard licensed diagnostic test for HIV was performed:

(A) the date the blood specimen was taken; and

(B) whether the test was performed during pregnancy or at the time of delivery.

(3) If a standard licensed diagnostic test for HIV was not performed, the reason the test was not performed.

As added by P.L.237-2003, SEC.12.

IC 16-41-6-10

Distributing information on HIV treatment options

Sec. 10. The state department shall distribute to physicians and to other individuals who are allowed by law to attend a pregnant woman information available from the federal Centers for Disease Control and Prevention that explains the treatment options available to an individual who has a positive test for HIV.

As added by P.L.237-2003, SEC.13.

IC 16-41-6-11

Rules

Sec. 11. (a) The state department shall adopt rules under IC 4-22-2 that include procedures:

(1) to inform the woman of the test results under this chapter, whether they are positive or negative;

(2) for explaining the side effects of any treatment for HIV if the test results under this chapter are positive; and

(3) to establish a process for a woman who tests positive under this chapter to appeal the woman's status on a waiting list on a treatment program for which the woman is eligible. The rule must:

(A) include a requirement that the state department make a determination in the process described in this subdivision not later than seventy-two (72) hours after the state department receives all the requested medical information; and

(B) set forth the necessary medical information that must be provided to the state department and reviewed by the state department in the process described in this subdivision.

(b) The state department shall maintain rules under IC 4-22-2 that set forth standards to provide to women who are pregnant, before delivery, at delivery, and after delivery, information concerning HIV. The rules must include:

(1) an explanation of the nature of AIDS and HIV;

(2) information concerning discrimination and legal protections;

(3) information concerning the duty to notify persons at risk as described in IC 16-41-7-1;

(4) information about risk behaviors for HIV transmission;

(5) information about the risk of transmission through breast feeding;

(6) notification that if the woman chooses not to be tested for HIV before delivery, at delivery the child will be tested subject to section 4 of this chapter;

(7) procedures for obtaining informed, written consent for testing under this chapter;

(8) procedures for post-test counseling by a health care provider when the test results are communicated to the woman, whether the results are positive or negative;

(9) procedures for referral for physical and emotional services if the test results are positive;

(10) procedures for explaining the importance of immediate entry into medical care if the test results are positive; and

(11) procedures for explaining that giving birth by cesarean section may lessen the likelihood of passing on HIV to the child during childbirth, especially when done in combination with medications, if the test results are positive.

As added by P.L.237-2003, SEC.14.

IC 16-41-6-12

Completing HIV test history and assessment form; retaining copy of form in patient's medical file; systemwide evaluation of prenatal HIV testing

Sec. 12. (a) The state department shall provide that an HIV test history and assessment form from the patient's medical records or an interview with the patient must be filled out. The state department shall develop the form to determine if:

(1) the patient is HIV positive and has been informed; or

(2) the patient was tested during the current pregnancy and tested negative or was not tested during the current pregnancy and the HIV status is unknown.

(b) The form required under subsection (a) must identify what special support or assistance for continued medical care the patient might need as a result of a positive test.

(c) A copy of the form must be:

(1) kept in the patient's medical file;

(2) kept in the baby's medical file; and

(3) given to the doctor in the hospital designated to administer the newborn HIV testing program.

(d) The state department must maintain a systemwide evaluation of prenatal HIV testing in Indiana. The state department shall prescribe the HIV test history and assessment form and a newborn blood screening form. The state department shall remove all identifying information from the maternal test history before the state department performs its analyses and shall not maintain HIV test history data with identifying information.

As added by P.L.237-2003, SEC.15.

IC 16-41-6-13

Treatment program access for women who test positive for HIV

Sec. 13. (a) Women who:

(1) meet all qualifications to participate in the children's health insurance program, the AIDS drug assistance program, the health insurance assistance program, or any other health care program of the state; and

(2) test positive under section 5 or 6 of this chapter;

shall be given first priority on a waiting list for the program if a waiting list exists. If a program does not have a waiting list, the woman described in this subsection shall be automatically approved and accepted into the program.

(b) If the state department determines during the process described in section 11(a)(3) of this chapter that the treatment of a woman who tests positive under this chapter should not be interrupted because of medical necessity, the woman may enter a program described in subsection (a) regardless of the existence of a waiting list for the program.

As added by P.L.237-2003, SEC.16

APPENDIX M

MENTAL HEALTH SCREENING TOOL (CHILD 5 YEARS TO ADULT)

Referent: Date
Telephone: Agency: ☐ Social Services ☐ Probation ☐ Other: _____
Child's Name: Date of Birth:
Child's Ethnicity: Primary Language:
Child's Current Telephone: SSN #:
Child's Current Residence: ☐ Shelter ☐ Group Home ☐ Relative ☐ Juvenile Hall ☐ Foster Care ☐ Other : _____
Caregiver/Contact Person (if known): .
Child's Current Address:

Please check applicable boxes on both pages of this form. Following each question are examples of behaviors or problems that would require a "YES" check. ***Please circle any that apply****. This list is not exhaustive. If you have a question about whether or not to check "YES," please indicate the issues under the COMMENTS section on the reverse side of the form.*

YES	NO	UNKNOWN	IDENTIFIED RISK
☐	☐	☐	1. Has this child been a danger to him/herself or to others in the last 90 days? *Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.*
☐	☐	☐	2. Has this child experienced severe physical or sexual abuse or has s/he been exposed to extreme violent behavior in his/her home in the last 90 days? *Subjected to or witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.*
☐	☐	☐	3. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy? *Persistent chaotic, impulsive or disruptive behaviors; daily verbal outbursts; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other discipline, etc.*
☐	☐	☐	4. Has the child exhibited bizarre or unusual behaviors in the last 90 days? *History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); smears feces; etc.*
☐	☐	☐	5. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill? *Either needs immediate evaluation of medication or needs a new prescription.*

If you checked any of the above boxes YES, the child requires urgent referral to Mental Health. Please forward this form to the agency listed on the next page of this form immediately. Please continue on the next page.

COMMENTS ADDITIONAL INFORMATION: _____

YES	NO	UNKNOWN	RISK ASSESSMENT
☐	☐	☐	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____

☐	☐	☐	2. Does the child have problems with social adjustment? *Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.*
☐	☐	☐	3. Does this child have problems making and maintaining healthy relationships? *Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.*
☐	☐	☐	4. Does this child have problems with personal care? *Eats or drinks substances that are not food; regularly enuretic during waking hours (subject to age of child); extremely poor personal hygiene.*
☐	☐	☐	5. Does this child have significant functional impairment? *No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.*
☐	☐	☐	6. Does this child have significant problems managing his/her feelings? *Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive; etc.*
☐	☐	☐	7. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication? *Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.*
☐	☐	☐	8. Is this child known to abuse alcohol and/or drugs? *Child regularly uses alcohol or drugs.*

If any of the above boxes are checked "YES", the child needs to be referred to Mental Health to determine if an assessment or services are required. Please forward the form to:

COMMENTS/ADDITIONAL INFORMATION: _____

Mental Health Follow Up Response

Name: _____ Date: _____

☐ MH Assessment complete: no follow up MH required.

☐ MH Assessment complete. MH follow up required.

☐ Other: _____

SERVICE STANDARDS

Chafee Foster Care Independence Program

All Programs funded through Chafee money must follow these Service Standards

I. Service Description

Independent Living services consist of a series of developmental activities that provide opportunities for young people to gain the skills required to live healthy, productive, and responsible lives as self-sufficient adults. The Foster Care Independence Act of 1999 and the Chafee Foster Care Independence Program makes clear that independent living services should be seen as a service to young people that will help them transition to adulthood, regardless of whether they end up on their own, are adopted, or live in another permanent living arrangement. Services are based on an independent living assessment as identified by the case plan. Young people must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from experiences/failures.

Youth development programming is based on the principle of meeting needs of children and adolescents in four areas:

1. Developing both competence and feelings of competence in many areas.
2. Developing a sense of usefulness to the group and the community.
3. Developing a sense of belonging to a group, organization, club, team, or some other organized cohort.
4. Developing a sense of empowerment over one's circumstances and a feeling that one can influence people, places, and events to meet personal needs.

Youth ages **14 and 15** will receive individual guidance, case management, and soft skill independent living services, which are reflected in the independent living assessment. Youth ages **16 and 17** will have the same services available to them as the 14-15 year olds, based on need for services, but will also have available transitional living services. In addition to the independent living assessment, programming services include but are not limited to: counseling/therapy, tutoring, mentoring, education, housing, health care, transportation/drivers education, self-esteem building, life interest explorations such as history, government, sports, reading, writing, music, etc., money management, incentive programs, personal relationship education, and life interest explorations.

Youth ages **18-20** who have not reached their twenty first birthday and who have left foster care will be offered guidance on: financial issues, assessment services, housing, health care, counseling, employment, education opportunities, incentive program and other support services that are unique for the development of self-sufficiency.

- Enrollment in Independent Living programs can occur concurrently with continued efforts to locate and achieve placements in adoptive families, guardianship and kinship care.
- CFCIP services may start earlier and/or may continue for some amount of time after permanency has been achieved (e.g., through reunification or adoption).
- A portion of funds must be used to serve young people ages 18-21 who age out of foster care because they reach 18 years of age
- Services should be provided according to the developmental needs and differing stages of independence of the young person. As such, independent living services should not be seen as a single event, or as being provided in a substitute care setting, but rather as a series of activities designed over time to support the young person in attaining a level of independence that allows for a productive adult life. Services, therefore, should address all of the preparatory requirements for independent adulthood and recognize the evolving and changing developmental needs of the adolescent.

II. Service Components

Independent Living Programs are designed to assist young people by advocating, teaching, training, demonstrating, monitoring and/or role modeling new, appropriate skills in order to enhance self-sufficiency. Service components must include all of the following based on the youth's needs as identified through the Independent Living assessment and documentation in the case plan.

- Assessment
- Service Coordination
- Mentoring
- Client Advocacy
- Life Skills/Social Skills
- Educational Services
- Transportation
- Vocational And Employment Services
- Health Services
- Housing Services
- Youth Development
- Social Services

III. Service Criteria

Service components must include all of the following based on the youth's needs as identified through the Independent Living assessment and documentation in the case plan.

Assessment

The independent living assessment must include a comprehensive, written assessment of the youth strengths as well as areas of improvement. The following assessment tools are approved for use: Daniel Memorial Assessment and Ansell-Casey Life Skills Assessment. Other tools must be submitted and approved by the State Independent Living Coordinator.

Mentoring

Service providers will provide or monitor that each youth receives mentoring services, either directly or by referral, that include:

- Mentors will offer one-on-one guidance, support and encouragement within a structured, formal program. The program should appropriately match youth with screened and trained adults for exclusive one-to-one relationships. Mentors must not be current programmatic IL staff, child welfare professionals, or caregivers that already have an existing relationship with the child. An exception may be made to this criteria if a mentoring relationship is already established prior to the initiation of the IL referral and meets exclusive criteria.
- Mentors and young people meet on a regular basis as determined through the IL assessment.
- Mentor functions include listening, coaching, educating, sponsoring, encouraging, counseling, and role modeling. Meetings and activities should support a youth's need for a caring and supportive adult in their life.
- Mentors may guide people in the use of free or leisure time by sharing their own interests and encouraging the young person to do the same.
- Consistent and committed mentoring efforts may focus on faith-based activities, music, art, cultural support, education/vocation needs and participation in civic service and community activities.
- Providers must ensure that mentoring programs adhere to the following programmatic guidelines for mentoring, which include, recruitment efforts, screening process, CPS and criminal background checks, valid IN drivers license and insurance, training curriculum, making and supporting appropriate matches, and on-going mentor support.
- Efforts should be made to match IL youth 14-18, as well as those 18-21 that return for services.
- Provider must cooperate with any research or evaluation efforts by FSSA.

Minimum Qualifications for Mentors:

- Must have and provide proof of a valid driver's license and minimum car insurance coverage.

- Must have a high school diploma or GED and a general interest in helping transitioning youth.
- Supervision or oversight must be obtained by providers with Bachelor's Degree in Social Work or Bachelor's in another human service field and no less than three (3) years of successful experience in providing in-home and/or center based services.
- Mentors must have completed CPS and criminal background checks with no criminal or substantiated CPS findings, proof of a valid IN drivers license and of proof automobile insurance coverage.

Educational Services

Service providers will provide or monitor that the youth receives educational services, either directly or by referral that include:

- An assessment of the youth's skills, learning styles, and aptitudes;
- An educational plan or IEP/ITP consistent with the youth's case plan;
- Assistance with obtaining access to appropriate resources, such as a public or private school, college or university, as well as specialized vocational training programs. Including receiving academic support (HS/GED/Vocational Certificate);
- Advocating with the public school system for the young person's right to an education as provided in federal law;
- Assistance with receiving financial support related to educational support;
- Receiving planned driver's education services (if over the age of 16 and there is an adult willing to take legal responsibility for the youth regarding insurance and liability); and
- Assistance with career preparation to reinforce preparedness and possession of a marketable skill set. Such services may include assessment of a skilled occupation competency based on the youth's interest and aptitudes.

