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302. Appendix A – Substance Affected Families

a) Background

The *DASA/Child Welfare Integrated Services Program* was previously known as *Project Safe* and the *Division of Alcoholism and Substance Abuse (DASA)/ Department of Children and Family Services (DCFS) Initiative*. The *DASA/Child Welfare Integrated Services Program* provides **enhanced outreach, case management, transportation, and child care services** as part of the client's treatment process. Persons served by DCFS receive priority admission to the program.

b) Eligibility Requirements for Referral to the DASA/Child Welfare Integrated Services Program

Persons eligible to receive services through the DASA/Child Welfare Integrated Services Program must be family members and persons who are significant to the family (i.e., ongoing members of the household) that have an open case with the Department, or the subjects of a child abuse or neglect investigation, or a child for whom the Department is legally responsible. There are no age limitations for persons eligible to receive services from the DASA/Child Welfare Integrated Services Program.

c) DASA/Child Welfare Integrated Services Providers

Regional directories of DASA treatment providers funded to serve DCFS/POS adult and youth referrals may be accessed through the "Resource Links" on the DCFS D-Net, and the "Features" tab on the DCFS web page, www.state.il.us/dcfs. Directories are also available from the DCFS Division of Service Intervention.

Note: If a DASA/Child Welfare Integrated Services Program provider is not available in your service area, contact the Division of Service Intervention for assistance in locating a DASA provider or to obtain other treatment options.

d) Adult Substance Abuse Screen (CFS 440-5)

The **CFS 440-5** is not a diagnostic tool. It is a tool developed for use by Investigation Specialists and follow-up workers to help identify *potential* alcohol and other drug abuse (AODA) problems to determine if an individual should be referred to a *licensed substance abuse treatment provider* for an AODA assessment. The **CFS 440-5** must be completed for all adults in the household or any adult acting as the child's caregiver that is relevant to a child abuse and neglect investigation. The **CFS 440-5** must also be completed any time there is an indication that substance abuse may be present or whenever the case file lacks documentation that a screen was completed. The completed **CFS 440-5** must be placed in the case file and the results of the screen entered in the SACWIS Adult Substance Abuse Screening Summary.

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The **CFS 440-5** has eight sections. Section I, Observations of the Person Being Screened, lists physical signs that may be exhibited by persons abusing alcohol and/or drugs. A “no” response to any of the items in Section II, Facts, concerning drug or drug related criminal charges; non-drug related criminal charges and driving under the influence of alcohol (Section V) charges must be verified through LEADS information. A “no” response concerning a substance-exposed infant must be verified through a SACWIS/CANTS check. Response to items in Section IV, Family, should be asked of an adult member of the household, if available. When a family member is not available to respond to the items in Section IV, it should be noted on the form that the questions were asked of the client and not a family member. All sources providing information on the screening form should be noted for supervisory review and signature.

Note: When Law Enforcement Agencies Data System (LEADS) information indicates issues of drug or alcohol abuse, workers shall assess the underlying documents supporting the LEADS information.

DASA treatment providers will not admit clients with outstanding or unresolved arrest warrants. If the LEADS summary or underlying documents indicates the presence of an outstanding arrest warrant impacting the parent or other member of the substance affected family, the worker shall do the following to resolve the warrant prior to the individual entering AODA treatment.

- Notify the client’s attorney or public defender of the outstanding warrant.
- Instruct the client to surrender to law enforcement.
- Work with the court to quash the warrant based on the client’s willingness to enter AODA treatment.
- Notify law enforcement of the whereabouts of the client.

If the screen indicates a need for further assessment, the worker shall complete the referral information in Section VIII of the form, have the client sign a **CFS 440-7, Consent for Disclosure of Information**, and complete the SACWIS Adult Substance Abuse Screening Summary documenting the finding and referral activities.

Note: Concurrent with the completion of the **Adult Substance Abuse Screen** the Investigation Specialist must initiate the **Substance Affected Families Procedures Checklist, CFS 440-11**. Subsection (p) of this appendix contains detailed information concerning the **CFS 440-11**.

e) **CFS 440-7, Consent for Disclosure of Information – Substance Abuse Assessment and/or Treatment**

Records of the identity, diagnosis, prognosis or treatment of any patient maintained in connection with performance of any program or activity related to alcohol or other drug abuse or dependency education, early intervention, intervention, training, treatment or rehabilitation which is regulated, authorized, or directly or indirectly assisted by any state

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department or agency shall be confidential and only disclosed with consent. See **Procedures 431**, Subsection (e) for detailed information concerning substance abuse treatment records.

The **CFS 440-7** allows the sharing of information that is required for DCFS and the courts to evaluate the safety and risk to a child, and to support the client's success in both the child welfare system and AODA treatment. A parent or caretaker may seek treatment without signing the **CFS 440-7**, but his or her treatment assessments, attendance and/or progress cannot be recognized by DCFS unless the AODA treatment provider directly reports the information to DCFS.

In order to obtain the client's cooperation in signing the **CFS 440-7**, it is important that the worker fully explain the types of information that will be exchanged and with whom. It is also essential that the client understand that the exchange of this information is required to ensure that DCFS and the court receive accurate information regarding his or her progress, and that the information also allows both the Department of Human Services and DCFS to assess the strengths and weaknesses of the integrated services program.

*Clients cannot be referred for services under the DASA/Child Welfare Integrated Services Program if they refuse to sign the **CFS 440-7**. In special circumstances, it is possible to obtain AODA treatment information on a non-consenting client. Consult your Regional Counsel if it is necessary to obtain this information through a court order.*

f) **AODA Assessment Referral**

Workers shall refer clients to a DASA/Child Welfare Integrated Services Program provider for an AODA assessment when the results of the **CFS 440-5** indicates that the client may have a potential problem with alcohol or other drugs. The DASA provider is required to schedule an assessment for the client no later than the next working day. Call the provider in the presence of the client so that the client can confirm the appointment. Assist the client in keeping the appointment by making any necessary transportation or child care arrangements with the provider. If arrangements cannot be made with the provider, consult with your supervisor concerning the use of auxiliary services. Inform the client that he or she will be held responsible for follow through with the assessment and any recommended treatment.

Forward the completed **CFS 440-5**, **CFS 440-6**, **DCFS Referral For Adult Alcohol and Other Drug Treatment Services**, and **CFS 440-7** via facsimile with any relevant LEADS information to the provider in advance of the client's assessment appointment. Ensure that the client has the provider's name, contact person, address, and telephone number in writing.

The provider will notify the referring Department or POS worker no later than the next working day if the client fails to attend the assessment appointment. Follow-up with the client should occur within two working days for intact and split cases and within one

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week for placement cases. Workers must reinitiate the referral to the provider if the client is willing to proceed with the assessment.

When a DASA provider does not have the capacity to provide or refer to treatment services at the necessary level for the client, the provider must establish interim services for the client until appropriate treatment services become available. When a client is placed on a waiting list or a provider does not have AODA treatment capacity, workers or supervisors are required to notify the DCFS Division of Service Intervention of the situation. The Divisions of Service Intervention should also be notified when other problems or questions arise related to a DASA provider.

g) Juvenile Court Assessment Program - Cook County Placement Cases

The Juvenile Court Assessment Program (JCAP), which is located in the Cook County Juvenile Court Building (312/666-4688), provides alcohol and drug assessments to persons referred to the program that are no younger than 18 years of age. Assessments are conducted Monday through Friday from 8:30 a.m. to 4:30 p.m. Appointments are not necessary. Investigation Specialists and caseworkers, DCFS assessment screeners and court personnel may refer persons to JCAP by submitting a completed JCAP Referral/Status Form to the JCAP Intake Specialist. The Intake Specialist will explain the assessment process to the client and have the client sign the **CFS 440-7** that has been completed by the client's worker.

The JCAP assessor will explain the results of the assessment and the rationale for any treatment recommendations to the client and caseworker upon completion of the assessment. The JCAP assessor will also provide a copy of the client's assessment and written narrative summarizing the client's history and outcome results to the court, Department or POS worker, DCFS assessment screener and DCFS legal staff.

If the client is eligible for the IV-E AODA, the Recovery Coach liaison will meet with the client immediately following the assessment to explain the services that are offered by the Recovery Coach.

The JCAP assessor will set an intake appointment with a DASA provider within 48 hours of the assessment. JCAP will also forward the client's **CFS 440-7**, **CFS 440-5** and assessment results to the provider. JCAP will follow-up with the provider for thirty days or until the client is admitted to the treatment program.

When a client is court-ordered to complete drug testing, the client's worker shall escort the client to the testing site. Results of the urinalysis are critical to the client's AODA assessment and must be provided to JCAP or DASA provider, whichever is appropriate.

h) Client Fails to Enter Treatment

Workers must coordinate a joint client visit with the DASA provider within one week after being notified that the client failed to attend an appointment to enter treatment. The

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visit may occur at the client's home, the DCFS office or the office of the POS or DASA provider. If the client's reason for failing to enter treatment appears reasonable, the worker must make alternative arrangements for the client to enter treatment.

Workers shall inform clients resistive to cooperating with an AODA assessment and/or treatment recommendations that the Department has the option to do the following:

- Terminate the client's safety plan and take appropriate actions to ensure the safety of the children (Safety plans are designed to provide short-term control of specific threats to the child's safety and not to serve as a long term solution to the problem.);
- Complete a new risk assessment to determine the effect of the client's continued use of alcohol or drugs on his or her ability to supervise, protect or care for the children and take appropriate actions to ensure the safety of the children;
- Seek court ordered intervention requiring the client to cooperate with the AODA assessment and treatment recommendations;
- Seek involuntary termination of parental rights if the parent fails to demonstrate reasonable progress in correcting the conditions that led to the removal of the child within the time frames required by the permanency goal of return home.

i) AODA Treatment

AODA treatment services must ensure the accountability on the part of the clients, the Department and other service providers.

- 1) Investigation Specialists, caseworkers, the client and family shall do the following when the client enters AODA treatment:
 - A) Ensure that the client receives the level of service from the AODA provider that is appropriate to the severity of his or her substance abuse problem.
 - B) Establish service plan outcomes that are appropriate to the client's presenting problems and needs.
 - C) Enroll all pre-school children in protective day care, early childhood development or Head Start that are part of an intact family case that do not attend the mother's treatment.
 - D) Monitor the client's progress through the Client Progress Reports and Observation of Parent Behavior Reports provided by the DASA provider every 30 days while the client is in treatment. Notify the DCFS Division

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of Service Intervention if the DASA provider fails to provide these reports.