Vocational and Employment Services

Service providers will provide vocational and employment services, either directly or by referral that include:

- An assessment of interests, abilities, and aptitudes as well as strengths and weaknesses in obtaining and maintaining employment;
- Assistance in developing habits, skills, and self-awareness essential to employability;
- Making use of all available community employment and training resources including on the job training, job coach if eligible for service, and helping the young person access them, as appropriate;
- Assistance with receiving career planning/job placement/job retention services; and
- Developing job leads in the private sector and working with employers who may employ young people, including internships, job mentoring, apprenticeship, summer employment programs and other supportive services.

Health Services

Service providers will provide or advocate for health services to the youth that include:

- Documentation of his/her physical health status, and referral for services as needed
- A written summary or Medical Passport of his/her known medical history, including family health history, that includes immunizations, operations, and childhood illnesses
- Assessment and documentation of special needs, if any
- Age-appropriate education regarding basic hygiene and nutrition, medical and dental care, sex education and HIV prevention, substance abuse prevention/intervention, teen parenting education
- Assistance with accessing formal individual and group counseling, including crisis counseling and family therapy.
- Receiving Medicaid coverage, State alternative, or other insurance coverage for self and children.
- Education regarding safety skills (personal safety, fire, etc).

Housing Services

Definition: Young persons seeking independence should be helped in their efforts to locate suitable living arrangements, an essential step in making a successful transition to independence. Service providers will provide housing services either directly or by referral that, include:

- Education regarding the range of housing options;
- Budgeting for consistent payments of rent to assure a positive rental history;

- Education on tenant rights and responsibilities;
- Education to develop understanding of the importance of following Apartment Communities rules and regulation policies;
- Advocacy on behalf of particular youth for affordable, appropriate housing;
- Assistance with obtaining a safe, growth-enhancing living environment suitable to the needs of the youth and his/her level of maturity and functioning;
- Receiving formal supervised independent living services where the youth is under the supervision of an agency and receiving agency financial support, but without 24-hour adult supervision, as appropriate and outlined in the case plan; and
- Receiving room and board payment (for youth 18 years or older only) as appropriate.

Life Skills and Social Skills Services

Service providers will provide life and social skills training that include:

- Access to legal services and training on exercising legal rights and responsibilities;
- Information and referral regarding public assistance from the state and local township trustee;
- Opportunity to meet and interact with others in small and large groups and to develop a consistent, ongoing mentoring relationship with an appropriate caring adult;
- Participation in peer support and community service programs;
- Specific education and training in the areas of problem-solving, conflict resolution, resource management, stress management, communication skills, interpersonal skills, community resources, support systems, and goal-setting;
- Training in life skills, self-care, and the activities of daily living as necessary, including budget and financial management services;
- Referral to and advocacy within the community for services that are not provided directly by the agency; and
- Obtaining and maintaining written documentation of all physicians, dentists, social workers, schools, mental health providers, social security, court records, etc., related to their case, including name, address, and phone number.

Youth Development

Service providers will provide opportunities for social, cultural, recreational, and/or spiritual activities that:

- Are designed to expand the range of life experiences;
- Are sensitive to the cultural needs of youth;
- Are sensitive to youth with special needs;
- Form meaningful and growth-producing adult relationships with families, peers, and other persons;
- Assist the young person in managing relationships with family, peers, and significant others;
- Provide regular feedback from service provider on observations of the relationships;
- Introduce various available recreational and social activities for leisure time;
- Offer experiential learning in communication skills and conflict resolution management;
- Allow for participation in youth conferences and other developmental opportunities, which include leadership activities and mentoring services (mentoring services include group pairings of youth with adult role models to provide a support system to guide and advise youth); and
- Provide mentoring in the school, workplace and/or community.

Designated providers will facilitate youth involvement in local, regional or state Chafee youth advisory councils.

Social Services

Definition: Consistent with the case plan, individual, group and family counseling services should be provided for youth and young adults to help them better understand their past and present, and prepare for their future, including the possibility of reconnection with significant persons from the past. Social services are essential to the well-being and psychosocial development of all youth and young adults.

Service providers will provide social services either directly or by referral that

- Include a comprehensive independent living assessment and written plan, which is strengths-based, developmentally appropriate, which involves the youth and significant persons in its development.

- Build on the young person's positive behaviors and personal strengths.
- Recognize the need for advocacy by case managers, social workers, counselors, foster parents/caregivers, and others, in developing and obtaining services for youth and young adults who are approaching or managing transition to independence.
- Assistance with obtaining copy of birth certificate, social security card, a State ID card if unable to obtain a valid driver's license, and other necessary documents.

IV. Target Population (does not include room and board)

Eligible young people for CFCIP funds other than room and board, are those who are in need of independent living services based on an assessment of need. Eligible categories are:

1) Youth ages 14-21, up to the 21st birthday, who are in foster care under the supervision of the local office of the Division of Family and Children, with a case plan establishing the need for independent living services.
2) Youth ages 14-18 who were formerly in foster care as a CHINS between the ages of 14-18 who have been adopted and were receiving independent living services prior to their adoption.
3) Youth ages 14-21 who were formerly in foster care as a CHINS between the ages of 14-18 that were returned to their own homes and remain a CHINS with a case plan establishing the need for independent living services.
4) Youth up to the age of 21 who were formerly in foster care as a CHINS between the ages of 14-18 under the supervision of the local office of the Division of Family and Children.
5) Young people who are 18-21 who would otherwise meet the eligibility criteria above and who were in the custody of another state or were a "ward of another state" will be eligible if through the Interstate Compact for the Placement of Children there is a verification of wardship and all eligibility criteria from the state of jurisdiction.
6) Probation youth, adjudicated a delinquent and placed in out of home care, between the ages 14, 18, up to their 18th Birthday, and have a current case plan identifying independent living needs. In addition, the county of residence must have an interagency agreement between the court and local DFC relating responsibilities of each party for meeting all state and federal mandates.

V. Evaluation and Reporting Requirements

In accordance with the requirements (Chafee Foster Care Independence Program) to identify outcome measures that can be used to "assess the performance of States in operating independent living programs" and to identify data elements for purposes of tracking performance, the National Youth in Transition Database (NYTD) was developed. NYTD is a comprehensive system that integrates information pertaining to the characteristics of the youth served, services delivered, and outcomes achieved into a unique data collection and data reporting process.

Independent Living Outcome Measures Report Procedure and Clarifications
The Indiana Family and Social Services Administration (IFSSA), has approved the Independent Living Outcome Measures Report which includes questions related to each of the outcome measures mandated by the Chafee Foster Care Independence Act of 1999 (CFCIP).

The State is requiring that all independent living service providers complete the Outcome Measures Report. Every provider will complete an Independent Living Outcome Measures Report when a youth enters the independent living program. A report will be completed for each youth every six months following the initial interview until discharge. *Each report needs to be completed to reflect the current reporting period.* When filling out an initial report, the form is to be used as a background inventory for everything that happened to the youth prior to beginning the program. The six-month report should include everything that happened with the youth between intake and 6 months. The one year report should show everything between 6-months and one year, etc.

Intake: Must be completed when a child enters an IL program

Six-Month Progress Report: Must be completed every six months for each child enrolled in the IL program (e.g., at six months, 12 months, 18 months, and so on), and include information from the six months prior to date of report.
Discharge: Must be completed when a child is discharged from an IL program. The information on a discharge report will be relevant from the last completed report to the date of discharge.

Copies of these reports will be submitted to the Indiana Independent Living Initiative and the State Independent Living Coordinator two times per year (April 30 and October 31).

In addition, providers will be required to submit a mid-year and an annual evaluation report to the Regional Child Welfare Services Coordinators, using the forms provided by the Division of Family and Children. To meet these reporting requirements, providers should be collecting data in the following areas on the individual youths served by the program.

- **Outcome 1: Increase the percentage of youth who have resources to meet their living expenses.**
  Measure 1.1: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent were employed full-time(%) and part-time (%) during the reporting period?
  Measure 1.2: Of all youth discharged from foster care or receiving independent living services during the reporting period who were not employed full time, what percent were enrolled in school?
  Measure 1.3: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent held a job apprenticeship, internship, etc., for at least 3 consecutive months during the reporting period?
  Measure 1.4: Of all the youth discharged from the foster care or receiving independent living services during the reporting period, what percent had financial resources other than employment, such as SSI (%), scholarships (%), stipends (%), TANF (%), support from family or spouse (%), Chafee room and board (%), or other (%) during the reporting period?
  Measure 1.5: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent had a bank or credit union account?

- **Outcome 2: Increase the percentage of youth who have a safe and stable place to live.**
  Measure 2.1: Of all youth receiving independent living services during the reporting period, what percent was homeless at some point during the reporting period?
  Measure 2.2: Of all youth who were homeless, what was the duration of homelessness (3 or fewer nights, more than 3 nights but less than 2 weeks, 2 weeks to a month, or more than a month)?
  Measure 2.3: Of all youth receiving independent living services during the reporting period, what percent received CFCIP room and board payments (for youth 18 to 21)?
  Measure 2.4: Of all youth receiving independent living services during the reporting period, what percent that obtained housing maintained that housing for a period of 3 months?

- **Outcome 3: Increase the percentage of youth who attain education (Academic or Vocational) Goals.**
  Measure 3.1: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent had a high school diploma (%), GED (%), Special Education Certificate (%), or AA/BA (%)?
  Measure 3.2: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent had a vocational certificate or license?
  Measure 3.3: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent were enrolled in high school (%), GED classes (%), or post-high school vocational training or college (%) during the reporting period?
  Measure 3.4: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent received planned driver's education services (if over the age of 16) and/or obtained a driver's permit or license?
  Measure 3.5: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent of those receiving special education services through the public schools had an Individual Transition Plan and were receiving services through the plan?

- **Outcome 4: Increase the percentage of youth who have positive personal relationships with adults in the community.**

  Measure 4.1: Of all youth discharged from care or receiving independent living services during the reporting period, what percent reported that there is at least one adult in the community that they could go to for emotional support (%)?

  Measure 4.2: Of all youth discharged from care or receiving independent living services during the reporting period, what percent reported that there is at least one adult in the community that they could go to for job/school advice or guidance (%)?

  Measure 4.3 **Of all youth discharged from care or receiving independent living services during the reporting period, what percent reported participating in at least one leadership activity, conference, cultural, spiritual, and/or recreational activity?**

  Measure 4.4 Of all youth discharged from care or receiving independent living services during the reporting period, what percent reported their involvement with a mentor at school, in the workplace, and/or in the community?

- **Outcome 5: Increase the percentage of youth who avoid involvement in high risk behaviors.**

  Measure 5.1: Of all youth discharged from care or receiving independent living services during the reporting period, what percent were referred for substance abuse assessment or counseling during the reporting period?

  Measure 5.2 Of all youth discharged from care or receiving independent living services during the reporting period that received a substance abuse or counseling assessment with services deemed necessary, what percent participated in services weekly following the assessment for a period of at least 60 days?

  Measure 5.3: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent had been incarcerated one time (%), two times (%), or more than two times (%) during the reporting period?

  Measure 5.4: Of all youth discharged from foster care or receiving independent living services during the reporting period that were incarcerated, what percent was charged with a crime(%) and remained incarcerated until their trial date(%)?

  Measure 5.4: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent gave birth or fathered a child born during the reporting period?

  Measure 5.5: Of all youth discharged from foster care or receiving independent living services during the reporting period, what percent that became parents participated in services related to sex education and HIV prevention (%), teen parenting (%), and/or pre-natal care(%)?

- **Outcome 6: Increase the percentage of youth who are able to access needed physical and mental health services.**

  Measure 6.1: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth had (or would have after discharge) medical insurance?

  Measure 6.2: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth had (or would have after discharge) health insurance with mental health benefits?

  Measure 6.3: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth had (or would have after discharge) dental insurance?

  Measure 6.4: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth required ongoing medication for maintenance of physical, medical, and/or mental health?

  Measure 6.5: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth who required ongoing medication was able to make arrangements either through the Local Mental Health Agency or other sources to continue receiving their medications?

  Measure 6.6: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth that continue to receive any type of Medicaid can

name their physician, dentist, mental health or other service providers and maintain appointments as scheduled?

Measure 6.7: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage of youth received formal counseling, crisis counseling, or family therapy?

- **Outcome 7: Increase the percentage of youth who have or know how to obtain essential documents.**

  Measure 7.1: Of all youth discharged from care during the reporting period, what percent received their birth certificate, social security card, medical records, and education records at the time of discharge?

  Measure 7.2: Of all youth discharged from care during the reporting period who did not receive all their essential documents at discharge, what percentage was given information on how to obtain the documents?

  Measure 7.3: Of all youth discharged from care or receiving independent living services during the reporting period, what percentage were given written documentation of their physicians, social workers, dentists, etc. related to their case, including name, address, and phone number?

VI. Qualifications

Minimum Qualifications:
Personnel planning and providing independent living case management services, must hold a bachelor's degree in social work or a comparable human service field and have experience in case work, group work and case coordination.

Supervision of Bachelors level personnel providing direct client contact service must be obtained from one of the following:

- An individual with a Master's Degree in Social Work or a Master's Degree in another human service field and no less than two (2) years of successful experience in providing in-home and/or center based services. Persons with such degrees and experience may substitute a consultative relationship. OR
- An individual with a Bachelor's Degree in Social Work or Bachelor's Degree in another human service field and no less than three (3) years of successful experience in providing in-home and/or centered based services. Persons with such degree and experience may substitute a consultative relationship.

- Supervision/consultation is to include not less than one (1) hour per week of service provided, nor occur less than every two (2) weeks. Knowledge of available community services in the county and region.
- Must have and provide proof of a valid driver's license and minimum car insurance coverage.

Minimum Qualifications for Mentors:

- Must have and provide proof of a valid driver's license and minimum car insurance coverage.
- Must have a high school diploma or GED and a general interest in helping transitioning youth.
- Supervision or oversight must be obtained by providers with Bachelor's Degree in Social Work or Bachelor's in another human service field and no less than three (3) years of successful experience in providing in-home and/or center based services.
- Mentors must have completed CPS and criminal background checks with no criminal or substantiated CPS findings, proof of a valid IN drivers license and of proof automobile insurance coverage.

Billing Units

- IL group instruction: per face-to-face hour of group instruction (regardless of number in group)
- IL individual instruction: per face-to-face hour
- Telephone consultation
- Mentoring: per face-to-face hour
- OFC case conferencing or staffing, including meeting with other service professionals: per face-to-face hour
- Travel per hour

- Per mile, not to exceed .28 cents per mile
- Outcome Measures Report – due April 30th and October 31st (1 set each due date)
- Court time: per face to face hour

APPENDIX O

SERVICE STANDARDS

CFCIP – Room And Board

I. Service Description

Young people leaving foster care or re-entering the system to receive CFCIP independent living services must do so on a voluntary basis and sign an agreement with the service provider for case management services. This agreement should outline the services to be provided, the length of time expected for the service, and the plan for the young person's contribution. The young adult must participate directly in designing their program activities, accept personal responsibility for achieving independence, and have opportunities to learn from experiences and failures. In addition, the independent living plan must include an operational plan describing how the young adult is going to assume responsibility once assistance ends.

II. Service Components

Independent Living Programs are designed to assist young people by advocating, teaching, training, demonstrating, monitoring and/or role modeling new, appropriate skills in order to enhance self-sufficiency. Service components can include one or more of the following:

- Room and Board
- Assessment
- Service Coordination
- Client Advocacy
- Life Skills/Social Skills
- Educational Services
- Vocational And Employment Services
- Health Services
- Housing Services
- Youth Development
- Social Service
- Transportation

III. Service Criteria

A young person's eligibility for services under the CFCIP is not determined by placement or geography, but by their legal status with a state. A young person, who moves from one state to another, does not lose eligibility for independent living services. The state of that young person's current residence bears responsibility for providing, and paying for, those services. Young people who are 18-21 who would otherwise meet the eligibility criteria for the target population in Section IV of this service standard and who were in the custody of another state, or were a "ward of another state" must have verification of wardship in that state through the Interstate Compact.

CFCIP funds must be used to supplement, not supplant existing programs. In other words, youth must have exhausted all other sources of room and board assistance before CFCIP Room and Board dollars can be utilized to meet needs.

Definition of Room and Board:
Room and board expenses may be considered as rent payments, deposits (i.e. apartment or house rental deposits, utility deposits), utilities, dormitory housing (includes food if part of the structure of dormitory expenses). No furniture can be purchased with these funds. These services are contingent on funding availability and eligibility requirements of the youth

Length of time for room and board payments:
Eligible young adults for room and board payments are eligible to receive a maximum, lifetime cap of $3000.00 for assistance, as established in the IL plan. Young adults may access this assistance as long as they continue to meet eligibility requirements, until the $3,000.00 limit is exhausted.

Amount/range of payments for room and board:
Young people are eligible for a maximum of $3,000 to ensure stability and move towards self-sufficiency. All young people who access this service will be required to participate in an IL plan that includes a full time schedule of work or school.. All subsequent requests for emergencies will be considered on a case-by-case basis by DFC central office staff only, based on availability of funds.

Housing Options:
Foster parents are not excluded but will be paid through a contracted service provider.
Potential housing options may include family foster homes, youth/young adult shelters, shared houses, single room occupancy, boarding houses, semi-supervised apartments, subsidized housing, scattered site apartments, and transitional groups homes.

Room and Board Payments
Room and Board payments will only be made through a contracted service provider who is providing independent living case management services to the youth.

IV. Target Population

Youth eligible for room or board services under the CFCIP are those who have left foster care because they have attained 18 years of age and who have not attained 21 years of age.

- This includes young people who have aged out at age 18 or older up to age 21 who move directly from foster care into independent living programs, as well as those who age out, lose touch with the Local Office of the Division of Family and Children, and then return for assistance before reaching the age of 21.
- This also includes young people who leave care voluntarily at age 18 but find themselves in need of supportive services after leaving, but prior to turning age 21.
- Up to 30% of Indiana's federal CFCIP allocation can be used to provide room and board services to young people who leave foster care at the age of 18.
- Young persons with child(ren) and those married or have a roommate must meet eligibility requirements for room and board assistance.

V. Evaluation and Reporting Requirements

Below are the overall goals and expected data collection items anticipated for the CFCIP Room and board dollars. During the program year, providers will be asked to provide a progress report, by youth, every 6 months to the local Family Case Managers on these different items, using the form provided by the Division of Family and Children. Copies of these reports should also be sent to the Regional Child Welfare Services Coordinators. In addition, providers will be required to submit a mid-year and an annual evaluation report to the Regional Child Welfare Services Coordinators, using the forms provided by the Division of Family and Children. To meet these reporting requirements, providers should be collecting data in the following areas on the individual youths served by the program.

1) Increase the percentage of youth who have resources to meet their living expenses.
2) Increase the percentage of youth who have a safe and stable place to live.
3) Increase the percentage of youth who have positive personal relationships with adults in the community.

4) Increase the percentage of youth who avoid involvement in high risk behaviors.

Definition of Foster Care: F*oster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. The young person's placement could be in a family foster home, group home, child caring institution, kinship care home, pre-adoptive home, emergency shelter, ILP or other state sanctioned voluntary placement. Pursuant to the definition of foster care, facilities that are outside the scope of foster care include, but are not limited to: detention facilities; psychiatric hospitals; forestry camps; or facilities that are primarily for the detention for children who are adjudicated delinquents. Children placed in such facilities are not in foster care and may not be considered candidates for foster care because they have already been removed from the home.*

APPENDIX P

SERVICE STANDARDS

CFCIP – Youth Advisory Boards

I. Service Description

Youth Advisory Boards are designed to give youth ages 14-21, the opportunity to practice leadership skills and learn to be advocates for themselves and others through the guidance of contracted IL service providers who serve as adult role models through the YAB development process. Enhancing partnerships between and youth and adults will be a direct result of a successful board. The goal(s) of YAB's are to provide an avenue whereby youth in care can inform service providers and policy makers on the issues that impact teens and young adults in the foster care system. Fostering YAB development and youth participation will also further enhance collaboration, cultural competence and permanent connections with other youth and adults as they navigate the Board process. This program will also assist with preparing youth as they transition from adolescence to adulthood by recognizing and accepting personal responsibility.

The Youth Advisory Board meeting sites will be held in the following counties: Lake, St. Joseph, Allen, Tippecanoe, Howard, Delaware, Vigo, Johnson, Ripley, Washington, and Vanderburgh. The Youth Advisory Boards will meet six times annually, approximately every other month. The regional boards will collaborate quarterly by teleconference to review and discuss direction of the program and exchange information regarding their agendas, research, and projects.

Service providers and/or placement agencies may submit potential member names of youth that return to request assistance following wardship dismissal to the local office of the Division of Family and Children. Each office of the Division of Family and Children will identify potential members and provide the names to the State Independent Living Coordinator for distribution to service providers in each area.

II. Service Components

Youth Advisory Board Meetings will be held every other month for a minimum of two hours including face-to-face contact with the youth board member. The contracting agencies will providing mailings to all youth members reminding them of meetings and arrange for transportation for each youth to attend the meetings. Quarterly teleconference meetings will be held to link the regional Youth Advisory Boards with Central Office personnel to discuss issues that each board has on the agenda and to provide assistance as needed to reach their stated goals. The board members will design their mission statement, develop group guidelines, and develop meeting agendas.

The youth will be involved in design and implementation of independent living services and programs. They will be involved in decision making, shaping policy and monitoring implementation of services for young people as well as serving as advisors to provide feedback to program administrators, legislators and other involved in providing youth services. The youth will provide broad consultation to state child welfare administrators in the long-term implementation of the state plans and represent the voices of foster youth across Indiana.

Childcare must be available for any participating youth board member that requires assistance. Financial stipends will be provided to each youth board member. The stipend will be consistent across all Boards and distributed to the youth by the service provider at the close of each meeting.

In their proposal**,** providers must outline procedures for recruiting YAB members and implementing a plan to include the entire area to be served.

YAB Seat: St. Joseph County

Serving counties: St. Joseph, LaPorte, Marshall, Elkhart, Koscuisko, Fulton,

YAB Seat: Lake County

Serving counties: Lake, Porter, Newton, Jasper, Starke, Pulaski

YAB Seat: Allen County
Serving counties: LaGrange, Steuben, Noble, Dekalb, Whitley, Allen, Huntington, Wells, Adams

YAB Seat: Howard
Serving counties: Cass, Miami, Wabash, Howard, Tipton

YAB Seat: Tippecanoe:
Serving counties: Benton, White, Carroll, Clinton, Tippecanoe, Warren, Fountain and Montgomery

YAB Seat: Johnson
Serving counties: Marion, Johnson, Morgan, Shelby, Hendricks, Hancock, Hamilton, and Boone

YAB Seat: Delaware
Serving counties: Madison, Delaware, Jay, Randolph, Grant, Henry, Blackford

YAB Seat: Wayne County
Serving counties: Wayne, Rush, Fayette, Union, Franklin

YAB Seat: Ripley
Serving counties: Jennings, Jefferson, Switzerland, Decatur, Bartholomew, Ripley, Dearborn, Ohio

YAB Seat: Vigo
Counties served: Vigo, Clay, Owen, Monroe, Sullivan, Vermillion, Parke, Putnam

YAB Seat: Daviess
Counties served: Daviess, Greene, Knox, Martin, Dubois, Perry

YAB Seat: Vanderburgh
Counties served: Gibson, Pike, Posey, Vanderburgh, Warrick, Spencer

YAB Seat: Washington
Counties served: Brown, Lawrence, Jackson, Orange, Washington, Scott, Crawford, Harrison, Floyd, Clark

I. Service Criteria

It is expected that participation on the Youth Advisory Boards will:

- Balance youth need for support and empowerment
- Accommodate a broad range (type, intensity) of youth participation
- Demonstrate clear, concrete, sincere appreciation of youth contributions
- Provides preparation to assist youth in assuming roles traditionally reserved for adults for which they have no prior experience
- Encourage participation in Legislative Day, annual Mayor's conferences, annual child welfare conferences, ex. IFCAA, Juvenile Judges Symposium and other educational forums.

Sign-in sheets will be maintained for each meeting and completed by the youth participants including their name, date of birth, social security number, contact phone number, and address. The agenda for each meeting and minutes of the previous meeting will be provided to each board member prior to a scheduled board meeting.

II. Target Population

1) Youth Advisory Board members, ages 14 to 21, are current participants in independent living programs or have successfully completed an independent living program.

2) Youth involved with the juvenile justice system, adopted teens, teens involved with drug and alcohol rehabilitation programs, parenting teens, homeless youth, unattached youth, and youth that represent ethnic and cultural diversity that were previously placed in foster care between the ages of 14 and 18.
3) Youth returning for assistance from previous service providers, private foster home agencies, or residential facilities.

III. Evaluation and Reporting Requirements

The overall goals of the Youth Advisory Boards are to:

- Allow for consistent opportunities to give structured feedback regarding the quantity and quality of services and supports provided to them in care and after they have aged out.
- Facilitate development of personal responsibility by ensuring that young people participate in the planning and implementation of services at the individual level.
- Initiative opportunities for youth leadership and service development.
- Develop coordination with the Workforce Investment Act Youth Councils
- Provide an opportunity to learn from youth what is really important to them
- Improve the quality of Independent Living services by obtaining direct input and feedback from youth members that are receiving services.
- Assist with the opportunity to develop or change public policy to improve lives of individuals and families involved in the system.

1) Increase the percentage of youth that attend and actively participate in programming related to their experiences and needs.
2) Increase the percentage of youth that demonstrate the ability to discuss openly their needs and concerns regarding their future.
3) Increase the percentage of youth that exhibit interpersonal skills among peers.
4) Increase the percentage of youth that exhibit interpersonal skills among adults.
5) Increase the percentage of youth that actively participate in developing public policy to improve their future as adults.

IV. Qualifications

Minimum Qualifications:

- The agency providing Youth Advisory Board services must have experience working with youth ages 14 to 21.
- Personnel providing Youth Advisory Board services as a facilitator must hold a Master's degree in social work or a comparable human service field and have experience in case work and group work. Mediation skills would be preferable.