- E) Document in the SACWIS risk assessment any alleged or observed drug or alcohol use by any member of the household that may seriously affect his or her ability to protect, supervise or care for the child. Risks associated with an adolescent's alleged or observed drug or alcohol use must be documented to support the adolescent's need of AODA services.
- F) Document the assessed need for AODA services in the family's integrated assessment as part of the comprehensive assessment of the family's overall functioning and needs.
- G) Document the AODA services provided to the family in their service plan.
- H) Ensure that appropriate actions are taken to ensure the safety of the children when child safety issues are identified in any verbal or written reports received from the DASA provider.
- I) Maintain weekly contact with the client during the first six weeks of the client's AODA treatment. Contact with the client after the first six weeks may be no less than monthly. Contacts with children in the home and school and/or day care personnel should be in accordance with **Procedures 302.388(f)(8)**.
- J) If it is clinically required, establish the service plan task that the client complete urine toxicology and Breathalyzer testing. The task should be placed under the appropriate problem/outcome statement and include the frequency of the testing. Coordinate urine toxicology and Breathalyzer testing either through DCFS funded drug testing contracts or through the DASA provider. Document all drug testing results in the client's file and AODA treatment file.

Note: Urine toxicology testing is performed in a two-step procedure, initial drug screen and confirmation results. When only the initial drug screen has been completed prior to a court hearing and determined to be positive, notify the court of the initial results. Provide the court with the confirmation results as soon as they are available. If there are delays in receiving the urine toxicology screening or the confirmation reports, notify the DCFS Divisions of Service Intervention.

- K) File all forms required for treatment, progress reports and correspondence with the DASA provider in the client's case file.
- L) Coordinate the delivery of AODA education services to the client and the client's family that include:

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- The impact of parental substance abuse on the children and family;
 - The children's understanding of the signs of substance abuse;
 - The children's understanding of what to do if they are unsafe;
 - The relative's and other caregiver's understanding of how to set boundaries for the substance abuser, how to avoid enabling and what to do if the children are unsafe; and
 - The signs and symptoms of relapse and the concept/use of a relapse prevention plan.
- M) Convene a family meeting within 45 days after case opening that incorporates the following elements:
- The parents or caregivers are the key participants in the meeting;
 - The parents or caregivers identify the supportive persons and family members that should be members of the team;
 - The presence of the children at the meeting should be determined by the issues discussed and the age of the children;
 - The AODA treatment provider and all other key service providers must attend or submit relevant documentation of the client's progress and services provided.

Note: Workers must convene an interagency staffing with the AODA provider within two weeks after the client enters AODA treatment to coordinate service planning and prepare for the family meeting. Whenever possible, workers should coordinate interagency staffings and family meetings for integrated assessment cases with the integrated assessment screeners. The staffings should include the service providers involved with the family being staffed and the parent's probation/parole officer if he or she has one. Interagency staffings must be ongoing and occur at least quarterly; prior to changes in the level of AODA services; prior to a initiation of unsupervised visits; prior to closure of an intact family case; prior to a change in child custody; prior to reunification, prior to the client's planned discharge from treatment; or whenever events occur that might affect child safety, permanency plans or AODA treatment needs.

Note: Family meetings can fulfill interagency staffing requirements as long as all persons required to attend the staffing are present at the family meeting.

Note: With the consent of the family, members of the family team may attend the family's administrative case review for the purpose of reviewing the client's progress towards achieving service plan goals.

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- N) Ongoing family meetings shall be conducted in accordance with **Rules 315.120(c)**;
 - O) Monitor and revise the family's safety plan as needed;
 - P) Conduct background and LEADS checks on newly identified members of the household, fathers, potential caregivers and other adults who frequent the family's home;
 - Q) Verify the children's medical information with their medical provider (i.e., immunizations, well-child visits, and chronic or acute medical conditions);
 - R) Verify the children's school information with their school;
 - S) Ensure that the parents/caregivers receive parent training that also addresses the impact of alcohol and other drug abuse on parenting and families. This training can sometimes be provided as part of the client's AODA treatment;
 - T) Ensure that the parents are involved with and participate in any Illinois Department of Human Services 0-3 early intervention services if their permanency goal is return home.
 - U) Ensure that the parents are involved in their children's health care, school and/or day care activities. Document this information in the case file and report it to the court.
- 2) If the client is administratively discharged from treatment; leaves treatment against advice of the treatment provider; misses two consecutive treatment appointments; or tests positive for alcohol or other drugs, the client's worker shall do the following.
- A) Contact the client to determine the reason for the client's failure to comply with treatment.
 - B) Visit the client with the DASA provider within one week for placement cases and 48 working hours for intact and split cases. The visit may occur at the client's home, the worker's office or the DASA provider's office.
- 3) Investigation Specialists and caseworkers shall provide the DASA provider with the following information to ensure that the provider understands the client's child welfare obligations that may affect the outcome of the client's treatment:
- A) A copy of the client's integrated assessment and service plan within one week of the client's entering treatment;

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Note: Document the AODA services provided the client and family, and service tasks required of the client and the frequency the family will receive those services and their desired outcomes. Tasks requiring the client to complete urine toxicology and Breathalyzer testing must be included in the client's service plan if clinically required.

- B) If the client's comprehensive service plan and/or integrated assessment are not completed at the time the client enters treatment, the information must be provided to the DASA provider no later than one week after they are completed;
- C) Notification of when the client's case is transferred to another worker or when there are other significant case issues such as court hearings, administrative case reviews, removal or return of children to their home, and changes in service plan outcomes.

j) Substance Exposed Infants (SEI)

The Illinois Department of Public Health requires hospitals to report SEI births to the Adverse Pregnancy Outcome Reporting System (APORS). Reports are then forwarded to local health departments for follow-up by visiting nurses. The Investigation Specialist shall also notify the local health department of a pending report involving allegation #15/65, substance misuse, within 24 hours of receipt of the report at the State Central Register; and contact the hospital social worker and charge nurse responsible for the SEI case to obtain information concerning the child's condition and relevant information concerning the family's history and dynamics. The Investigation Specialist shall collaborate with the public health nurse or other health care professional on data collection, levels of intervention, child health care and case management programs.

- 1) Workers shall also do the following for SEI intact family cases:
 - A) Develop a back-up child care plan that will remain in effect until the substance-abusing parent is in AODA treatment and experiencing clean time;
 - B) Maintain ongoing contact with the public health department nurse, AODA provider and other service providers to coordinate services and monitor safety issues;
 - C) Maintain weekly face-to-face contact with the family (parents/caregivers and children) during the 45-day assessment period. Investigation Managers may waive weekly face-to-face contacts within the 45-day assessment period if the assessment has been completed. Contact with the family must occur twice per month following the 45-day assessment period unless a waiver has been obtained from the Investigation Manager.

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- 2) Workers shall do the following for cases involving a second or subsequent SEI birth:
 - A) Screen the case with the State's Attorney for an order of protection requiring the mother to complete an AODA assessment and any follow-up treatment recommendations;
 - B) Continue to attempt to connect the mother with recommended treatment during the intervening period between the screening and court hearing. If the mother complies with treatment recommendations prior to the court hearing, the worker will present this information to the court and follow through with the order of protection, and continue to monitor the mother's progress in treatment. If the mother refuses to comply with treatment recommendations, the worker must present this information at the court hearing for the order of protection with an updated risk assessment.

k) Case Hand-Off/Transitional Visit

It is the responsibility of the investigative and child welfare services teams to ensure the continuity of intervention and oversight of services during the transfer process to ensure that children are not placed at risk. To avoid any lapse in services to the family, the worker transferring the case maintains the responsibility for delivery of services to the family as well as safety plan monitoring until the transitional visit occurs. The worker assigned to the case shall assume responsibility for service planning and delivery, as well as monitoring any existing safety plans, after the transitional visit with the family occurs.

The formal transition of a case shall take place in the presence of the family (caregiver, extended family and other living in the household) with the transferring and receiving workers and the AODA provider, if possible, no later than 48 hours following the hand-off conference. The following agenda shall be followed during the transitional visit:

- Introductions and purpose of the visit;
- Reasons for the Department's involvement with the family;
- Assessment of safety and risk issues;
- Review of initial services provided to the family;
- Full disclosure and review of client rights;
- Assessment of level of service provision: and
- Workers shall alert the DASA treatment provider completing the AODA assessment or providing treatment services to any parental literacy or communication barriers, which includes lack of access to a telephone, that may impact treatment participation or case progress.

Note: For detailed information concerning the case hand-off/transitional visit see **Procedures 302, Subsection 302.388 (d)**.

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l) Home Safety Checklist

Workers shall utilize the **Home Safety Checklist** to identify potential fire hazards and to educate the parents/caregivers on measures that can be taken to reduce those risks.

Note: See Policy Guide 2005.04, Revised Home Safety Checklists, located directly behind **Procedures 300, Appendix G** or **Procedures 315, Appendix A** for detailed information concerning the use of the checklists.

m) Assessment of Parental Recovery Progress and Readiness for Reunification

Worker assessment of a parent's progress in recovery must be ongoing. These assessments must not be made solely on the basis of the parent's completion of fixed number of days in treatment. Parent's must also demonstrate through objective measurable behavior a willingness and readiness for increased visitation, return home of their children and reunification.

Workers shall complete the **Recovery Matrix – Placement Cases, CFS 440-9**, to measure and document parental progress in recovery and readiness for reunification. The matrix is administered prior to the completion of the 45 day service plan, at 90 days, prior to the first administrative case review or six months, at nine months, and prior to the second administrative case review or permanency hearing if there is a return home goal. Continue to use the 12-month matrix worksheet at three-month intervals as long as the goal remains return home. The **CFS 440-9** must be completed with the parent if the parent's location is known and the parent is willing to participate in the assessment.

Workers must use the parent's self report, monthly AODA treatment provider reports, urine toxicology testing reports, reports from other service providers, and information obtained from family members when completing the **CFS 440-9**. If the parent participated in the completion of the matrix, the parent and the worker must sign the form. The worker should submit the completed form to his or her supervisor for review and signature. The parent receives a copy of the completed form and the original is filed in the assessment section of the case file. Copies of the completed matrix are submitted to the court prior to any scheduled hearings and prior to an administrative case review.

Note: The **CFS 440-9** cannot be used for intact family cases. A separate matrix, **CFS 440-10**, has been developed for those cases.