Personnel providing assistance to the facilitator regarding transportation must have and provide proof of a valid driver's license and minimum car insurance coverage.

V. Billing Units

- (6) Youth Advisory Board Meetings as documented by meeting minutes, agendas, and attendance sheets and a detailed monthly statement of YAB Coordinator's activities; with completed and signed referrals on each YAB member sent to the Indiana Independent Living Initiative
- (1) Midyear Outcome Measures Report
- (1) Year end Outcome Measures Report

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NORTH WEST REGION CHAFEE INDEPENDENT LIVING CONTRACTS **Appendix Q**

October 1, 2002 FY 2002/2004

Child Welfare Services Coordinator-Dodson Shively and Associates ~~ 260-982-7234 ~~ DSA@CTLnet.com

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Apostolic Youth & Family Services, Inc. 4840 Broadway Gary, IN 46408	Clifton Smith	219-887-9691	apostolicyouth1@aol.com FAX: 219-887-9692	Lake	1. IL skills assessment 2. IL group training/instruction 3. Diagnostic Assessment 4. Home-based therapy/ mentoring with /telephone intervention 5. CQIT testing/Vocational testing 6. Staff travel 7. Emancipation kit up to $350
The Otis R. Bowen Center for Human Services, Inc., P.O. Box 497 850 N. Harrison St. Warsaw, IN 46580	Stephen Possell	574-267-7169	stephen_possell@bowencenter.org FAX: 574-269-3995	Marshall	1. IL services 2. Emancipation kit up to $350
Camelot Community Care 833 W. Lincoln Hwy, Ste 410 W Schererville, IN 46375	Ms. Elena Dwyre	219-864-7988	edwyre@camelotcare.com FAX: 219-864-7495	St. Joseph	1. In-home counseling 2. Case management/ telephone interventions 3. Emancipation kit up to $350 **4. Room and Board**
Christian Haven 12501 N. State Rd. 49 Wheatfield, IN 46392	Randy Schrock	219-956-3125	rkschrock@juno.com FAX: 219-956-4128	Jasper Lake Newton	1. Counseling/telephone intervention 2. IL case management services 3. Staff travel 4. Four hour IL class 5. **Room and Board**

					6. Emancipation kit up to $350
Families United P.O. Box 340 Attica, IN 47918	Karmen York	765-762-0611	familiesunited@k-inc.com FAX: 765-762-1753	Benton	1. IL case management/ telephone intervention 2. Staff travel time 3. LOFC approved case conference 4. LOFC approved/requested testimony 5. No show per occurrence 6. Emancipation kit up to $350
Four County Comprehensive Mental Health, Inc. 1015 Michigan Avenue Logansport, IN 46947	Kim Hazlett IL-Nancy Helstern	574-722-5151 574-224-4566 x21	khazlett@fourcounty.org NHelstern@fourcounty.org FAX: 574-722-9523	Cass Fulton Pulaski	1. IL case management/ telephone intervention 2. Group instruction 3. Emancipation kit up to $300
Gibault, Inc. 6301 S. U.S. Hwy 41 P.O. Box 2316 Terre Haute, IN 47802	James M. Sinclair IL-William Smith	812-299-1156	william.smith@gibault.org FAX: 812-299-0019	Lake	1. IL counseling/home based therapy includes telephone intervention. May include IL skills, educational/apartment (residence) counseling
Home Team Advantage, Inc. 1116 W. CR. 700 N. Crawfordsville, IN 47933	Paula Morton IL-Ms. Jacque Ratcliff	765-339-4925	hometeam@link2000.net ratcliff@tctc.com FAX: 765-361-5852	Starke	1. IL case management/ telephone intervention 2. Mentoring services 3. Class instruction includes direct client contact/ telephone intervention 4. **Room and Board** 5. Emancipation kit up to $350
LaPorte Co. Comprehensive Mental Health Center, Inc. dba Swanson Center 1230 W. St. Rd. 2, Suite B Laporte, IN 46350	David Johnson IL-Kathleen Matuszak	219-362-2145 Laporte	djohnson@swansoncenter.org Laporte FAX: 219-362-1143	LaPorte	1. IL skills development/ telephone intervention 2. Case Management 3. Individual counseling 4. Group counseling

450 St. John Road Michigan, City, IN 46360-7350		219-879-4621 Michigan City	Michigan City FAX: 219-873-2388		5. **Room and Board** 6. Emancipation kit up to $350
KidsPeace National Centers for Kids in Crisis, Inc. 1441 E. 84th Place Merrillville, IN 46410	Ms. Jen Brown	219-736-1308	jbrown@kidspeace.org FAX: 219-736-1640	Lake Starke	1. IL Services/telephone intervention 2. Group training 3. IL Assessment 4. Emancipation kit up to $350
PSI Services III, Inc. 3229 Broadway, Suite 207 Gary, IN 46408	Alfred Barrow IL-Melvin Swope	219-884-0185 x 140	psiindiana@psifamilyservices.com FAX: 219-884-4403	Lake St Joseph	1. Individual or Foster Parent Counseling/telephone intervention 2. Case management/service coordination 3. Social skills training group 4. No show per occurrence, counseling 5. **Youth Advisory Board – Lake and St. Joseph**
Pyramids, Inc. 2410 Interstate Plaza Drive Hammond, IN 46324	Kathy Wise Assistant-Alice Vockell	219-845-3113	pyramids49@aol.com FAX: 219-845-2092	Lake	1. Classroom experience to include counseling and door to door transportation
Tree of Life Community **Development Corp. & Care Center** 561 Broadway Gary, IN 46402-1910	Mr. Lee Cameron	219-886-7475	treecdc@aol.com FAX: 219-885-2246	Lake	1. Individual or Group training 2. GED classroom training
The Villages of Indiana 2405 N. Smith Pike Bloomington, IN 47404	Amy Sanderson IL- William	812-332-1245 219-980-6185	asanderson@villages.org FAX: 812-333-4717 wdavis@villages.org	Lake, St. Joseph	1. Home based IL skill development/ telephone intervention 2. **Room and Board** **3.** Emancipation kit up to $350

Regional Contact	Davis		219-980-6195		
White's Residential and Family Services, Inc. 5233 S. 50 E. Wabash, IN 46992	Nancy Fisher IL: Linda Zumbrum	260-563-1158	nancy.fisher@whitesrfs.org FAX: 260-563-5825	Starke White	1. IL services/telephone intervention 2. **Room and Board** 3. Emancipation kit up to $350
Willowglen Academy-Indiana, Inc. 308 E. 21st Avenue Gary, IN 46407	Lorene Cameron	219-886-1320	FAX: 219-886-1319	Lake	1. IL Assessment/telephone intervention 2. Individual or group counseling/telephone intervention 3. LOFC approved/requested testimony 4. Transportation to and from activities 5. Staff mileage 6. LOFC approved case conference 7. Social/cultural activities 8. No show per occurrence
Youth Service Bureau of Porter County, Inc 253 W. Lincolnway Valparaiso, IN 46383	Carol Tomerlin IL – Nancy Van Volkenburgh	219-464-9585	ctomerlin@fysb.org FAX: 219-462-4159	Porter	1. IL Case Management 2. IL Assessment 3. Parenting Group 4. Life skills group training 5. Process group 6. Emancipation kit

October 1, 2002 FY 2002/2004
Child Welfare Services Coordinator-Dodson Shively and Associates ~~ 260-982-7234 ~~ DSA@CTLnet.com

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Camelot Community Care 833 W. Lincoln Hwy, Ste 410 Schererville, IN 46375	Ms. Elena Dwyre	219-864-7988	edwyre@camelotcare.com FAX: 219-864-7495	Elkhart	1. In-home counseling 2. Case management/ telephone interventions 3. Emancipation kit up to $350 **4. Room and Board**
The Otis R. Bowen Center for Human Services, Inc., P.O. Box 497 850 N. Harrison St. Warsaw, IN 46580	Stephen Possell	574-267-7169	stephen_possell@bowencenter.org FAX: 574-269-3995	Kosciusko	1. IL services 2. Emancipation kit up to $350
DeKalb Co. Parent Group/dba Children First 1752 Wesley Road P.O. Box 166 Auburn, IN 46706	Ms. Pat Zakula IL-Maureen Prebynski	260-349-1222 800-824-2698 IL 877-349-1222	HOME@childrenfirstcenter.org FAX: 260-925-3892 IL FAX: 260-349-1222	DeKalb Noble Steuben	5. Client services/telephone intervention 6. Staff travel time 7. No show, per occurrence 8. LOFC approved /requested testimony 9. Emancipation kit up to $350
Family Service Society, Inc. 428 S. Washington St., Ste 327 Marion, IN 46953	Connie Rose IL-	765-662-9971 Ext. 116	famsvc@comteck.com FAX: 765-651-6556	Grant	1. IL services/telephone intervention 2. LOFC approved Case Conference 3. Staff travel time 4. LOFC approved/requested testimony 5. No show, per occurrence

Foster Care Services, Inc. 1016 W. 7th St., Ste 330 Auburn, IN 46706	Dona Kinkle	260-925-4142	fostercs@fwi.com FAX: 260-925-4142	DeKalb LaGrange Noble Steuben Whitley	6. Case management/telephone intervention 7. Mile staff travel 8. Unit supplies/activity fund **9. Room & Board** 10. Emancipation Kit up to $350
KidsPeace National Centers for Kids in Crisis, Inc. 401 E. Colfax, Suite 303 South Bend, IN 46617	Nancy Klopfenstein	800-433-2363	nancyklop@aol.com FAX: 574-237-1048	Elkhart	1. IL Services/telephone intervention 2. Group training 3. IL Assessment 4. Emancipation kit up to $350
Lifeline Youth & Family Services, Inc. P.O. Box 5058 Kendallville, IN 46755	Mark Terrell IL: Rick Humbarger	260-343-9942	lifelyfs@aol.com FAX: 260-745-0234 lifeline@ligtel.com	Huntington LaGrange Steuben	1. IL Services/telephone intervention 2. LOFC approved case conference 3. Staff travel time 4. LOFC approved/requested testimony 5. No show per occurrence 6. Emancipation kit up to $350
The Villages of Indiana 2250 Lake Avenue #160 Fort Wayne, IN 46805 (Fort Wayne Office)	Amy Sanderson IL-John Garner	800-831-4154	asanderson@villages.org jgarner@villages.org FAX: 260-422-3655	Allen	1. Home based IL skill development/telephone intervention 2. **Room and Board** 3. Emancipation kit up to $350 **4. Youth Advisory Board**
White's Residential and Family Services, Inc. 5233 S. 50 E. Wabash, IN 46992	Nancy Fisher IL: Linda Zumbrum	260-563-1158	nancy.fisher@whitesrfs.org FAX: 260-563-5825	Adams Grant Huntington Miami Wabash	1. IL services/telephone intervention 2. **Room and Board** 3. Emancipation kit up to $350

Whitington Homes and Services for Children 2423 Fairfield Ave. Fort Wayne, IN 46807	Bill Blanks IL-Millie McDonald	260-745-9431 Ext. 123	bblanks@whitington.org FAX: 260-745-0734	Adams	1. IL services/telephone intervention 2. Staff travel time 3. Group services 4. No show per occurrence 5. Emancipation kit up to $350 6. **Room and Board**
Youth Service Bureau of Jay County, Inc. 603 West Arch Street Portland, IN 47371	Reda Theurer-Miller	260-726-8520	Ysbjc@jayco.net FAX: 260-726-8535	Blackford Wells	1. IL Services/telephone intervention 2. Emancipation kits up to $350 3. **Room and Board**

October 1, 2002 FY 2002/2004

Child Welfare Services Coordinator-Roth Associates, Penny Pitcock ~~ 317- 736-8871~~ westcentral234@aol.com

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Children's Bureau of Indianapolis-Horizons 615 N. Alabama Street, Room 426 Indianapolis, IN 46204-1434	Lisa Peck IL-Nikki Clark	317-264-2700	lmpeck@childrensbureau.org FAX: 317-686-3812	Marion	1. IL counseling/telephone intervention 2. Client/staff transportation 3. Client no show per occurrence 4. **Room and Board** 5. Emancipation kit up to $350
Families United, Inc. P.O. Box 340 Attica, IN 47918	Karmen York	765-762-0611	familiesunited@k-inc.com FAX: 765-762-1753	Fountain	1. IL case management/ telephone intervention 2. Staff travel time 3. LOFC approved case conference 4. LOFC approved/requested testimony 5. No show per occurrence 6. Emancipation kit up to $350
Family Works, Inc. 3675 Washington Blvd. Indianapolis, IN 46205	Judy Kendrick	317-923-4437	judykendrick@msn.com FAX: 317-923-4437	Marion	7. IL services/telephone intervention
Hamilton Centers Youth Service Bureau, Inc. 294 South 9th Street Noblesville, IN 46060	Mr. Kelly Kochell	317-773-6342	Hc_ysb@onet.net FAX: 317-773-3340	Fountain Hamilton	1. IL training/telephone intervention 2. IL group training 3. LOFC approved/requested testimony 4. LOFC approved case conference 5. Staff travel
Home Team Advantage, Inc. 1116 W. CR. 700 N. Crawfordsville, IN 47933	Paula Morton IL-Ms. Jacque Ratcliff	765-339-4925	hometeam@link2000.net ratcliff@tctc.com FAX: 765-361-5852	Boone Clinton Fountain Hendricks Howard Montgomery Morgan	1. IL case management/ telephone intervention 2. Mentoring services 3. Class instruction includes direct client contact/ telephone intervention 4. **Room and Board** 5. Emancipation kit up to $350

				Parke Putnam Tippecanoe Vermillion Warren	
Indiana United Methodist's Chidren's Home 515 W. Camp Street, P.O. Box 747 Lebanon, IN 46052	Gary Davis	765-482-5900	iumch@iumch.org FAX: 765-482-5900	Boone	1. IL skills/telephone intervention 2. Group services 3. LOFC approved case conference 4. LOFC approved /requested testimony 5. Staff travel time
On Target, Inc. B.L.A.S.S.T. P.O. Box 967 North Vernon, IN 47265	Peggy Faulk	812-346-7763	peggyf@fspp.org FAX: 812-346-6067	Johnson Marion	1. IL Skills/telephone intervention Emancipation kit up to $350
Quest for Excellence dba Ada's Place 2051 N. College Avenue Indianapolis, IN 46202	H.F. Foldz, Jr. IL-Keena Sowers	317-283-5730	Adas_Place@p4e.org	Marion	1. IL program direction/telephone intervention 2. IL case management/telephone intervention 3. IL Skills training, Level 1 4. IL Skills training Level 2 5. **Room and Board**
St. Vincent New Hope 8450 Payne Road, Suite 300 Indianapolis, IN 46268	Jim VanDyke IL-Kathy Ballard	317-338-4489	KDBallar@stvincent.org FAX: 317-338-4585	Marion	1. Family mentoring/telephone intervention. 2. Family mentor staff travel 3. IL skills development/training 4. Job skill development 5. Community service component 6. Case Management
The Villages of Indiana 2405 N. Smith Pike Bloomington, IN 47404	Ms. Amy Sanderson	812-332-1245 IL Scott Dyer	asanderson@villages.org FAX: 812-333-4717	West Central Region	**1. Youth Advisory Board**

EAST CENTRAL REGION CHAFEE INDEPENDENT LIVING CONTRACTS **Appendix T**

October 1, 2002 FY 2002/2004

Child Welfare Services Coordinator - Ball State University ~~ 765-285-5491 ~~ Lisa Rich [lrichroh@gw.bsu.edu]

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Anchor Families 1119 Race Street New Castle, IN 47362	Kenneth McCoy IL-Tracy Chambers	765-529-2213	tic41266@aol.com FAX: 765-529-2495	Henry Rush	1. IL skills service/telephone intervention 2. IL group 3. **Room and Board**
Heart House, Inc 6815 U.S. 50 Aurora, IN 47001	Craig Beckley	812-926-4890	hearthouse@seidata.com FAX: 812-926-1550	Dearborn	1. IL services/instruction 2. Room and Board 3. Youth Advisory Board
Moore, Inc 2311 Airport Road Centerville, IN 47330	Kendra Suminski	765-962-4585	 FAX: 765-855-3481	Franklin Union Wayne	1. IL Counseling and instruction 2. **Room and Board**
Preventative Aftercare, Inc P.O Box 1058 Grove City, PA 16127	James Poulos	724-458-9330		Decatur Dearborn Ohio Ripley	1. IL skills/services 2. Room and Board
Shelby Co. Youth Center 212 N. Harrison St. Shelbyville, IN 46176	Jim Bush	317-398-3633	scyc@shelbynet.net	Shelby	1. IL Skill s training 2. Counseling 3. Case Conferences 4. Emancipation Kits 5. Room and Board

The Villages of Indiana 2405 N. Smith Pike Bloomington, IN 47404	Ms. Amy Sanderson	812-332-1245	asanderson@villages.org FAX: 812-333-4717	Dearborn Hancock	1. Home based IL skill development/telephone intervention 2. IL group skill development 3. **Room and Board**
White's Residential and Family Services, Inc. 5233 S. 50 E. Wabash, IN 46992	David Spencer IL: Linda Zumbrum	260-563-1158	Dave.spencer@whitesrfs.org FAX: 260-563-5825	Fayette	1. IL services/telephone intervention 2. **Room and Board**
Youth Service Bureau of Jay County, Inc. 603 West Arch Street Portland, IN 47371	Reda Theurer-Miller	260-726-8520	Ysbjc@jayco.net FAX: 260-726-8535	Jay Randolph	1. IL skill services/ individual/group 2. **Room and Board** 3. Staff mileage 4. IL travel time 5. No show per occurrence 6. LOFC requested case conference
Youth Opportunity Center 3700 West Kilgore Avenue Muncie, IN 47304	Carol Ammon	765-289-8940	cammon@yocinc.org FAX: 765-289-0455	Delaware Madison	1. IL individual instruction 2. IL group instruction 3. Staff mileage 4. Staff travel time 5. Client incentives per group instruction 6. IL Counseling 7. Emancipation kit up to $250 8. **Room and Board** 9. **Youth Advisory Board**

October 1, 2002 FY 2002/2004

Child Welfare Services Coordinator-Dodson Shively and Associates ~~ 260-982-7234 ~~ DSA@CTLnet.com

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Children and Family Services, Inc. P.O. Box 244 1301 Willow Street Vincennes, IN 47591	Jackie Elkins IL-Kim Bivens	812-886-4470	jackie87@vincennes.net cfs@wvc.net FAX: 812-886-4480	Daviess Knox	1. IL Skills/telephone intervention 2. Staff travel time 3. Group services 4. **Room and Board** 5. Emancipation kit up to $350
Debra Corn, Inc. P.O. Box 354 Bloomfield, IN 47424	Renee Rottet	812-384-8253	debracornblfd@joink.com FAX: 812-384-8263	Greene	1. IL skills services/telephone intervention 2. No show per occurrence-IL skills 3. Home-based IL counseling/therapy /telephone interventions 4. No show per occurrence-IL counseling/therapy 5. Emancipation kit up to $350
Gibault, Inc. 6301 S. U.S. Hwy 41 P.O. Box 2316 Terre Haute, IN 47802	IL-William Smith	812-299-1156	william.smith@gibault.org FAX: 812-299-0019	Vanderburgh Sullivan	1. IL counseling/home based therapy includes telephone intervention. May include IL skills, educational/apartment (residence) counseling 2.
Family Solutions, Inc. P.O. Box 1817 315 Dodds St. Bloomington, IN 47402	Nancy Hughes	812-335-1926	Nhughes@familysolutions.org FAX: 812-335-1918	Monroe	1. IL skills services/telephone intervention 2. No show per occurrence 3. Mileage for IL skills services 4. Emancipation kit up to $350

Hamilton Center, Inc. 620 Eighth Avenue P.O. Box 4323 Terre Haute, IN 47804	Nancy Edgerton IL - Tuovia Owen	812-231-8453 812-231-8376	nedgerton@HamiltonCenter.org FAX: 812-231-8208 Towen@hamiltoncenter.org	Owen Vigo	1. IL counseling/telephone intervention 2. Staff travel (transporting client) 3. No show per occurrence 4. Incentives fund for goal completion 5. Activity fund for fees, tuition, books 6. Emancipation kit up to $350 7. **Room and Board** 8. **Youth Advisory Board**
Home Team Advantage, Inc. 1116 W. CR. 700 N. Crawfordsville, IN 47933	Paula Morton IL-Ms. Jacque Ratcliff	765-339-4925	hometeam@link2000.net ratcliff@tctc.com FAX: 765-361-5852	Clay	1. IL case management/ telephone intervention 2. Mentoring services 3. Class instruction includes direct client contact/ telephone intervention 4. **Room and Board** 5. Emancipation kit up to $350
Ireland & Luzio Behavioral Services 3101 N. Green River Road, Suite 910 Evansville, IN 47715	Susan Ireland	812-479-1916	jireland@irelandluzio.com FAX: 812-479-5014	DuBois Pike Posey Vanderburgh Warrick	1. IL services/telephone intervention 2. Emancipation kit up to $350
Indiana Youth Advocate **Program** 4755 Kingsway Drive, Suite 314 Indianapolis, IN 46205	Tawanna Clarke-Powell	800-471-4795 317-475-9294	Tclarke-powell@nyap.org FAX: 317-475-0081	Gibson Martin	1. IL services/telephone intervention 2. Staff travel 3. Emancipation kit up to $350
Lincoln Hills Development Corp. P.O. Box 336 Tell City, IN 47586	Lori McIntire	812-547-3435	lhdcfpre@evansville.net FAX: 812-429-0835	Posey Vanderburgh	1. IL services/telephone intervention 2. Emancipation kit up to $350

United Methodist Youth Home, Inc 2521 Burkhardt Rd. Evansville, IN 47715	Dr. Barbara Jessen IL-Nick Oldham	812-479-7535	bjessen@umyh.com FAX: 812-479-7203	Pike Spencer Vanderburgh Warrick	1. IL services/telephone intervention 2. Staff travel 3. **Room and Board** 4. Emancipation kit up to $350 5. **Youth Advisory Board**
White's Residential and Family Services, Inc. 5233 S. 50 E. Wabash, IN 46992	Nancy Fisher IL: Linda Zumbrum	260-563-1158	nancy.fisher@whitesrfs.org FAX: 260-563-5825	DuBois	1. IL services/telephone intervention 2. **Room and Board** 3. Emancipation kit up to $350

SOUTH EAST REGION CHAFEE INDEPENDENT LIVING CONTRACTS Appendix V

October 1, 20002 FY 2002/2004
Child Welfare Services Coordinator-Dodson Shively and Associates ~~ 260-982-7234 ~~ DSA@CTLnet.com

Provider	Contact	Phone	Email Address-FAX	County Served	Billable Services
Cassandra McConn, Inc 3716 Cameron Ave. Bloomington, IN 47401	Cassandra McConn	812-331-7399	gazelle@kiva.net FAX: 812-334-3438	Brown Lawrence Washington	1. IL services/telephone intervention 2. Emancipation kit up to $350
Clark County Youth Shelter & Family Services, Inc. P.O. Box 886 Jeffersonville, IN 47131	Laura Fleming-Balmer IL-Shara Wilson	812-284-5229	ccadmin@aye.net FAX: 812-284-5301	Clark Floyd Harrison Jefferson Jennings Scott Switzerland	1. IL services/telephone intervention 2. Classroom based IL services 3. LOFC approved/requested case conference 4. No show per occurrence 5. Emancipation kit up to $300
Indiana Youth Advocate Program 4755 Kingsway Drive, Suite 314 Indianapolis, IN 46205	Tawanna Clarke-Powell	800-471-4795 317-475-9294	Tclarke-powell@nyap.org FAX: 317-475-0081	Harrison	1. IL services/telephone intervention 2. Staff travel 3. Emancipation kit up to $350
Lincoln Hills Development Corp. P.O. Box 336 Tell City, IN 47586	Lori McIntire	812-547-3435	lhdcfpre@evansville.net FAX: 812-429-0835	Perry	1. IL services/telephone intervention 2. Emancipation kit up to $350

Providence Self Sufficiency Ministries, Inc. (Providence House) 8037 Unruh Drive Georgetown, IN 47122	Ms. Robin Peterson Nancy McCoskey	812-951-1878	rpeterson@pssm.win.net FAX: 812-951-1659	Clark Crawford Floyd Harrison Washington	1. IL Case management/telephone intervention 2. IL initial assessment 3. Therapy 4. IL individual mentoring 5. Group coaching 6. Emancipation not to exceed $300, or Educational Emancipation kit not to exceed $500 7. Classroom time, includes educational field trips 8. **Room and Board**
Regional Youth Services, Inc 224 E. Court Avenue Jeffersonville, IN 47130	Laura Keys	812-282-8479	lkeys@regionalys.com FAX: 812-282-8636	Clark	1. Pre or Post IL assessment 2. Counseling/telephone intervention 3. Field trip 4. Group session 5. Emancipation kit up to $350
The Villages of Indiana 2405 N. Smith Pike Bloomington, IN 47404 Regional Contact	Amy Sanderson IL – Nancy Baldwin	812-332-1245 800-822-4888	asanderson@villages.org FAX: 812-333-4717 nbaldwin@villages.org	Bartholomew Jackson Orange	1. Home based IL skill development/ telephone intervention 2. **Room and Board** 3. Emancipation kit up to $350 4. Youth Advisory Board

Provider: _____ Service Title: _____

310 Date: _____ Service ID Date: _____ Referral Date: _____ End Date: _____

Case Manager: Name _____ ICWIS ID # _____ Phone - -

Parent/Guardian _____ Case No. _____

Address (1) _____ Phone No. - -

City/Zip _____

Address (2) _____ Phone No. - -

City/Zip _____ 1st Language: _____

Family Members (X Left Column If Referred)