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n) Continuing Care (Aftercare), Recovery and Relapse Prevention

An individual's and family's recovery from alcohol and other drug abuse is a lifelong process. However, traditional residential, intensive outpatient and AODA outpatient treatment programs are designed as time limited intervention models. Relapse prevention is an ongoing process that involves the substance abuser, his or her family, significant others, extended family, friends, coworkers and the treatment team.

A client's discharge from treatment can be stressful and it is important that continuing care services begin when treatment has been successfully completed. These services provide the client an opportunity to develop new behaviors, practice drug free living and relapse prevention techniques. During the planning and delivery of these services caseworkers shall:

- Participate with the treatment provider in an interagency staffing two to four weeks prior to the client's discharge from the AODA treatment;
- Complete the risk assessment in accordance with the schedule identified in Department CERAP procedures or when necessary;
- Establish service plan outcomes that are appropriate to the client's presenting problems and needs;
- Assess and document the client's progress in achieving his or her service plan outcomes prior to each administrative case review ;
- Develop a continuing care plan for the client in consultation with the AODA provider and the client;
- Maintain primary casework responsibility for the family following the client's completion of AODA treatment;
- Maintain contact with the client to monitor his or her compliance with the continuing care plan and to assess the need for subsequent services;
- Maintain contact with continuing care providers.
- Engage the client if relapses occur; and
- Work with the client and his or her family on relapse prevention strategies.

o) Case Closing Requirements

When making a decision to close an intact or reunified substance affected family case, the worker and his or her supervisor shall staff the case using the following criteria.

1) Risk and Safety Assessments

Ongoing risk and safety assessments indicate the absence of any threats of harm or sufficiently demonstrate that any threats to harm are adequately addressed within the family and/or through extended family or community.

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2) Service Plan Outcomes and Permanency Goal

The family has achieved service plan outcomes and permanency goal and there are no new stressors that significantly impact the stability of the family system and the safety of the children.

3) Family Functioning

Workers must consider the following guidelines when assessing the family's ability to meet their current and future needs.

- The children show evidence of improved care in the areas of health (i.e., immunizations and well-child examinations are current, chronic or acute medical conditions are being treated), supervision and responsiveness by the parent/caregiver. The risk assessment indicates that the children are safe and there have been no additional SCR reports within the previous six months. The parent/caregiver has had negative urinalysis reports for the past six months and a LEADS check is free of current drug related or violence charges.
- Children in the family have access to a specific adult or adults outside the home to which they can call for assistance in the event of inappropriate activities related to substance misuse, violence, inadequate supervision; and an adult or adults within the family or extended family have assumed the responsibility for reporting any alleged incidents of abuse or neglect to the SCR.
- The AODA provider confirms that the parent/caregiver has fully engaged in the recovery process for the past six months or that substance abuse issues have been addressed and no longer represent a risk to the children. If the parent/caregiver has not successfully completed a substance abuse treatment program, the worker has verified that the physical, emotional and well being needs of the children are being met and that the children are safe. And the conditions in paragraphs one and two above have been met.
- The parent has shown substantial progress in assuming parental responsibilities necessary for reunification as documented on the **Recovery Matrix**.

p) **Substance Affected Families (SAF) Procedures Checklist (Quality Assurance and Record Compliance)**

The **SAF Procedures Checklist, CFS 440-11**, is an inventory form used to document the completion of required screens, forms and tools for substance-affected families. Workers are only required to complete Section I of the form if the **CFS 440-5** or **CFS 440-8** do not

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result in the adult or adolescent being referred for an AODA assessment or treatment. Document the completion and case entry for the required form/screen/tool by entering the date in the column of the family member involved in the task. The form shall be reviewed and signed by the worker and his or her supervisor prior to each administrative case review and submitted with a copy of the client's **CFS 497** to the case reviewer. The original form shall be maintained in the case record.

q) Services to Substance Affected Youth

1) Eligibility Requirements for Referral to DASA Treatment Services

- The Department must be involved with the youth either through an open case or an abuse or neglect investigation.
- The youth must consent to and maintain consent for the exchange of necessary information between the DASA provider, DCFS and the court if the youth is 12 years of age or older. The youth's parent or guardian may consent to the exchange of information if the youth is less than 12 years of age.
- The youth receiving services may be part of an intact family case, relative or traditional foster home care, group home or residential program, pregnant and/or parenting teen, or in a transitional living or independent living program.

2) DASA/Child Welfare Integrated Services Providers

Regional directories of DASA treatment providers funded to serve DCFS/POS adult and youth referrals may be accessed through the "Resource Links" on the DCFS D-Net, and the "Features" tab on the DCFS web page, www.state.il.us/dcfs. Directories are also available from the DCFS Division of Service Intervention.

Note: If a DASA/Child Welfare Integrated Services Program provider is not available in your service area, contact the Division of Service Intervention for assistance in locating a DASA provider or to obtain other treatment options.

3) Identification of AODA Problems

Workers for youth that have not received an integrated assessment, or who have received an integrated assessment but whose circumstances have changed, must be screened for alcohol and other drug abuse using the **Adolescent AODA Indicator, CFS 440-8**, when any of the following circumstances exist.

- A) When the youth's worker, parent, caregiver, teacher, therapist, primary care physician, or other persons that have a significant relationship with

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the youth suspect or know that the youth is using alcohol, cannabis or other drugs.

- B) When the youth is administered the Ansell Casey Life Skills Assessment on his or her 14th and 16th birthdays.
- C) When the youth is referred to the Child and Youth Investment Teams (CAYIT) or other type of clinical staffing.
- D) When the quarterly residential monitoring review is conducted if the youth is known or suspected of having AODA issues.
- E) When a youth for whom the Department is legally responsible gives birth to a substance-affected infant.

Note: Document the results of the assessment in a SACWIS contact note and refer the youth for further assessment if required.

4) Referral for AODA Assessment

Workers shall refer youth to a DASA/Child Welfare Integrated Services Program provider for an AODA assessment when the results of the **CFS 440-8** indicate that the youth may have a potential problem with alcohol or other drugs. The DASA provider is required to schedule an assessment for the youth no later than the next working day. Call the provider in the presence of the youth so that the youth can confirm the appointment. Inform the youth that he or she will be held responsible for follow through with the assessment and any recommended treatment. Assist the youth in keeping the appointment by making any necessary transportation or child care arrangements.

Forward the completed **CFS 440-8** via facsimile with any relevant LEADS information to the provider in advance of the youth's assessment appointment. Ensure that the youth has the provider's name, contact person, address, and telephone number in writing.

The provider will notify the referring Department or POS worker no later than the next working day if the youth fails to attend the assessment appointment. Follow-up with the youth should occur within one week after the missed appointment. Workers must reinitiate the referral to the provider if the youth is willing to proceed with the assessment.

When a DASA provider does not have the capacity to provide or refer to treatment services at the necessary level for the youth, the provider must establish interim services for the youth until appropriate treatment services become available. When a youth is placed on a waiting list or a provider does not have AODA treatment capacity or problems with a DASA/Child Welfare Integrated

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Service provider occurs, workers are required to notify the DCFS Division of Service Intervention of the situation.

Note: Refer Cook County pregnant and/or parenting youth for a court benchmark hearing and notify the youth's guardian ad litem of the referral.

- 5) AODA Treatment
 - A) When a youth receives an AODA assessment and is referred for treatment but fails to enter treatment, the youth's worker shall do the following.
 - i) Contact the youth to determine the reason or reasons why the youth failed to enter treatment. If the youth is willing to enter treatment, contact AODA provider to reinitiate the treatment referral.
 - ii) If the youth is unwilling to enter treatment, coordinate a meeting with the youth and the DASA provider within one week after the youth failed to enter treatment.
 - iii) If the youth continues to resist entering treatment, initiate a staffing or family team meeting to discuss the options for engaging the youth in accepting treatment.
 - iv) If the youth is in placement, consider filing a supplemental petition requesting a dispositional order requiring the youth to enter AODA treatment or filing a petition under the provisions of the Illinois Addicted Minor Act (705 ILCS 405/4-1).
 - v) Advise pregnant and/or parenting youth of the options available to the Department if they fail to comply with treatment recommendations. Options available to the Department are listed in subsection (f).
 - B) When a youth enters AODA treatment, the youth's worker shall provide the DASA provider the following information to ensure that the provider understands the youth's child welfare issues that may affect the outcome of the youth's treatment:
 - i) A copy of the youth's portion of the integrated assessment and service plan within one week of the youth's entering treatment;
 - ii) If the youth's integrated assessment and service plan are not been completed at the time the youth enters treatment, the information must be provided no later than one week after they are completed;

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- iii) Notification when the youth's case is transferred to another worker or when there are other significant case issues such as court hearings, administrative case reviews, removal or return of children to their home, and changes in service plan outcomes.
 - iv) Notification of the youth's parenting status, the Department's legal relationship with the youth's children, and the current living arrangements for the children.
- C) The youth's DCFS or POS workers shall also do the following while the youth is in treatment.
- i) Maintain weekly contact with the AODA provider either in-person or by telephone during the first six weeks of the youth's treatment. Contact with the provider may be no less than monthly after the first six weeks.
 - ii) Maintain weekly contact with the youth during the first six weeks of his or her AODA treatment. Contact with the youth after the first six weeks may be no less than monthly.
 - iii) Monitor the youth's progress through progress and behavior reports provided by the DASA provider every 30 days while the youth is in treatment. Notify the DCFS Division of Service Intervention if DASA provider fails to provide these reports.
 - iv) Workers must convene interagency staffings with the AODA provider which shall occur at least quarterly; prior to changes in the level of AODA services; prior to a change in child custody; prior to the youth's planned discharge from treatment; or whenever events occur that might affect child safety, permanency plans or AODA treatment needs.
- Family meetings can fulfill interagency staffing requirements as long as all persons required to attend the staffing are present at the family meeting.
- v) Ensure that parenting youth receive parent training that also addresses the impact of alcohol and other drug abuse on parenting and families. This training can sometimes be provided as part of the client's AODA treatment.
- D) Continuing Care (Aftercare), Recovery and Relapse Prevention

An individual's and family's recovery from alcohol and other drug abuse is a lifelong process. However, traditional residential, intensive outpatient

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and AODA outpatient treatment programs are designed as time limited intervention models. Relapse prevention is an ongoing process that involves the substance abuser, his or her family, significant others, extended family, friends, and the treatment team.