	Name	Service Level	ICWIS ID No.	Birthdate	Relationship	Race	Sex	Soc. Sec. #
☐	1.							- -
☐	2.							- -
☐	3.							- -
☐	4.							- -
☐	5.							- -
☐	6.							- -
☐	7.							- -
☐	8.							- -
☐	9.							- -
☐	10.							- -

Name	DFC Status	Case Plan Goal 1	2	Residence Situation	Place Date	Removal Date	Medicaid Number	Fund Srce
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Reason for OFC Contact _____

Reason for Referral for Service _____

Specific Objectives to be Accomplished through this Referral

1. _____
2. _____
3. _____
4. _____

Additional Comments _____

Other Services Being Provided: _____

INFORMATION AVAILABLE UPON REQUEST

Form 311: ☐ DFC Caseplan: ☐ DFC Narrative: ☐ Court Summary: ☐ SRA: ☐ Other: ☐

Informal Adjustment: ☐ Psychological Eval.: ☐ Approved By: _____

Furnished by Dodson, Shively & Associates Revised, 11/2002

Indiana Referral for Youth 18-21

Chafee Independent Living Program

Date: _____

Referred By: Name: _____ Phone: _____

Agency: _____

Section A

_____ _____ ____/____/____
Client Name ICWIS Case ID Date of Birth

☐ Female ☐ Male

Race: ☐ White, Not Hispanic ☐ Hispanic ☐ Black, Not Hispanic
☐ Asian/Pacific Islander ☐ American Indian/Alaskan ☐ Bi-Racial, Not Hispanic

_____ _____-_____-_____
Maiden Name (If Applicable) Social Security Number

_____ _____ _____ _____
Address City State Zip Code

_____ (_____)_____ (_____)_____
County of Residence Home Phone Other Phone

_____
E-mail Address (If Applicable)

Section B

_____ (_____)_____ _____ _____
Name of Last Case Manager Phone Number Office Location County, State

_____/_____/_____
Wardship Termination Date

Note: For the following questions, the definition of Foster Care is as follows:
Foster Care refers to a young person's status with the state as opposed to a particular placement. Foster Care means 24 hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. The young person's placement could be in a family foster home, group home, child caring institution, kinship care home, pre-adoptive home, emergency shelter, ILP or other state sanctioned voluntary placement. Pursuant to the definition of Foster Care, facilities that are outside the scope of Foster Care include, but are not limited to: detention facilities, psychiatric hospitals, forestry camps or facilities that are primarily for the detention of children who are adjudicated delinquents. Children placed in such facilities are not in Foster Care and may not be considered candidates for Foster Care because they have already been removed from the home.

1. Was the client in Foster Care between the ages 14-18? ☐ Yes ☐ No
2. Did the client age out of Foster Care after turning 18? ☐ Yes ☐ No
3. What was the client's living situation on his/her 18th birthday? ☐ Homeless ☐ Foster Home
   ☐ Room and Board ☐ Group Home ☐ Shelter ☐ AWOL/Runaway

☐ Therapeutic Group Home ☐ Residential Treatment Center ☐ Therapeutic Foster Home

☐ Department of Corrections/Detention ☐ Other, please specify _____

4. Does the client currently have resources with a combined value of more than $10,000? ☐ Yes ☐ No

Section C

1. Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

2. Number of Children 0 1 2 3 4+ Currently Pregnant? ☐ Yes ☐ No

How many of these children are living with client? _____

Living situation of other children: _____

3. Living arrangements of client (ex. With relative, roommate, etc….)_____

4. Level of Education Completed or Last Grade Completed 7 8 9 10 11 12 12+ GED

5. Is the client currently enrolled in an educational program? ☐ Yes ☐ No

If yes, where? _____

6. Is the client currently employed? ☐ Yes ☐ No

_____ _____ _____

Employer (If applicable) Occupation Date Started

Current Salary or Wage/hr $_____ Full Time Part Time Seasonal

Does the client have current medical coverage? ☐ Yes ☐ No

If yes, name of insurance provider: _____

Section D

1. What other services are currently being provided to the client? _____

_____

2. List three adults and their phone numbers who would always know the client's whereabouts:

1. Name _____ Phone Number: (_____)_____

2. Name _____ Phone Number: (_____)_____

3. Name _____ Phone Number: (_____)_____

Section E

1. What type of assistance does the client need? (Check all that apply)

☐ Housing ☐ Student Financial Aid
☐ Educational/Vocational ☐ Food
☐ Transportation ☐ Clothing

☐ Counseling
☐ Independent Living Skills Training
☐ Health Care
☐ Medical Insurance
☐ Other (Please Specify) _____

☐ Child Care
☐ Household Goods
☐ Cleaning Supplies
☐ Parenting Classes

Additional Information/Comments: _____

_____

Section F

Independent Living program including establishing and accepting responsibility for my Independent Living goals. I understand that in order to receive room and board assistance, I must be involved in an independent living skills program. I hereby authorize the Independent Living provider to release all information regarding my Independent Living goals and progress to the Division of Family and Children. I understand that the Division of Family and Children may share information with consultants and consulting bodies to help develop plans for myself. This release expires when I turn 21 years of age or am discharged from services.

_____ _____
Client Name Printed Client Signature

_____
Date

Section G

I have verified that this client meets the eligibility criteria for:

☐ IL Skills Service
☐ Room & Board

_____ _____
DFC Representative Signature Date

_____ _____
DFC Representative Name Printed Phone

County of Referral_____ Date_____

Indiana Independent Living Youth Advisory Board Referral FY 2002-2003

Please fill out information as accurately as possible

Target Population:

1) **Youth Advisory Board members, ages 14 to 21, are current participants in independent living programs or have successfully completed an independent living program.**
2) Youth involved with the juvenile justice system, adopted teens, teens involved with drug and alcohol rehabilitation programs, parenting teens, homeless youth, unattached youth and youth that represent ethnic and cultural diversity that were previously placed in foster care between the ages of 14 and 18.
3) Youth returning for assistance from previous service providers, private foster home agencies, or residential facilities.

_____ _____/_____/____
Name Date of Birth

☐ Female ☐ Male

Race:
☐ White, Not Hispanic ☐ Hispanic ☐ Black, Not Hispanic ☐ Other
☐ Asian/Pacific Islander ☐ American Indian/Alaskan ☐ Bi-Racial, Not Hispanic

_____-_____-_____ _____
Social Security Number E-mail Address (If Applicable)

_____ _____ _____ _____
Address City State Zip Code

_____ (_____)_____ (_____)_____
County of Residence Home Phone Other Phone

1) What is your current living situation?
☐ Receiving Chafee Room & Board ☐ Group Home ☐ Foster Home
☐ Therapeutic Group Home ☐ Residential Treatment Center ☐ Therapeutic Foster Home
☐ Living Independently ☐ Other, please specify _____

2) Why are you interested in the Youth Advisory Board?

_____

_____

_____

_____

3) One of the hopes of the Youth Advisory Board is to help influence and change policies regarding youth in foster care. What are the issues that most interest you?

_____

_____

_____

4) Have you had experience working with similar types of boards/committees? ☐ Yes ☐ No

If yes, please list experience: _____

5) What do you feel are your best qualities to offer to the Board? _____

_____

_____

the Youth Advisory Board understanding both the expectations and time commitment, approximately two hours every other month. I understand that this is an application, not a guarantee of my selection for participation. I understand, that if selected, my region's Youth Advisory Board Coordinator will notify me. It is at that time I will fully accept the expectations and responsibilities of becoming a youth advisory board member. I hereby authorize the Youth Advisory Board facilitator to release the information on this form and all information regarding the goals and progress of the Youth Advisory Board to the Division of Family and Children and the Indiana Independent Living Initiative. I understand that the Division of Family and Children may share information with consultants and consulting bodies to help develop plans for myself. This release expires when I turn 21 years of age or am discharged from services.

_____ _____

Youth's Name Printed Youth's Signature

_____

Date

For the interviewer:

Name _____

Agency and/or Program _____

Address _____

_____

Phone Number_____

Final Recommendations or Comments _____

_____

_____

For the Family Case Manager

Family Case Manager_____

Address_____

Phone_____

Note: Youth Advisory Boards will meet for approximately two hours every other month. By giving consent, you, the Family Case Manager, agree that the youth has the ability to meet the time commitment without it affecting the youth's academics or current living situation. I am consenting that the previously mentioned youth may be considered to participate on the Youth Advisory Board.

_____ _____

Signature of Family Case Manager Date

After approval, please fax to:
Ball State University
Social Science Research Center (765) 285-5462

DIVISION OF FAMILY AND CHILDREN

APPLICATION AND AGREEMENT OF RESPONSIBILITY FOR INDEPENDENT LIVING VOLUNTARY SERVICE AGREEMENT

DATE:_____

Part I

I hereby make application to the Division of Family and Services for independent living services, which may include room and board if eligible.

Name:_____ Birthdate:_____

Address:_____ Phone No.:_____

Part II

The terms of this agreement are as follows:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that this contract will be terminated if I do not follow through with this agreement.

I understand that either the Division of Family and Children or I may terminate this voluntary agreement by a ten-day notice in writing. If this agreement is terminated, I understand that I have a 90-day period within which to renegotiate this agreement under terms that are mutual between my case manager, IL service provider, and myself. I also understand that I have the right to request a meeting with my IL service provider and the State Independent Living Coordinator to discuss any decision to terminate under the terms of my agreement.

I understand that the Division of Family and Children and/or the IL service provider will not be financially responsible for damages that I am responsible for nor will the Division of Family and Children provide legal counsel for me if I am involved in a legal situation.

I understand that the Division of Family and Children and/or the IL service provider will not be financially responsible for any contracts that I enter into.

Youth's Signature:_____

Division of Family and Children Referring Case Manager:_____

Contracted Independent Living Service Provider:_____

SUGGESTED BUDGET WORKSHEET

EXPENSES		INCOME			
Housing		Main Income			
House payment/rent		Second Income			
Taxes & Insurance (Renter's)		Other Income			
		Total Income			
Other Bills		Income Available for Savings			
Car Payment					
Car Insurance		Total Income			
Life & Health Insurance		Total Expenses Minus			-
Electric		**Savings**			
Other Utilities (i.e. water)		Approximate Bill Percentages			
Telephone					
Internet Fees		Housing (approximately 30%)			
Credit Card 1		Household Expenses (approximately 30%)			
Credit Card 2		Other Bills (approximately 30%)			
Credit Card 3		Savings (approximately 10%)			
Loans		Paycheck Distribution with approximate percentages			
Cable					
Other Bill 1		Amount Deposited in Checking for Housing & Other Bills 60%		Weekly	Monthly
Other Bill 2		Amount of Cash For Household expenses 30%			
Other Bill 3		Amount for Long Term Savings (invested) 5%			
		Amount for Crisis Fund (Savings Account) 5%			
Household					
Household Budget					
Total Expenses					

Below is a list of items to be listed under each topic. This list is only to be used as a guide and does not include all possible items.

Housing
House payment
Rent
Renter's Insurance
Property Taxes
Property Insurance

Other Bills
Utilities
Car Payments
Credit Card Payments
Installment Loans
Life & Health Insurance
Internet Fees
Cable/Sat TV
Telephones
Auto Insurance

Household
Groceries
Health & Beauty
Car Gas
Dining Out
Haircuts & Beauty Shop
School Lunches
Kid's Allowances
Books & Magazines
Church Offerings
Public Transportation
Entertainment
Gifts
Pet food & Supplies

Savings

Crisis Fund

Home Repair & Maintenance
Auto Repair & Maintenance
Appliance Repair or Replacement
Unexpected Expenses or Bills
Pet Veterinarian bills

Long Term Savings

College Fund
Home Purchase
Auto Purchase

Independent Living
Discharge Summary

Client Name_____
Date Completed_____

1) Did you hold a job, either full-or part-time for at least three consecutive months in the past six months?
___YES ____NO

2) Did you participate in an apprenticeship, internship, or other employment-training situation, either paid or unpaid, for at least three consecutive months in the past six months?
____YES ____NO

3) Do you currently have a savings, checking or money market account or CD at a financial institution such as a bank or investment company?
____YES ____NO

4) Have you ever received a vocational certificate or vocational license?
____YES ____NO

5) During the past six months, were you enrolled in and attending any of the following: high school, GED classes, a vocational training program, or college?
____YES ____NO

6) Currently is there at least one adult in the community you can go to for emotional support?
____YES ____NO

7) Currently is there at least one adult in the community you can go to for job or school advice or guidance?
____YES ____NO

8) During the past seven months were you referred for substance abuse assessment or counseling?
____YES ____NO

9) During the past seven months were you incarcerated or detained in a jail, prison, or juvenile detention facility?
____YES ____NO

10) Female-Did you give birth to a child in the past six months?
___YES ____NO

Male-Did you father a child in the past six months?
____YES ____NO

11) After discharge will you have health insurance that covers physical health care?
____YES ____NO

12) After discharge will you have health insurance that covers mental health care?
____YES ____NO

13) Do you currently require ongoing medication prescribed by a doctor to maintain your physical or mental health?

____YES ____NO

14) In the future will you be able to do what is necessary to continue taking your medication, getting a doctor's prescription, getting the prescription filled, and paying for the medication?
____YES ____NO

15) Have you received all the following documents: birth certificate, social security card, medical records, and education records?
____YES ____NO

16) Were you given information on how to obtain all documents, which were not provided to you?
____YES ____NO

Family Case Manager or Probation Officer Name:_____ **Interviewee Name:**_____
Please print ***Please print***

Signature:_____ **Signature:**_____

Appendix CC

Independent Living
Post Discharge Summary

Client Name_____
Date Completed_____

1) Did you hold a job, either full-or part-time for at least three consecutive months in the past six months?
___YES ___NO

2) Did you participate in an apprenticeship, internship, or other employment-training situation, either paid or unpaid, for at least three consecutive months in the past six months?
___YES ___NO

3) Did you receive SSI at any time during the last six months?
___YES ___NO

4) Did you use a scholarship to cover any living or educational expenses during the past six months?:
___YES ___NO

5) Did you receive a stipend to cover any living, educational or vocational expenses during the last six months?
___YES ___NO

6) Did you receive TANF, general assistance, food stamps, WIC, or LIHEAP (energy assistance) at any time since January 15, 2000?
___YES ___NO

7) Did you receive money, housing, or food from family or spouse, or did family or spouse pay any of your living or educational expenses during the past six months?
___YES ___NO

8) Did you receive financial resources or support from any other source, excluding paid employment, during the past six months?
___YES ___NO

9) Do you currently have a savings, checking or money market account or CD at a financial institution such as a bank or investment company?
___YES ___NO

10) Were you ever homeless at any time during the past six months?
___YES ___NO

11) How long were your homeless?
___YES ___NO

12) Have you received a college degree?
___YES ___NO

13) Have you ever received a vocational certificate or vocational license?
___YES ___NO

14) During the past six months, were you enrolled in and attending any of the following: high school, GED classes, a vocational training program, or college?
____YES ____NO

15) Currently is there at least one adult in the community you can go to for emotional support?
____YES ____NO

16) Currently is there at least one adult in the community you can go to for job or school advice or guidance?
____YES ____NO

17) During the past seven months were you referred for substance abuse assessment or counseling?
____YES ____NO

18) During the past seven months were you incarcerated or detained in a jail, prison, or juvenile detention facility?
____YES ____NO

19) Female-Did you give birth to a child in the past six months?
____YES ____NO

Male-Did you father a child in the past six months?
____YES ____NO

20) Are you currently covered by health insurance that pays toward physical health care?
____YES ____NO

21) Are you currently covered by health insurance that pays toward mental health care?
____YES ____NO

22) Do you currently require ongoing medication prescribed by a doctor to maintain your physical or mental health?
____YES ____NO

23) Are you able to continue taking your medication, getting a doctor's prescription, getting the prescription filled, and paying for the medication?
____YES ____NO

Family Case Manager or Probation Officer Name:_____ **Interviewee Name:**_____
Please print ***Please print***

Signature:_____ **Signature:**_____

IL OUTCOME MEASURES REPORT

Date of Report: ____/____/____

Type: ☐ Intake ☐ Six Month Review ☐ Discharge Reason for Discharge:

Date of Initial Interview ___/___/___

☐ Successfully Completed Planned Service
☐ Client Moved/Unable to Locate
☐ Client Refused Service/Uncooperative
☐ Aged Out
☐ No Longer Eligible
☐ Other:

_____

Name of Agency_____ Date _____

_____

Name of Program_____ Region (circle): NW NE WC EC SW SE

Name of person completing form_____ Phone ( )_____
Fax
(_____)_____

Client's Name _____

1) DOB___/___/___ 2) ☐ Male ☐ Female 3) ☐ White, Not Hispanic
☐ Hispanic
☐ Black, Not Hispanic
☐ Asian/Pacific Islander
☐ American Indian/Alaskan
☐ Bi-Racial, Not Hispanic

4) Special Needs (please check all that apply):
☐ Developmental Disability
☐ Clinically Diagnosed Mental Illness
☐ Clinically Diagnosed Emotional Disturbance
☐ Moderate to Severe Hearing Impairment
☐ Moderate to Severe Sight Impairment
☐ Diagnosed Specific Learning Disability
☐ Other: _____

5) How long has the client been in foster care (e.g. foster home, residential treatment center, group home)?
_____ Number of years _____Number of months

6) Number of children client has _____ 7) Number of children living w/client _____

****REMINDER: Answer all questions for the current reporting period only****

Outcome 1: Increase the percentage of youth who have resources to meet their living expenses.

1) Employment:

☐ Full-time ☐ Part-time ☐ Not Employed ☐ Unknown

2) School or GED Classes:

☐ Enrolled ☐ Not Enrolled ☐ Unknown

3) Is the client enrolled in a job apprenticeship or internship?

☐ No ☐ Yes If yes, from _____ to _____

4) Assistance (for this reporting period please check all that apply):

☐ SSI ☐ Scholarship ☐ TANF

☐ Financial Support from Family or Spouse ☐ Chafee Room and Board
☐ Stipend (Specify): _____ ☐ Other (Specify): _____

5) Does the client have either a checking or savings account with a bank or credit union account?

☐ Yes ☐ No ☐ Unknown

Any additional comments: _____

****REMINDER: Answer all questions for the current reporting period only****

Outcome 2: Increase the percentage of youth who have a safe and stable place to live.

1) Was the client homeless at any time since last Outcome Measures Report, or if initial interview, has the client ever been homeless?

☐ Yes ☐ No

If yes, for what period of time?

☐ 3 or fewer nights ☐ More than 3 nights but less than 2 wks
☐ 2 wks to a month ☐ More than a month

2) What is the client's current living situation?

☐ Residential Treatment Center ☐ Emergency Shelter ☐ AWOL/Runaway
☐ Group Home ☐ Foster Home ☐ Homeless
☐ Therapeutic Group Home ☐ Therapeutic Foster Home
☐ Department of Corrections/Detention ☐ Other, please specify

_____

Answer questions 3 through 5 only for those clients who are emancipated:

3) Has the client obtained housing?

☐ Yes ☐ No

4) Had the client kept the same housing for at least 3 months prior to entering the program?

☐ Yes ☐ No ☐ Don't know

5) Since entry into the program, has the client kept the same housing for at least 3 months?

☐ Yes ☐ No

Any additional comments: _____

****REMINDER: Answer all questions for the current reporting period only****

Outcome 3: Increase the percentage of youth who attain education (Academic or Vocational) goals.

1) Have any of the following diplomas or certifications been obtained during the current reporting period? Check all that apply:

☐ High School Diploma ☐ GED ☐ Special Education Certificate

☐ Associate's Degree ☐ Bachelor's Degree ☐ Vocational Certificate or License

2) Is the client currently enrolled in any of the following (Check all that apply)?

☐ High School ☐ GED Classes ☐ Post HS Vocational Training ☐ College

FOR CURRENT REPORTING PERIOD:

3) Has the client received planned driver's education?

☐ Yes ☐ No ☐ Unknown

4) Does the client have a driver's license or learner's permit?

☐ Yes ☐ No ☐ Unknown

5) Has the client received Special Education services?

☐ Yes ☐ No ☐ Unknown

If yes, does the client have an Individual Transition Plan?

☐ Yes ☐ No

If yes, is the client receiving services through the Individual Transition Plan?

☐ Yes ☐ No

Any additional comments: _____

_____

REMINDER: Answer all questions for the current reporting period only

Outcome 4: Increase the percentage of youth who have positive personal relationships with adults in the community.

1) Does the client have at least one adult in the community he/she can go to for emotional support?

☐ Yes ☐ No ☐ Unknown

2) Does the client have at least one adult in the community youth he/she can go to for job/school advice or guidance?

☐ Yes ☐ No ☐ Unknown

3) Has the client participated in at least one (please check all that apply):

☐ Leadership activity ☐ Conference ☐ Cultural activity

☐ Spiritual activity ☐ Recreational activity ☐ Unknown

4) Has the client been involved with a mentor at school, in the workplace and/or in the community?

☐ Yes ☐ No ☐ Unknown

Any additional comments: _____

REMINDER: Answer all questions for the current reporting period only

Outcome 5: Increase the percentage of youth who avoid involvement in high-risk behaviors.

1) Has the client received a substance abuse assessment?

☐ Yes ☐ No ☐ Unknown ☐ N/A

2) If deemed necessary by substance abuse assessment, has the client participated in services weekly for a period of:

☐ Less than one month ☐ 1-2 Months ☐ More than two months
☐ Youth Refused ☐ Not Deemed Necessary ☐ N/A, did not receive assessment

3) Has the client received a counseling assessment?

☐ Yes ☐ No ☐ Unknown ☐ N/A

4) If deemed necessary by counseling assessment, has the client participated in services weekly for a period

☐ Less than one month ☐ 1-2 Months ☐ More than two months
☐ Youth Refused ☐ Not Deemed Necessary ☐ N/A, did not receive assessment

5) Was the client incarcerated or detained in a jail, prison or juvenile detention facility due to a criminal or status offense?

☐ Yes ☐ No

If yes, please complete the following.

Offense (Include criminal and status offenses. Be specific)	Was the client charged? (Please circle one)	Did client remain detained/incarcerated until trial/hearing? (Please circle one)	How long was this period of time? (in months)
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	
	Yes No	Yes No	

	Yes No	Yes No	

6) Did the client give birth to or father a child?

☐ Yes ☐ No ☐ Unknown

7) Which of the following services did the client receive (Check all that apply)?

☐ HIV Prevention ☐ Sex Education ☐ Teen Parenting Classes ☐ Prenatal Care ☐ Other

Additional comments: _____

_____

****REMINDER: Answer all questions for the current reporting period only****

Outcome 6: Increase the percentage of youth who are able to access needed physical and mental health services.

1) Does the client currently have medical insurance?

☐ Yes ☐ No ☐ Unknown

If Yes, what type of insurance does client have: ☐ Medicaid ☐ Other Insurance

2) Which of the following does the coverage include? (check all that apply)

☐ Dental Benefits ☐ Mental Health Benefits ☐ N/A

☐ Eye Care Benefits ☐ Prescription Benefits

3) Can he/she name his/her (check all that apply):

☐ Physician (Medical Provider) ☐ Dentist ☐ Mental Health Provider

☐ Other Service Provider ☐ Unknown ☐ N/A

4) Has the client maintained scheduled physical appointments?

☐ Yes ☐ No ☐ Unknown ☐ N/A

5) Has the client maintained scheduled mental health appointments?

☐ Yes ☐ No ☐ Unknown ☐ N/A

6) Did the client receive any of these services? (check all that apply)

☐ Formal counseling ☐ Crisis counseling ☐ Family therapy

7) Did the client require ongoing medication for maintenance of physical, medical and/or mental health?

☐ Yes ☐ No ☐ Unknown ☐ N/A

8) **ANSWER ONLY AT DISCHARGE:** If the client requires ongoing medication, has the client made arrangements to continue receiving his/her medication?

☐ N/A, does not require medication ☐ No ☐ Yes

Explain if 'Yes' or 'No': _____

Additional comments: _____

_____

REMINDER: Answer all questions for the current reporting period only

Outcome 7: Increase the percentage of youth who have or know how to obtain essential documents.

1) Does the client have an original or copy of any of the following? (check all that apply)

☐ Birth Certificate ☐ Social Security Card

☐ Medical Records ☐ Educational Records

2) Has the client been given information on how to obtain the documents listed above?

☐ Yes ☐ No ☐ Unknown ☐ N/A

3) Has the client been given written documentation of their physicians, social workers, dentists, etc. related to his/her case, including name, address and phone number?

☐ Yes ☐ No ☐ Unknown ☐ N/A

Additional comments: _____

Please send completed original form to:

Kelley TrumbullBall State University
Social Science Research Center AR201
Muncie, IN 47306

EDUCATON AND TRAINING VOUCHER (ETV)

PROGRAM GUIDELINES

TARGET POPULATION:

7) Youth ages 14-21, up to the 21st birthday, who are in foster care under the supervision of the local office of the Division of Family and Children, with a case plan establishing the need for independent living services.
8) Youth adopted from foster care after attaining age 16.
9) Youth ages 14-21 who were formerly in foster care as a CHINS between the ages of 14-18 that were returned to their own homes and remain a CHINS with a case plan establishing the need for independent living services.
10) Youth up to the age of 21 who were formerly in foster care as a CHINS between the ages of 14-18 under the supervision of the local office of the Division of Family and Children.
11) Probation youth, adjudicated a delinquent and placed in out of home care, between the ages 14-18, up to their 18th Birthday, and have a current case plan identifying independent living needs. In addition, the county of residence must have an interagency agreement between the court and local DFC relating responsibilities of each party for meeting all state and federal mandates.

Youth participating in the voucher program on their 21st birthday, may continue until they turn 23 years old, as long as they are enrolled in a post-secondary education or training program and are making satisfactory progress toward completion of that program.

TO RECEIVE ETV FUNDS, THE YOUTH MUST:

1. Meet the eligibility criteria stated above.

2. Possess a Special Education Certificate, Vocational Certificate or must be above the age of compulsory education and not enrolled in secondary education for training programs. Some training programs may require a High School Diploma or GED for admission.