A youth's discharge from treatment can be stressful and it is important that continuing care services begin when treatment has been successfully completed. These services provide the youth an opportunity to develop new behaviors, practice drug free living and relapse prevention techniques. During the planning and delivery of these services caseworkers shall:

- Participate with the treatment provider in an interagency staffing two to four weeks prior to the youth's discharge from the AODA treatment;
- Complete the risk assessment in accordance with the schedule identified in Department CERAP procedures or when necessary;
- Develop a continuing care plan for the youth in consultation with the AODA provider and the youth;
- Maintain primary casework responsibility for the family following the client's completion of AODA treatment;
- Maintain contact with the youth to monitor his or her compliance with the continuing care plan and to assess the need for subsequent services;
- Maintain contact with continuing care providers;
- Engage the youth if relapses occur; and
- Work with the youth and his or her family on relapse prevention strategies.

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302.APPENDIX B – SERVICES FOR OLDER CAREGIVERS AND THEIR FAMILIES

a) Purpose

These procedures provide DCFS and POS staff with direction and information that will support the safety and stability of children and youth living with older caregivers (**age 65 and older**). The following procedures ensure that older caregivers and the children for whom they care have access to services provided by the Department of Children and Family Services and the Illinois Department on Aging (IDoA).

The Illinois Department on Aging (IDoA) was created by the state Legislature in 1973 to improve the quality of life for Illinois' senior citizens by coordinating programs and services enabling older persons to preserve their independence as long as possible. It is the State agency in Illinois authorized to receive and dispense Federal Older Americans Act funds, as well as specific State funds, through Area Agencies on Aging and community-based Service providers.

The State of Illinois is divided into thirteen (13) Planning and Service Areas (PSAs). There is one Area Agency on Aging designated by the Department on Aging located within each PSA. In Illinois, twelve (12) not-for-profit agencies and one unit of local government (city of Chicago) serve as Area Agencies on Aging. Each Area Agency on Aging is responsible for planning, coordinating, and advocating for the development of a comprehensive and coordinated system of services for senior citizens within the boundaries of the individual PSA.

These procedures describe the circumstances for collaboration with the IDoA, and its contracted partners, to support older caregiver families and describe the “lifespan approach” that must be followed when the Department is:

- Placing children with older caregivers as the result of a safety plan or at the request of the biological parent with no safety plan in place;
- Providing Intact Family Services;
- Placing children in a foster care placement;
- Moving towards achieving Permanency;
- Contacted for Post Adoption/Adoption Stabilization services; or
- Providing Extended Family Support Services (EFSP).

Early supervisory consultation improves the coordination of services for youth and their older caregivers and can anticipate age related challenges to prevent unnecessary disruptions. Ongoing training and education regarding issues affecting older caregivers and the resources available to older caregiver families through collaboration between the DCFS and IDoA will be provided for all child protection and child welfare staff and is available through the DCFS Office of Training and Professional Development.

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b) **Background: Illinois Caregiving Communities**

One in four Illinois households takes on the role of providing care to an older family member or friend, and over 100,000 Illinois grandparents are caring for their grandchildren. The Illinois Department on Aging Family Caregiver Support Program offers services targeted to both of these caregiver populations. Whether caring for an older family member or a grandchild, the caregiving role often evolves over time.

What may be a stable and secure placement at the onset of the placement or permanency can unexpectedly and rapidly change in an older adult population. A sudden illness can turn an independent person into someone who needs assistance on a daily basis. As an individual ages, their alertness, vigor, physical and cognitive well-being changes. Likewise, the needs of developing children change over time.

Understanding issues of aging and what is “normal” often changes over time and can be confusing. It is imperative that workers evaluate older caregiver families utilizing a Lifespan approach and work to assess the on-going viability of the placement in terms of safety and stability for both the children and the older caregiver.

A lifespan approach looks at the developmental stages of children and pairs knowledge of what a particular child can or cannot do at each stage of their development with the ongoing capability of the older caregiver to meet the child’s needs until the child reaches the age of eighteen.

c) **Definitions**

“**The Aging Network**” means the network of State agencies, Area Agencies on Aging, Title VI grantees, and the Administration; organizations that are providers of direct services to older individuals; or are institutions of higher education; and receive funding under the Older Americans Act.

“**Back-up Caregiver Plan**” means a supplemental plan through which a parent or guardian plans and arranges for a second person to become responsible for a child’s legal, economic, educational and personal safety and well being when the caregiver is no longer able to care for the child. If conceived and executed properly, the back-up plan allows for the child to remain within the family or extended family circle which contributes to the stability of the placement and the well-being of the child. The back-up plan can also allow the child to be placed with a person who is not a family member but who will, with the aid of legal, social, mental health and community services, provide a long-term and nurturing placement. Please refer to **Rule 302.40 (d)(2), Department Service Goals**.

“**Capacity**” means an individual's ability to make an informed decision such as capacity to make a will, marry, enter into a contract, vote, drive a car, stand trial in a criminal prosecution, etc.

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“Competence” refers to the degree of mental soundness necessary to make decisions about a specific issue or to carry out a specific act. All adults are presumed to be competent unless adjudicated otherwise by a court.

Legal Competence vs. Capacity

Although decision-making capacity and competence both describe a person’s ability to make decisions, they are not synonymous. Whereas competence is determined by a court of law, decision-making capacity is a clinical assessment. Competence is a legal term – to say a person is incompetent indicates that a court has ruled the person unable to make valid decisions and has appointed a guardian to make decisions for the person.

In contrast to legal competence, decision-making capacity is assessed by clinicians as an everyday part of clinical care. Decision-making capacity is defined as the ability to understand and appreciate the nature and consequences of decisions.

It is important to respect and understand the older caregiver’s right to self-determination. This includes the older adult’s right to make decisions that may not be in their own best interest. However, if these decisions affect the long-term safety and stability of the child, the Department must be involved. It is the responsibility of the Department to make placement decisions and/or changes based on the best interests of the child regardless of the older caregiver’s right to self determination.

“Determination of Need” or “DON” is an assessment tool used in the Community Care Program (CCP) and as a pre-admission screening tool to nursing homes to determine if a person needs enough help with their activities of daily living (ADLs) to qualify for assistance or placement.

“Grandparents Raising Grandchildren (GRG)” means a program through which the Illinois Department on Aging provides assistance to grandparents and other relatives (regardless of their age) who are raising related children. The program assists relatives who are seeking resources and referrals to support their efforts to provide safe, stable and loving homes for children. The program establishes and funds support groups, legal services, respite, outreach, counseling, and gap filling funds.

“Lifespan Approach” means the perspective which must be considered when placing children with older caregivers. This perspective considers changes occurring throughout people’s lifetimes. In most people’s lives, such things as alertness, vigor, and physical and mental well-being change as aging occurs. Plans made at one point in a family’s life may no longer be viable years down the line. A lifespan approach recognizes that older caregivers will experience physical or cognitive changes as they age and that some of these changes may affect older caregivers’ abilities to provide a healthy and safe environment not only for themselves but also for the children in their care. Further, use of a lifespan approach looks at the developmental stages of children and pairs knowledge of what a particular child can or cannot do at each stage with the

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on-going capability of the older caregiver to meet the child's needs until the child reaches the age of majority (18).

“Minor Requiring Authoritative Intervention (MRAI)” means any minor under 18 years of age who:

- is absent from home without the consent of a parent, guardian or custodian;
- is beyond the control of his or her parent, guardian or custodian, or circumstances which constitute a substantial or immediate danger to the minor's physical safety;
- after being taken into limited custody (21 days for the first instance and five for the second, third, fourth) and offered interim crisis intervention services, where available, refuses to return home after the minor and his or her parent, guardian or custodian, and cannot agree to an arrangement for an alternative voluntary residential placement or to the continuation of such placement.

“Dependency” or “Dependent Child” means a *child who is without proper medical or other remedial care recognized under State law or other care necessary for his or her well being through no fault, neglect or lack of concern by his parents, guardian or custodian, provided that no order may be made terminating parental rights, nor may a minor removed from the custody of his or her parents for longer than 6 months, pursuant to an adjudication as a dependent minor under this subdivision (c), unless it is found to be in his or her best interest by the court automatically closes as provided under section 2-31 of this Act. 705 ILCS 405/2-4(1)*

“Older Individual” as used in these procedures means, an individual who is **65 years of age or older**.

Note: *The Older Americans Act* allows for delivery of services to older caregivers **55 and older** who are “Grandparent or Older Individual Who Is a Relative Caregiver,” defined as a grandparent or step grandparent of a child, or a relative of a child by blood, marriage or adoption, who **is 55 years of age or older** and;

- lives with the child; and
- is the primary caregiver of the child

“Service Providers” means community based-providers, representing a key segment of the Aging Network in Illinois because they provide the programs and direct services to older persons. The success that the Aging Network has had in linking older persons with needed services is one tangible result of cooperation and coordination between the Department on Aging, the Area Agencies on Aging and local service providers. Care Coordination Units (CCUs), created in 1983, function as gatekeepers to the State long-term care system by coordinating and integrating community-based long-term care services available throughout the entire aging network for and on behalf of older persons.

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d) DCFS – IDoA Intergovernmental Agreement

With the agreement, IDoA and DCFS delineate their respective roles, responsibilities, and resources associated with ensuring that the parties collaborate to ensure that older caregivers are provided the appropriate needs assessments, services and referrals in order to provide stability for both the caregiver and any child(ren) living in the home. Information shall be shared between the parties in order to ensure stability for children living in the home of an older caregiver and to ensure appropriate services are provided to the older caregiver family.

The Agreement facilitates a joint effort between DCFS and IDoA to obtain services for older caregiver families. Pursuant to the Illinois Children and Family Services Act, 20 ILCS 505/1 *et seq.*, DCFS is the entity authorized to provide social services to children and their families, to operate children's institutions, and to provide certain other rehabilitative and residential services. IDoA provides a comprehensive and coordinated service system for the State's aging population.

As the Agreement applies to older adults who are caregivers to minor children for whom DCFS has, or may have, responsibility for, DCFS is required to do the following:

- 1) Assure the safety and well-being of the child;
- 2) Maintain effective communications between DCFS/POS staff and IDoA/Aging Network;
- 3) Support and offer services to older caregivers when there are concerns about the caregiver's ability to safely care for the child in their home over time (lifespan approach);
- 4) Notify older caregivers of the concerns noted and any referrals made to the Aging Network;
- 5) Train direct service staff and supervisors on all of the policies and procedures relevant to the Agreement;
- 6) Implement and maintain a record-keeping system; and
- 7) Review compliance by Department service providers.

e) Reporting Requirements

It is the duty of DCFS and IDoA to serve and protect society's most vulnerable children, disabled, and elderly. To this end, staff (full time or contractual) of both agencies are required to report to the appropriate hotline whenever incidents of abuse, neglect or exploitation of children, the disabled, or the elderly are suspected.

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Suspected incidents abuse, neglect or exploitation to the above populations shall be reported as follows;

- Suspected incidents of child abuse or neglect shall be reported to DCFS by calling the **Child Abuse Hotline at (800) 252-2873** (24/7 statewide).
- Suspected incidents of abuse, financial exploitation or neglect of an older person, or persons with disabilities aged 18-59 shall be reported to IDoA by calling the **Adult Protective Services Hotline at (866) 800-1409** (24/7 statewide).

f) Meeting Service Needs:

Upon the initial placement, or as early as possible in the life of the case, if a caregiver is **age 65 or older** and the use of the lifespan approach suggests that given the age of the child and the age of the caregiver it is not likely that the caregiver will be able to care for the child until the age of 18, the placing or Permanency worker shall conduct a diligent search in accordance with **Administrative Procedures #22, Diligent Search** to identify and locate viable relatives to care for the child to the age of 18. The diligent search shall include but not be limited to: non-custodial parents, maternal and paternal relatives, child-centered collaterals (children 4 years and older, if developmentally appropriate, should be asked to help identify their collaterals), and other adults the child may have a relationship with in their family, school, church, synagogue, mosque, and neighborhood. These efforts shall be documented as required per **Administrative Procedures #22**.

The Integrated Assessment (IA) Clinical Screener, in partnership with the Permanency worker, within the first 45 days of the case will assess the needs and strengths of all parents/guardians and substitute caregivers. For any parent/guardian or substitute caregiver **age 65 or older**, the Clinical Screener will assess the caregiver's ability to meet the child/youth's needs of safety, permanency, and well-being using a lifespan approach. IA recommendations will be based on the child/youth's need for placement and stability. Linkage to IDoA resources will also be recommended as needed.

When the Permanency worker or Clinical Screener identify concerns about the older caregiver's capacity to safely care for the child and/or him or herself in the home, the worker shall notify her/his supervisor and contact the IDoA **Senior HelpLine (1-800-252-8966)** to request assistance for the older caregiver. Assistance may be limited to provision of supports and services available to the older relative caregiver or may involve a comprehensive assessment of the older caregiver by a Care Coordination Unit, an agency contracted with IDoA for a specific geographic area.

The Permanency worker can refer the older caregiver for an assessment or for adult protective services by calling the **Senior HelpLine (1-800-252-8966)**, provide information and resources for the older caregiver, and participate in staffings regarding the older caregiver's family. With a completed and signed **CFS 600-3 Consent for the Release of Information**, the Permanency worker and supervisor are permitted to share information about the older caregiver's overall functional capacities in their case

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planning, including but not limited to, the information gathered for the caregiver section on the CANS and the IA. A signed and completed **CFS 600-3** is **NOT required** when calling Adult Protective Services to report suspected abuse, financial exploitation or neglect of an older person or persons with disabilities. Assistance for older caregivers may be requested by calling the following numbers:

- **Senior HelpLine:** (8:30 a.m. - 5 p.m., Monday through Friday)
1-800-252-8966
1-888-206-1327 (TTY)
aging.ilsenior@illinois.gov

Or as mentioned above, to report suspected abuse, financial exploitation or neglect of an older person or persons with disabilities aged 18-59:

- **Adult Protective Services Hotline:** (Calls 24/7 statewide)
1-866-800-1409
1-888-206-1327 (TTY).

g) **Requirements of DCFS / POS Child Protection Specialists and Permanency Workers**

1) **DCFS and POS**

A) **Initial Contact**

Department and POS staff who place children and/or work with older caregiver families shall ensure that the placement is in the best interest of the child ***and*** the placement is identified as an older caregiver placement. The Child Protection Specialist or Permanency worker must obtain from the older caregiver a completed and signed **CFS 600-3 Consent for the Release of Information** in order to facilitate the exchange of information between DCFS, IDoA, and potential service providers. The DCFS or POS worker shall also give to the older caregivers the **CFS 1050-86, Grandparents and Other Relatives Raising Children** pamphlet, which provides information on how to contact the Aging Network for assistance for themselves or those in the home for whom they provide care (e.g. spouse, parent, sibling, or disabled adult children), including the children placed by DCFS/POS. Each DCFS Regional Office shall maintain a list of resources and provide DCFS and POS workers with instructions regarding how to access them.

DCFS and POS workers shall document in a contact note when they provided older caregiver information regarding services for older caregivers and their families and explain any circumstances under which this information was not provided.

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B) Placement Considerations for Children

When selecting a placement for children, DCFS and POS Child Protection Specialists and Permanency workers must be guided by the caregiver's capacity to meet the unique and diverse needs of each child to be placed and the placement must be in accordance to **Procedures 301.60, Placement Selection Criteria**. As stated above, all placements are to be made consistent with the best interests of the children. The Department will make diligent efforts to place children in a home that can maintain sibling groups together and meet their long-term needs.

When a child is placed in the care of an older caregiver as defined in these procedures, it is critical that the placement be in a safe environment and be able to meet the child's future needs, including achieving the child's permanency goal. The child's worker may need to refer to IDoA for resources for the older caregiver to help them maintain a safe and healthy placement and permanency for the child.

Services for the older caregiver obtained through a referral to IDoA, or a change in placement, may be required when an older caregiver experiences age-related impairments or challenges that impact their ability to safely care for the child and/or themselves. Age related impairments or challenges include but are not limited to:

- i) Cognitive impairments due to Alzheimer's or other dementing diseases;
- ii) Deteriorating physical health;
- iii) Sudden onset of significant health problems; or
- iv) The need to become a caregiver to another family member such as a spouse, sibling or parent.

C) Meeting Service Needs of Older Caregivers and Children in their Care

As stated above, if at any time following the initial placement of a child/ren with an older caregiver, concerns about the placement arise related to the ongoing ability of the older adult to safely care for the child/ren in the home, the worker shall notify her/his supervisor to determine whether immediate action is needed on behalf of the child and shall contact the IDoA **Senior HelpLine (1-800-252-8966)** to request assistance for the older caregiver. Assistance may be limited to provision of supports and services available to the older caregiver or may involve a comprehensive assessment of the older caregiver by a Care Coordination Unit, an agency contracted for a specific geographic area with IDoA. The worker can refer the older caregiver for a comprehensive assessment that may trigger an array of services for older adults.

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This comprehensive assessment, referred to as a Determination of Need (DON), utilizes normed and standardized tools to assess older adults across multiple domains including functional and cognitive capabilities, finances and assets. Services are matched to meet the needs determined by the assessment. Identified services are designed to help senior citizens remain living independently in their own homes.

The worker and supervisor are responsible for including information about the older caregiver's overall functional capacities in their case planning including, but not limited to, the information gathered for the Caregiver sections on the CANS and Integrated Assessment.

2) Referrals from the Aging Network

When the State Central Registry (SCR) is called regarding concerns about the older caregiver's continuing capacity to care for the child, it typically results in a referral to the Extended Family Support Program (EFSP); however, a call *may* result in a child abuse or neglect investigation, information related to a pending investigation, to an open service case, **or** a Child Welfare Services Referral. Callers may also report if the child is out of the control of the older caregiver or "MRAI," or if the child is a "dependent child" as defined in these procedures.

EFSP provides short-term services to a child residing in the care of a relative for which short-term interventions will stabilize the relative household and allow for continued care of the child in the home. A child served by this program may not have a legal relationship with the Department and must be referred for EFSP services through the State Central Register (SCR), Child Protection, Intact Family Worker, the Post Adoption Unit, or an Aging Network/IDoA caseworker calling SCR to complete a referral in the presence of the older caregiver. However, if SCR is not available and needs to return the call to the Aging Network/IDoA caseworker at a time when the older caregiver is no longer available to be on the call, the SCR call floor worker may take an EFSP referral with the information that the IDoA representative provides when such a referral is appropriate.

A) Extended Family Support Program Services

Casework interventions provided by the EFSP provider for the child may include the following:

- i) Crisis intervention and other short-term interventions to address issues within the family that threaten to destabilize the relative household and allow for continued care of the child in that household;

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- ii) Enable the relative to obtain guardianship of the child through probate court. Facilitation may include assistance obtaining required documents and, when necessary, payment of fees with EFSP emergency cash assistance;
- iii) Assistance in obtaining pro-bono legal services. (When pro-bono legal services are not available, legal fees may be paid with EFSP emergency cash assistance allocated to the family.);
- iv) Assist the relative caregiver with registering the child in the local school;
- v) Advocacy to assist the family in obtaining benefits which may include Medicaid, food stamps, SSI housing supplements, day care, and other benefits for which the family may be eligible;
- vi) Referral and brokerage of needed services that may include employment, housing, budgeting, mental health and medical services, parenting training, counseling, and therapy;
- vii) Cash assistance provided through the Extended Family Support Program Emergency Cash Assistance as specified below;
- viii) Referrals to the Illinois Department on Aging (IDoA).

B) Extended Family Support Program Emergency Cash Assistance

Families must have an open EFSP case before the family can access EFSP emergency cash assistance funds. Emergency cash assistance may be used to purchase goods and services that the family requires in order to obtain guardianship or to support stabilization of the child's living arrangement. Goods (hard services) purchased with emergency cash assistance may include beds, dressers, other furniture as required, appliances, and food in emergency situations. Emergency cash may also be used for security deposits and legal services. (Emergency cash assistance amounts will vary depending on the individual needs of each case; however, it is limited to an average of \$500.00 per case per agency.)

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h) Resources

Additional resources and information on available programs to assist families with older caregivers can be found on the internet by clicking on the links below, and on the D-net or the DCFS Website under the “older caregiver” tab found under “resources.”