3. Possess a High School Diploma, GED to attend college. *(Youth attending college must have completed the Free Application for Federal Student Aid (FASFA) with financial eligibility determined prior to funding approval for from the ETV program. Twenty-First Century Scholars must also be accepted if eligible prior to use of ETV funds.)*

4. Be enrolled in an institution of higher education or a vocational program that provides training for gainful employment. The definition follows below:

   An Institution of Higher Education is a school that:
   - *Awards a bachelor's degree or not less than a 2 year program that provides credit towards a degree or,*
   - *Provides not less than 1 year of training towards gainful employment or,*
   - *Is a vocational program that provides training for gainful employment and has been in existence for at least two years.*

   And must meet all three of the following criteria:
   - *Admits as regular students only persons with a high school diploma or equivalent; or admits as regular students persons who are beyond the age of compulsory school attendance*
   - *Public or Non-Profit*
   - *Accredited or preaccredited and is authorized to operate in that state*

5. Must be enrolled as a full time student in an accredited institution if between age 21 to 23 to receive ETV funds.

6. Maintain a minimum grade point average of 2.0 out of 4.0 or equivalent on another GPA scale. If not in an academic program, the youth must meet the standards set forth by the program they are enrolled in.

7. Must provide a copy of each semester's grades immediately upon receipt to the State IL Coordinator.

8. Must resubmit a new application for ETV funds annually following the receipt of the FASFA determination regarding scholarship awards.

Funding may include any or all of the following and must not exceed the lesser of $5000 per year or the total cost of attendance per year. ETV funds may be used for the following: tuition; tutoring, transportation; consumables such as books, supplies, uniforms, tools, etc.; computer, printer, and related accessories; calculator; childcare, and housing. The amount of assistance from any federal sources combined with ETV funds cannot exceed the cost of attendance for college or training.

PROCEDURE TO RECEIVE ETV FUNDS:

1. Foster care youth may complete the ETV application following the determination of the youth's treatment team that a plan for independence has been approved and the youth meets the program guidelines. The application must be completed online at www.statevoucher.org. Once eligibility is determined through information in ICWIS, the youth will be contacted by the Orphan Foundation of America (OFA). All youth receiving ETV funds must have an email address for correspondence with OFA regarding their application and distribution of funds.

2. Former foster youth must meet the target population requirements, program guidelines, and complete an application online at www.statevoucher.org. Once eligibility is determined through information in ICWIS, the youth will be contacted by OFA. All youth receiving ETV funds must have an email address for correspondence with OFA regarding their application and distribution of funds.

Once an application is completed, the youth will be asked to complete the forms in Appendix GG that must be faxed or mailed to the Orphan Foundation immediately for processing.

FINANCIAL AID FORM – please print neatly

I have applied for state funding towards my **2004-5 school costs** through the federally-funded Indiana Education and Training Voucher (ETV) Program. In order to receive this funding, ETV requires the following information:

Student Name: _____

School Name: _____

Signature: _____

SSN: _____

Estimated cost of attendance **2004-5:** $_____

TUITION: $_____

Pell Grant $_____

SEOG $_____

Other grants/scholarships (please name)

_____ $_____

_____ $_____

_____ $_____

Subsidized loan $_____

Unsubsidized loan $_____

Other loan (please name)

_____ $_____

Work/Study $_____

Unmet Need **2004-5:** $_____

The student is □ fulltime (12 or more credit hours)
□ part-time (less than 12 credit hours)

Preparer's Signature: _____ Date: _____
(Financial Aid Advisor)

Thank you very much for providing this information in a timely fashion. If you have a form or letter which provides this same information, you are welcome to fax that instead. ***Please note that the student CANNOT RECEIVE ANY ASSISTANCE without the required information***

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Please fax this sheet to: 1.800.757.0863

The Indiana ETV Program

IN ETV PROGRAM Student loan repayment information form

A portion of you ETV funds may use to pay loans you have incurred for the following semesters.

Summer 2002	Summer 2003	Fall 2004
Fall 2002	Fall 2003	Spring 2004
	Spring 2003	

The IN ETV Program will send the funds directly to the banking institution from which you received your student loan. In order to send funds on your behalf, information must be provided for each outstanding loan. A determination of which loan(s) should be paid will be made based on whether it is a subsided loan or unsubsidized and the interest rate being charged.

Please list the following information for each loan. To find the information look on the notification letter you received from the bank/loan originator or the actual promissory note (documents you signed when you borrowed the money.) If you do not have the information or are not sure if you have outstanding loans that must be repaid ask at your school's financial aid office. They may be able to tell you the following or you will have to call the lender directly.

Please print neatly or it will not be accepted. Copy this sheet if you have more than two loans.

Your name _____ dob (date of birth) _____

Institution/Bank name _____

Address_____

_____

Loan number _____ Loan payoff amount_____

This loan is ☐ subsidized ☐unsubsidized Interest rate (if known) _____

Institution/Bank name _____

Address_____

_____

Loan number _____ Loan payoff amount_____

This loan is ☐ subsidized ☐unsubsidized Interest rate (if known) _____

Reducing your student loan debt will give you more flexibility upon completion of your training program or college graduation. *Fax this complete form to:*

FAX: 1 800 757-0863

Find out EXACTLY how much you have borrowed in student loans, EXACTLY how much you owe in student loans, and who is your loan provider.
It's EASY and QUICK!

First you must have the PIN number from your financial aid report (SAR).

1. Go to this web site: https://pin.ed.gov
2. Click on "PIN Request and Information"
3. Click on "Request a Duplicate PIN"
4. You will need to fill in the following information
    a. Enter your social security number (SSN) – only numbers; no hyphens
    b. Enter the first two letters of your **last name** - this **must** be in **lower case.**
    c. Enter your date of birth (mmddyyyy – only numbers; no hyphens, and use full year, for example 1981)
    d. Click "Submit Request"
2. If the Dept of Education has a file on you, you will see "Match Found" and you will be able to request that your PIN be mailed USPS or emailed to you.
3. If you need to update either your physical address or your email address, you will need to click on "Update my PIN information" in the left menu bar and go back through the above steps in order for your PIN to go to the updated address

How to find out about your loans

4. Go to this web site: http://www.nslds.ed.gov/
5. Click on Financial Aid Review
6. Click "Accept" on the next screen
7. You must confirm your identity with the Dept of Education
    a. Enter your your social security number (SSN0 – only numbers, no hyphens
    b. Enter the first two letters of your **last name** it **must** be in **lower case.**
    c. Enter your date of birth (mmddyyyy – only numbers; no hyphens, and use full year, for example 1981)
8. Enter your PIN – see above.
9. Click "Submit Request"
10. You will now see a list of all your loans and grants, if you click on any of the numbers in front of a loan (i.e. Stafford unsubsidized), you will open a new screen where you will see **the balance on the loan** and **who is the Loan Provider**.
11. Use the information from this screen to fill out the **ETV Loan Form**
12. Properly filling out the loan form will help us to pay off your loans faster, so you will have less debt to worry about.

Indiana
Education and Training Voucher Program
2003-2004 Student Budget

The IN ETV Program is authorized to pay tuition, fees and books for students in college and vocational training. However, after these have been paid, ETV funds MAY be used to cover a portion of other school-related costs including rent, childcare, health insurance, and living expenses such as groceries and some transportation costs. ETV funds may also be used to purchase a computer if this is needed for school.

Student Name:_____
Mailing Address: _____
_____
_____
Telephone Number: _____
eMail Address: _____

****You MUST keep a valid email address and you MUST check it regularly to participate in the IN-ETV Program****

Requested Payments:

1. Landlord/Rental Company Name: _____
   Monthly Rent Amount ($): _____
   Address Where Check is Sent: _____
   _____

Payment is made directly to the landlord; A COPY OF THE LEASE IS REQUIRED.

2. Childcare Provider Name: _____
   Monthly Payment Amount ($): _____
   Address Where Check is Sent: _____
   _____

Payment can only be made to a licensed provider; documented proof of licensure is required.

□ I request use of ETV funds to purchase a computer. *If you select this option you will be emailed further instructions once you have been accepted.*
□ I request use of ETV funds for health insurance. *If you do not have an insurance provider, Student Services at your school can help you select one; once you have a provider send us your premium statement.*
□ I request use of ETV funds for living expenses including groceries and transportation. *If you live in a residence hall and are on a food plan, you do not qualify for this assistance.*
□ I request use of ETV funds for summer school 2004
□ I have been attending post-secondary school since _____ and request use of ETV funds for outstanding student loans. *Documentation including provider's name, address and loan number must be attached.*

Before this form can be processed, you must fill out your student application at www.statevoucher.org (click on the state of Indiana)

Please return this form via fax to the ETV Program at **1.800.757.0863**

HOST HOME RENTAL AGREEMENT

Part I

Name (Renter):_____

Host Home Name:_____
Address:_____
Phone No.:

The agreed upon monthly rate to be paid by the renter is: $_____ per month.
This lease is a month to month agreement and begins on _____.

Rent is due on the 1st Saturday of each month by 5 p.m. and must be paid by cash, money order, or cashier's check. The Host Home will provide a receipt upon payment.

A deposit of $_____is due with the first month's rent prior to move in. Notice of the renter wishing to end this contract must be given 30 days in advance of move out. The deposit will be returned upon move out provided the renter has followed the guidelines of the agreement listed below in Part II-A-1, 2, and 3.

Part II

The terms of this agreement are as follows:

A. The Host Home will provide the following to the renter:

1) Bedroom will include the use of a bed, pillow, 2 sets of sheets, blanket, bedspread, desk, chest of drawers, dresser with mirror, closet, and laundry basket.
2) Shared bathroom or private bath with shower or bathtub, towels, cleaning supplies, shampoo, bath soap.
3) Use of the common areas of the home such as the living room, kitchen, dining room, porch, garage, and outbuildings. Use of TV or other common area items such as appliances if they are shared with host home family members.
4) Use of cleaning equipment such as sweeper, broom, mop, etc. will be made available.
5) Guidelines regarding garbage, dirt, litter or refuse will be provided with identification of the proper disposal of such.
6) Food for two meals a day (may or may not be prepared by the host family) and scheduled meal times if prepared. Guidelines regarding the storage of food and where food may be eaten will be provided.
7) Use of laundry facilities including laundry supplies such as detergent, fabric softener, and bleach.
8) Parking space for vehicle if applicable and guidelines for friends vehicles that may visit.
9) Guidelines regarding non-working vehicles and the repair of them.
10) Curfew hours if any or written expectations regarding coming and going from the residence.

11) Guidelines for acceptable noise level regarding music, TV, or other areas that this may apply.
12) Set guidelines for others that may visit the youth in the home and any rules that may apply when the host home family is home or not at home

B. The Renter will be responsible for the following:

1) Maintain the bedroom in the same condition, with allowance for normal wear, that it was when the contract began including weekly cleaning and dusting. Maintain clothing in closet, drawers or laundry basket.
2) Maintain bathroom in same condition that it was when the contract began including weekly cleaning.
3) Maintain orderliness in the common areas of the home when using and leave the areas as they were upon entering. Following the guidelines as to use of TV or other common area items.
4) Clean the bedroom and bath using designated cleaning equipment and return equipment following use.
5) Garbage, dirt, litter or refuse must be deposited in garbage cans used for that purpose.
6) Acknowledge the scheduled time for meals and be available for such or upon preparation of meals, leave the kitchen in the same condition that it was upon arrival. Follow the rules of the Host Home regarding the storage of food and where food may be eaten in the home.
7) Use laundry facilities when there is a sufficient amount of clothing for a load and at times that do not inconvenience the host home plans for laundry. Inform the host home if laundry supplies run low after use.
8) Follow the host home rules regarding parking the vehicle and where any friends may park if visiting.
9) Follow the rules regarding repairing a non-working vehicle.
10) Follow the expectations of the host home regarding coming and going from the residence.
11) Follow the guidelines that are acceptable for noise levels such as music, TV, or other areas that this may apply.
12) Follow the expectations regarding the presence of the renter's friends in the home when the host home family is home or not at home.

Rules and regulations not listed in A or B above

1) Smoking by the renter may only be done outside of the house. No smoking at any time inside the house.
2) No birds, cats, dogs, or other animals may be maintained in or about the Host Home without written consent from the Host Home.
3) When using electrical appliances such as irons, fans, hair dryers, curling irons, etc., it is the responsibility of the renter to be sure they are turned off after use.
4) The Host Home must approve, prior to installation, the use of small refrigerators, air conditioning units, and heaters in the rented room.
5) Follow the rules of safety when using any electrical appliances in the home

Part III

I understand that this contract will remain in effect as long as I follow these guidelines and that the contract will be terminated if I do not follow through with this agreement. I understand that either the Host Home or I may terminate this agreement by a thirty-day notice in writing.

I understand that the Division of Family and Children and/or the IL service provider assisting me with IL services will not have any legal responsibility for me including financially responsibility for damages that I am responsible for nor will the Division of Family and Children provide legal counsel for me if I am involved in any legal situation.

I understand that the Division of Family and Children and/or the IL service provider will not be financially responsible for any contracts that I enter into.

Youth's Signature:_____ **Date:**_____

Host Home signature:_____ **Date:**_____