Illinois Department on Aging

<http://www.state.il.us/aging/1intergen/grg.htm>

Administration for Community Living/Administration on Aging

<http://www.acl.gov/>

USA.gov

<http://www.usa.gov/Topics/Grandparents.shtml>

Administration for Children and Families: Child Welfare Information Gateway

<https://www.childwelfare.gov/preventing/supporting/resources/grandparents.cfm>

Womenshealth.gov

<https://www.womenshealth.gov/aging/caregiving/raising-children-again.html>

Brookdale Foundation

<http://www.brookdalefoundation.org/RAPP/rapp.html>

Generations United

<http://www.gu.org/>

Metropolitan Family Services (Elder Abuse (312) 986-4332; Cook only)

<http://www.metrofamily.org/>

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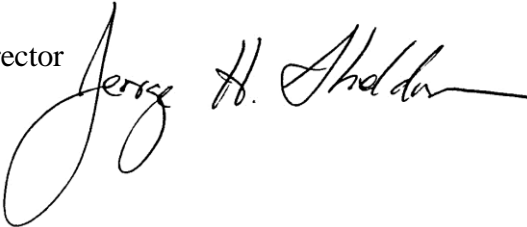
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DEPARTMENT OF CHILDREN AND FAMILY SERVICES

POLICY GUIDE 2016.10

Replaces PG 2014.20

**Procedures 300 Reports of Child Abuse and Neglect
Procedures 302 Services Provided by the Department
Procedures 315 Permanency Planning**

DATE: August 26, 2016
TO: All Child Protection and DCFS/POS Child Welfare Staff and Supervisors
FROM: George H. Sheldon, Director 
EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to provide Child Protection and Child Welfare staff for with revised and updated Safety Plan Rights and Responsibilities for Parents and Guardians, Safety Plan Rights and Responsibilities for Adult Caregivers and Safety Plan Participants and Safety Plan Rights and Responsibilities for Investigators and Caseworkers. The updated forms provide additional information for parents and caregivers, adult caregivers and safety plan participants and investigators and caseworkers regarding the formulation of the safety plan, the information that needs to be detailed in the safety plan document, the process for modification of safety plans and the process for continual review of safety plans.

The instructions in this Policy Guide will be incorporated into **Procedures 302.250 Paramour Involved Families; 302.260 Domestic Violence; 302.388, Intact Family Services, 302 Appendix A Substance Affected Families; 302 Appendix B Older Caregivers; Procedures 315.110 Worker Contacts and Interventions; Procedures 315 Appendix A CERAP and Procedures 300 Appendix G CERAP.**

This Policy Guide is effective immediately.

II. PRIMARY USERS

Primary users are all Child Protection Specialists and Supervisors and all DCFS/POS Child Welfare Workers and Supervisors.



III. BACKGROUND

Procedures 300 Appendix G CERAP/Procedures 315 Appendix A CERAP (Current)

Safety Plans

Safety plans are voluntary, temporary and short term measures designed to control serious and immediate threats to children's safety. They must be adequate to ensure the child's safety and be as **minimally disruptive** to the child and family as is reasonably possible. Additionally, families can request that a safety plan be modified or terminated at any time. The safety plan will indicate which safety threat or threats have led to the need for a safety plan according to the completion of the CERAP. The safety plan will require a written description of what will be done or what actions will be taken to protect children, who will be responsible for implementing the components of the safety plan and how/who will monitor it. It is important that safety plans be developed with the family to control specific threats and that the family understands the mechanism for ending each safety plan. **Under no circumstance is a safety plan to serve as the solution to a long-term problem. A family may request at any time to modify or terminate the safety plan.**

When a safety plan is implemented, it should be documented on a **CFS 1441-A, Safety Plan** when it is likely that a child could be moderately or severely harmed now or in the very near future. The safety plan must be developed whenever there are protective efforts that would reasonably ensure child safety and permit the child to remain in their caregiver's custody. After the safety plan has been developed, it must be immediately implemented to ensure that all of the designated tasks are completed effectively. The safety plan should contain timeframes for implementation and continued monitoring.

IV. OVERVIEW

Public Act 98-0830 amended Section 21 (f) of the Children and Family Services Act [20 ILCS 505/21] and required the Department or POS caseworker to provide information to each parent, guardian and adult caregiver participating in a safety plan explaining their rights and responsibilities. These updated forms add additional information to the Safety Plan Rights and Responsibilities forms with the following information:

- The investigator and caseworker shall implement a safety plan only when DCFS has a basis to take protective custody of a child(ren) and the safety plan is an alternative to protective custody;
- The investigator and caseworker shall explain to the parent(s)/guardian(s) the safety plan alternatives and that the parent(s)/guardian(s) have a voluntary choice to enter into the safety plan as an alternative to protective custody and to choose the individual(s) responsible for supervising or monitoring the safety plan if such person(s) is/are determined to be qualified by DCFS;
- The investigator and caseworker shall modify the safety plan if the family's circumstances change or if the participants request modifications, including a change in the person(s) preferred by the parent(s)/guardian(s) to supervise or monitor the safety plan or serve as a temporary caregiver;

- Terminate the safety plan as soon as the investigator and/or supervisor determine there is no longer a legal basis to take protective custody and provide the parent(s)/guardian(s) with the Safety Plan Termination form; and
- The Department or POS representative shall ensure that the safety plan is reviewed and approved by their respective supervisor.

V. INSTRUCTIONS

Effective immediately:

- Child Protection and Child Welfare staff shall provide the parent, guardian and adult caregiver participating in a safety plan with a copy of the **CFS 1441-A, Safety Plan** that has been signed by all adult participants and the DCFS/POS representative;

Note: Department and POS staff must use only the **CFS 1441-A, Safety Plan (Rev 12/2014)** that has been revised to meet the requirements of PA 98-0830.

- The Department or POS representative shall provide each parent/guardian, adult caregiver and safety plan participant with information explaining their rights and responsibilities including, but not limited to: information for how to obtain medical care for the child, emergency contact information for participants including phone numbers and information on how to notify schools and day care providers of safety plan requirements. The rights and responsibilities of each parent/guardian, adult caregiver, safety plan participant and child protection/child welfare staff are listed in new forms **CFS 1441-D, Safety Plans Rights and Responsibilities for Parents and Guardians; CFS 1441-E, Safety Plan Rights and Responsibilities for Responsible Adult caregivers and Safety Plan Participants; CFS 1441-F, Safety Plan Responsibilities for Child Protection Specialists and Child Welfare Caseworkers**. All **CFS 1441** forms are available in central stores, templates, and the website; and
- After receiving verbal supervisory approval of the safety plan prior to leaving the family home, the Department or POS representative shall submit the signed **CFS 1441-A** to their respective supervisor for review and approval.

VI. ATTACHMENTS

CFS 1441-D, Safety Plans Rights and Responsibilities for Parents and Guardians (Revised 08/2016);

CFS 1441-E, Safety Plan Rights and Responsibilities for Responsible Adult caregivers and Safety Plan Participants (Revised 08/2016); and

CFS 1441-F, Safety Plan Responsibilities for Child Protection Specialists and Child Welfare Caseworkers (Revised 08/2016).

Please note that the **CFS 1441-A** is printed on a 6 Part form and available from Central Stores. The **CFS 1441-D – F** are printed on regular paper and available from Central Stores, DCFS Website and T drive. All forms will be available in Spanish.

VII. QUESTIONS

Questions regarding this Policy Guide may be directed to the Office of Child and Family Policy at 217-524-1983 or via Outlook at OCFP – Mailbox. Non Outlook users may e-mail questions to cfpolicy@idcfs.state.il.us.

VIII. FILING INSTRUCTIONS

Remove and replace Policy Guide 2014.20 with this Policy Guide immediately after **Procedures 302.250 Paramour Involved Families; Procedures 302.260 Domestic Violence; Procedures 302.388 Intact Family Services; Procedures 302 Appendix B Older Caregivers; Procedures 315.110 Worker Contacts and Interventions; Procedures 315 Appendix A CERAP and Procedures 300 Appendix G CERAP.**

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APPENDIX C – HUMAN TRAFFICKING

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I. Purpose

The purpose of these procedures is to establish requirements and provide instructions for Department and Purchase of Service (POS) staff when children for whom the Department is legally responsible are believed to be the victims of human trafficking. The level of Department involvement will be individualized and in correlation to the assessed safety and risks of the child.

The Illinois Safe Children Act (2010) eradicates the pejorative term “juvenile prostitute” from Illinois statutes and requires that minors engaged in commercial sexual activities be treated as victims of human trafficking and not as juvenile offenders. The Illinois Safe Children Act also mandates that children be identified and served through IDCFS as minor victims of trafficking with access to all the services and support provided through federal and state laws.

Children who are victims of human trafficking often do not perceive the inherent risks or see themselves as victims. This is especially true for children who are identified as “high risk.” Because of the potential dangers to the child, if the child’s worker has reason to believe the child is a victim of human trafficking, the worker is to consider the event as requiring intensive intervention.

II. Definitions

“Coercion” means threats of serious harm to, or physical restraint of, any person; any scheme, plan or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to, or physical restraint against, any person; or the abuse or threatened abuse of the legal process.

“Commercial Sex Act” means any sex act on account of which anything of value is given to or received by any person. [U.S.C. §7102(8)]

“Commercial sexual exploitation of a child” (CSEC) means the use of any person under the age of 18 for sexual purposes in exchange for cash or in-kind favors; it can occur between a child and a customer, the pimp/trafficker of others (including family members) who profit from children for these purposes.

“Force” means the use of any form of physical force, including rape, beatings and confinement to control victims.

“Forced labor” means the obtaining of labor or services of another person through any one of the following prohibited means: (a) force, threats of force, physical restraint, or threats of physical restraint; (b) serious harm or threats of serious harm; (c) abuse or threatened abuse of the law or legal process; or (d) a scheme, plan, or pattern intended to cause or to believe that, if the person did not perform such labor and services, that the person would suffer serious harm or physical restraint.

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“Fraud” means false offers that induce people into trafficking situations.

“Harboring” means to receive or hold a person in a place without legal authority.

“High Risk Child” means that the child’s safety is severely compromised for one or more of the following reasons:

- The child is pregnant and/or parenting;
- The child has severe emotional problems that if not treated will place the child at severe risk;
- The child has a developmental disability that impairs the child’s ability to care for her or himself; or
- The child has a serious alcohol and/or substance problem.

“Involuntary servitude” means a condition of servitude induced by means of any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such condition, that a person or another person would suffer serious harm or physical restraint; or, the abuse or threatened abuse of the legal process.

“Labor” means work of economic or financial value.

“Recruitment” means the process of enlisting or convincing a person to join with another person for a stated purpose.

“Services” means a relationship between a victim and an individual in which the victim performs activities under the supervision of or for the benefit of the individual. Commercial sexual activity and sexually –explicit performances are forms of service under this definition.

“Servitude” means slavery; the condition where a person is forced to perform labor or services, against his or her will, by another person.

“Sexually-explicit performance” means a live, recorded, broadcast (including Internet) or public act or show intended to arouse or satisfy the sexual desires or appeal to the prurient interests of patrons.

“Sex Trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

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III. Identification of Human Trafficking

Federal law defines trafficking in persons as: sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, obtaining, patronizing or soliciting of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery. [22 U.S.C. §7102(10)]

Note: For the purpose of these procedures, victims of human trafficking include all youth for whom the Department is legally responsible, including those between the ages of 18-21.

Sex trafficking of minors occurs when minors are involved in commercial acts, including prostitution, sexually explicit performance or production of pornography. Sex trafficking cases involving minors do not require force, fraud, or coercion as they do for adults over 18 years. Therefore, any person under 18 years of age engaged in any type of commercial sexual activity is deemed a victim of human trafficking under Illinois and Federal laws.

Trafficking victims do not need to be in fact “locked up” by their trafficker, and sometimes attend school and participate in other normal activities. It is important to note that although the word “trafficking” implies movement, a victim of trafficking may never cross international or state lines.

Workers shall utilize the following list of indicators to identify possible human trafficking. It is important to note that not every child who exhibits one of these indicators is a victim of human trafficking. Although an indicator may warrant concern, none of these indicators stand alone or exist without context.

- History of running away or current status as a runaway;
- The child makes references to travel to other cities while on run;
- The child makes reference to being coerced into performing illegal activities;
- The child makes reference to having a pimp or “daddy”;
- The child has current signs of physical abuse and/or sexually transmitted diseases;
- The child seems submissive or fearful;
- Inexplicable appearance of expensive gifts, clothing, manicures, pedicures or other costly items;
- Presence of an older boyfriend/girlfriend;
- Withdrawal or lack of interest in previous activities;
- Tattoos or branding (could be pimp/trafficker’s name);
- Possession of a cell phone;
- Postings on social networking sites;
- Child was located in a hotel/motel;
- The child has been isolated from sources of support and protection;

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- The child makes reference to sexual situations that are beyond age-specific norms;
- The child engages in sexually provocative behaviors, is promiscuous and/or has unprotected sex with multiple partners; or
- The child makes references to terminology of the commercial sex industry.

IV. Prevention of Human Trafficking

Youth for which the Department is legally responsible are extremely vulnerable to, and are actively targeted by traffickers. Prevention is the key to building the protective factors and resiliencies of the youth living within the child welfare system and to deter the recruitment methods of individuals wanting to exploit them. Proper identification of possible trafficking is critical to ensuring the safety of youth in care. A comprehensive response to possible trafficking will increase the success of removing youth from dangerous and often life threatening situations before actual trafficking occurs.

Caseworkers should refer to Section III of these procedures, particularly for youth placed in residential facilities or group homes, to identify possible risk factors for human trafficking.

If a caseworker suspects a youth is vulnerable to human trafficking, he/she shall engage the youth with a discussion regarding the risks and realities of human trafficking. The caseworker must also discuss possible risk with the youth's caregiver and document the discussions with the youth and caregiver in a **Contact note**.

After consultation with supervisor, the consultation, discussions and known risk factors regarding human trafficking must be documented in a **Supervisory note**. The note will include a description of known risk factors and actions needed to deter the youth from possible human trafficking.

Additional information regarding prevention of human trafficking can be obtained via D-Net, under the "Human Trafficking" link or by contacting **the Statewide Human Trafficking Coordinator via "DCFS Human Trafficking" mailbox on Outlook**.

V. Reporting Requirements for Caregivers, Workers and Supervisors

a) Reporting Requirements for Caregivers

Caregivers, including foster parents, relative caregivers, and staff of residential facilities, shall immediately report alleged human trafficking to:

- 1) the child's case manager/worker; and
- 2) the DCFS Child Abuse Hotline (1-800-25-ABUSE) also known as the State Central Register (SCR) in accordance with Department **Rules 300, Appendix B, The Allegation System**.

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b) Reporting Requirements for Workers

When a worker learns that a youth for whom the Department is legally responsible is a victim of human trafficking, the worker shall immediately:

- 1) Notify the DCFS Guardian and the child's Guardian ad Litem;
- 2) Notify the child's counselor, therapist or mental health professional if applicable;
- 3) Report the alleged trafficking to SCR in accordance with Department **Rules 300, Appendix B** (if not already done by caregiver);

Note: If a report of child abuse/neglect is not accepted by SCR (or the child is 18 or over), the worker will have in-person contact with the child to engage the child, ascertain information and reduce the possibility of the child leaving care. Collateral contacts must also be made with individuals who may be able to provide information regarding the alleged human trafficking (e.g., residential/group home staff or foster family, peers, school personnel, family members, etc);

- 4) Document in SACWIS via human trafficking indicator in the child's record (required for the initial report of human trafficking only);
- 5) Complete the **CFS 119 Unusual Incident Report (UIR)**, using code L13 (Human Trafficking of a DCFS Ward) on Part 2 of the **CFS 119**, to report human trafficking in accordance with Department **Procedures 331, Unusual Incidents Involving Department Clients, Employees, and Facilities**;
- 6) If the youth is missing from care, refer to **Procedures 329, Locating and Returning Missing, Runaway and Abducted Children**, and select the "Human Trafficking/Prostitution" risk factor on the **CFS 1014, Missing Children Recovery Report** form, if applicable.

The worker shall document all known or suspected information regarding the alleged human trafficking in a case note including but not limited to:

- i. When and where the alleged trafficking occurred;
- ii. Name(s), including all "AKAs," and date(s) of birth or age(s) of alleged trafficker(s);
- iii. Describe the relationship of the trafficker to the youth/how did they come in contact with one another;
- iv. Methods of contact between the trafficker and the child (internet (specific: email, social networking sites, chat rooms, etc), cell phone, in-person, peers, family members, etc);
- v. Alias names or dates of birth for the youth used.

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c) Requirements for Supervisors

- 1) Upon notification by the worker of a child's involvement in human trafficking, the supervisor will immediately confirm the worker has completed all of the required reports and contacts as described in Section IV of these procedures;
- 2) The supervisor will confirm that the human trafficking indicator in SACWIS has been selected;
- 3) The supervisor will review the case note(s) completed by the worker to ensure the required information regarding the trafficking has been documented;
- 4) The supervisor will assist the worker in developing and implementing a plan to provide an appropriate change of placement if needed, and services for the child. A summary of the discussion and plan shall be documented in a **Supervisory note**.

VI. The Role of the Child Intake and Recovery Unit (CIRU)

Youth involved in human trafficking are almost always missing from placement when trafficking occurs, therefore including the DCFS Child Intake and Recovery Unit (CIRU) is crucial to the process of identification and recovery.

- a) CIRU will forward any information regarding a missing youth and human trafficking via **“DCFS Human Trafficking” mailbox on Outlook to the Statewide Human Trafficking Coordinator**, and also to the worker;
- b) CIRU will document the information in the missing child section in SACWIS to aid in current or future incidents of the child missing from care;
- c) When appropriate and necessary, CIRU will share information with law enforcement and shelter staff, to ensure the child's safety.

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VII. Assessment and Safety

Workers, in consultation with their supervisors, are responsible for determining the immediate actions to be taken when a youth is involved in human trafficking. The supervisor and worker shall assess any immediate safety concerns, identifying the actions that are necessary to minimize any risks and ensure those actions are taken as expeditiously as possible.

A trafficked child can be either abducted by his/her trafficker(s) or lured to meet them. Consideration should be given to moving the child to a new placement to ensure the child's safety when necessary. If the child is moved to a new placement, strict confidentiality (only those with an absolute need to know the location of the new placement should be informed) is necessary to avoid the trafficker(s) from obtaining information on the child's whereabouts. Consideration should be given to the role of those in contact with the youth and the specific reason why he/she would need to be made aware of the youth's new placement location. Additionally, the trafficked youth and other youth at the facility or placement should not be informed of where the trafficked youth is being moved. Every measure possible should be taken to protect the privacy and identity of child victims in order to ensure their safety and security.

On rare occasions it may be necessary to move a youth quickly and confidentially to avoid possible abduction and/or harm. On those occasions the Statewide Human Trafficking Coordinator will work directly with the Chief of the Bureau of Operations or his/her designee and the assigned caseworker and supervisor to facilitate such a rapid and confidential placement. Once the confidential placement has been accomplished the worker can proceed with development of the Human Trafficking Supervision Plan as described in Section VII (b) below.

Note: When trafficked victims are moved, other youth in the placement known to traffickers remain at risk. Measures should be taken to secure the facility or placement by notifying law enforcement and informing all facility staff or caregivers of any possible threat.

a) Risk Factors

Workers shall refer to the list below to determine any current or future human trafficking safety threat to the child or another child in care. Any of the following factors may contribute to increased risks and must be addressed when assessing safety and minimizing risks.

These factors include:

- 1) The child is in contact with an alleged trafficker;
- 2) The alleged trafficker knows the location of the child's placement;
- 3) The alleged trafficker has threatened to harm the child or others close to the child (including other foster children in the same placement);

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- 4) The child is in contact with other people involved in human trafficking;
- 5) The child has a history of running from placement;
- 6) The child states intent to engage in trafficking in the future;
- 7) The child expresses a fear for his/her safety;
- 8) The child has previously recruited or may attempt to recruit another child to become involved in human trafficking.

b) The Human Trafficking Supervision Plan

If based on factors outlined above in Section VII(a), the child is determined to be at a high risk of harm from a trafficker or subsequent commercial sexual exploitation, the worker shall convene a Child and Family Team meeting (CFTM), to develop a **Human Trafficking Supervision Plan**, to ensure the child has appropriate supervision in all areas of daily life. The Child and Family Team must include, among others: the youth, if age 12 or older, the primary caregiver, the caseworker and his/her supervisor, the youth's therapist or other treatment provider who is familiar with the youth's history, behavior and living arrangements, and other adults responsible for the youth's supervision.

Describe in detail (including phone and internet access) how an effective level of supervision will be provided to the youth during the following routine activities:

When planned supervision is required in the placement, the caseworker shall discuss the required supervision with the caregiver/facility staff and document the details of the planned supervision in a **contact note**.

When planned supervision is required in the school setting, the caseworker shall discuss the required supervision with school personnel and document the details of the planned supervision in a **contact note**. The caseworker will obtain all the required signatures on the **CFS 600-3, Consent for Release of Information** form regarding the youth who requires planned supervision.

When planned supervision is required for the youth to participate in recreational or community activities, the caseworker shall discuss the required supervision with the person or staff responsible for the supervision and document the details of the planned supervision in a **contact note**. The caseworker will obtain all the required signatures on the **CFS 600-3**, regarding the youth who requires planned supervision.

The caseworker will have a discussion with the youth regarding the Human Trafficking Supervision Plan and the safety measures the child will take if he/she has any contact whatsoever with the trafficker or with another person acting on behalf of the trafficker. Any specific tasks for the child regarding his/her safety shall be included in the child's **Service Plan**. The discussion with the youth will be documented in a **contact note**.

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The caseworker and supervisor will monitor the plan weekly via phone or email and monthly in-person with the caregiver/facility staff and any other staff/personnel currently providing supervision to the youth, to revise and/or terminate the plan as needed. The caseworker's review of the Human Trafficking Supervision Plan will be documented in **case note**.

c) Termination of the Human Trafficking Supervision Plan

Termination of the Human Trafficking Supervision Plan will be determined at a CFTM, which must include, among others: the youth, if age 12 or older, the primary caregiver, the caseworker and his/her supervisor, and the youth's therapist or other treatment provider, and other adults responsible for the youth's supervision. CFTM participants must consider the following factors when considering the need for an ongoing Human Trafficking Supervision Plan:

- 1) The youth's current behaviors and behavioral changes, including the youth's ability to effectively monitor and manage his/her behavior and his/her safety;
- 2) The youth's support network;
- 3) Amount and type of contact if any, the youth has with the trafficker or another person acting on behalf of the trafficker.

VIII. Placement Considerations

To ensure appropriate care and intervention for victims of human trafficking, caregiver(s) (including residential and group home staff) should have a firm grasp and understanding of trafficking including the characteristics of trafficking, effects on victims (psychological, emotional and physical) and the implications for service delivery.

Caregivers must be mindful that the crime of trafficking causes a severe breakdown of confidence and trust for victims and that to rebuild trust and a normal relationship for trafficking victims requires patience, awareness and skill. Caregivers should be empathetic and non-judgmental in their approach to victims.

- a) When human trafficking of a youth is alleged, suspected or known, a discussion concerning trafficking shall occur between the worker and the youth's caregiver to ensure the placement is appropriate and the caregiver continues to be able to meet the needs of the youth. A summary of the discussion shall be documented in a **contact note**.
- b) When human trafficking of a youth is alleged, suspected or known, the worker will convene a CFTM and/or a Clinical Intervention Placement Preservation (CIPP) meeting to evaluate the appropriateness of the child's current placement and/or to identify the need for a new placement, if necessary.

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- c) If a child is missing from care and is known or suspected to be involved in human trafficking, an appropriate placement plan must be determined for when the child is recovered. Every effort should be made to avoid emergency shelter placement of a trafficked youth.
- d) If a child who is a suspected or known victim of trafficking indicates that he or she will not accept the placement selected by the Department, every effort must be made to engage the child in identifying a placement the child is willing to accept in accordance with **Procedures 329.60, Placement Considerations**.

IX. Medical Examinations

Medical examinations of suspected or known trafficking victims shall be completed and include physical, sexual, and substance use assessments and/or screens. If a particular evaluation is refused, sustained efforts need to be made to engage the youth, and a plan developed with the youth to have the evaluation done at a later date.

a) Medical Examinations must include but may not be limited to:

- Routine physical assessment;
- Assess for signs of physical abuse;
- Assess for signs of medical neglect, nutritional status;
- Check for tattoos or other markings or branding.

b) Sexual Screens must include but may not be limited to:

- Pregnancy test (when appropriate);
- STD testing (when appropriate);
- Assess for signs of sexual abuse.

c) Substance Use screens must include but may not be limited to:

- Query about substance use history;
- Assess for signs of substance use;
- Test for recent substance use; and
- Assess for withdrawal symptoms.

X. Mental Health Assessment and Services

Victims of human trafficking require trauma-informed care which recognizes the impact of traumatic experiences (specifically violence and abuse) on an individual's life, behavior, and self-perception. "Do no harm" is the first principle of ethics in service delivery to trafficking victims given the extreme risks associated with trafficking, the fragile state of many of its victims, and the potential for increased trauma.

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Mental health effects that victims of human trafficking may present include:

- Post Traumatic Stress Disorder;
- Depression;
- Disconnection from feelings and/or a flat affect;
- Anxiety Disorders;
- Self-blame;
- Suicidal ideation and gestures;
- Paranoia;
- Stockholm Syndrome;
- Fatalism and rage;
- Dual diagnosis;
- Self-care issues;
- Sleeping issues;
- Dissociative Disorder;
- Feelings of hopelessness, helplessness;
- Nightmares;
- Anger and anger management issues.

a) **Mental Health and Trauma Assessment**

General mental health and trauma screening assessments shall be completed on all youth who are suspected or known victims of trafficking. If an initial screening is completed in an emergency room or by SASS, a thorough assessment should also be completed following placement. When a youth has an existing therapist and/or medication provider, the therapist or provider should be utilized for assessments whenever possible. The assessor will discuss with the youth any fears or concerns the youth has regarding his/her own safety. These assessments should be scheduled within (2) two weeks of identification as a trafficking victim.

b) **Clinical Consultation**

Per **Policy Guide 2012.03**, a clinical consultation can be requested to provide support to investigative and casework personnel in planning and obtaining clinical services for youth that are beyond the ability of the existing array of services. A consultation is a supportive clinical activity where a youth's case is reviewed and analyzed to provide guidance and insight. This may include the consideration of various practice alternatives that will enhance the determination of a course of action.

The worker and supervisor should discuss the need for a clinical consultation prior to completing the **CFS 399-1, Clinical Referral** form and emailing it to the Outlook mailbox "clinicalref" or calling 855-814-8421 or 312-328-2075.

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c) Mental Health Services

According to the International Organization for Migration (IOM) Handbook on Direct Assistance for Victims of Trafficking, individual counseling for human trafficking victims should consist of brief interventions focused on practical problem solving and behavior. The objective of individual counseling is to help the trafficking victim learn or develop skills to cope with, and adjust to, the immediate circumstances with a view to a full recovery. Interventions are aimed to assist trafficking victims to cope with specific life situations and the immediate next steps of the process towards recovery. Problem-solving strategies and coping mechanisms in relation to issues of immediate concern, such as restoration of emotional and physical stability, personal safety, cooperation with law enforcement in legal proceedings should be included in the therapeutic process.

The IOM Handbook on Direct Assistance for Victims of Trafficking may be downloaded and saved by clicking on the following link:

http://publications.iom.int/bookstore/index.php?main_page=product_info&products_id=116

If the youth is placed in a residential facility, the youth's needs and interventions addressing human trafficking will be included in the youth's treatment plan. Otherwise, the youth's needs and interventions addressing human trafficking will be included in the youth's treatment plan with the therapist/counselor.

XI. Involvement of Law Enforcement

The Illinois Safe Children Act ensures innocent youth under the age of 18 who are lured or coerced into prostitution are immune from criminal prosecution. Although immune from prosecution for a prostitution offense, youth can be taken into protective custody and detained by law enforcement for investigative purposes. When this occurs, the officer is required to report an allegation of human trafficking to SCR, which shall take a report for the Department to initiate an investigation of child abuse or neglect within 24 hours.

Encounters with law enforcement are stressful in many ways for trafficking victims. Youth may fear they are under suspicion or may be arrested, that they will not be believed or may suffer from anxiety related to the intrusive and intense nature of an investigation. Trafficked youth may have a pre-existing fear and suspicion of law enforcement officials, often due to the influence of his/her trafficker.

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In order to minimize any anxiety that may be felt by the youth, and to coordinate involvement with law enforcement:

- a) The Statewide Human Trafficking Coordinator will act as the Department liaison to law enforcement when youth in care have been trafficked and will refer information to the appropriate authorities.
- b) If law enforcement personnel request an interview with a youth (under the age of 18) regarding human trafficking, the Office of the DCFS Guardian (312-814-8600) must be notified and grant approval for the interview.
- c) The assigned worker shall have a discussion with the youth prior to the interview with law enforcement to explain the reason for the interview and to ensure the youth understands **he/she will be interviewed as a victim**. A summary of the discussion will be documented in a **contact note**.
- d) Sometimes, the youth will be arrested on allegations of committing other crimes, even though the initial encounter with law enforcement was based upon allegations of human trafficking. If the DCFS youth is subject to other criminal charges, the youth's worker shall contact the Office of the DCFS Guardian at 312-814-8600 to request legal representation for the youth.

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July 1, 1984

SUBPART C: DEPARTMENT CHILD WELFARE SERVICES

APPENDIX D – SERVICES TO UNACCOMPANIED MINORS

I. Purpose

The following outlines the necessary procedures to follow in providing services to unaccompanied minors.

II. Definition

According to the Department of Health and Human Services, "A refugee unaccompanied minor or a Cuban/Haitian Entrant unaccompanied minor is defined as a person who: 1) has not yet reached eighteen years of age or such higher age as may be established by the State of placement according to its child welfare plan under Title IV-B of the Social Security Act for the availability of such services for any other children in the State; 2) entered the Country unaccompanied by a parent or an immediate adult relative, ie., grandparent, aunt, uncle, or adult sibling who is willing and able as determined by a Court to care for the child, or any adult who arrived having documentable evidence of legal custody of the minor; 3) has no parent(s) in the United States." The vast majority of unaccompanied minors are from Indo-China. However, a small number of children can also be anticipated to arrive from other regions; i.e., Middle East, Eastern Europe, Africa and Central America.

III. Means of Entry Into Country

Most unaccompanied minors arrive in the United States through the efforts of national voluntary agencies which operate resettlement reception and placement services under contract with the Department of State. Others arrive as non-relative members of a family group from the same camp. These children do not arrive on a planned basis and the adults with whom they live do not have guardianship. Some also arrive after having falsified their birthdates.

IV. Responsibility for Service

Department of Health and Human Services policy states that "the State public child welfare agency should assume legal responsibility for unaccompanied minors within its geographic jurisdiction." Federal policy further states that "the purpose of establishing legal responsibility is to ensure that unaccompanied minors receive the full range of assistance, care and services to which a child in the State is entitled and to designate a legal authority to act in place of the child's unavailable parent(s)."

V. Procedures to Follow in Providing Service

When unaccompanied minors are identified by the voluntary agencies in Illinois which serve refugees and Cuban/Haitian entrants, the agencies will contact Ralph Hanebutt (217) 785-2687 in Central Office. Mr.

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Hanebutt will refer the case to the appropriate Region for follow-up. The first step will usually require the Field Office caseworker and the voluntary agency representative who is knowledgeable about the child to contact the State's Attorney's Office in the County where the child resides. The voluntary agency representative will provide the Court with the necessary information to substantiate a dependency petition.

Simultaneous with planning the Court process, the Department caseworker and the voluntary agency representative should arrive at a decision regarding the ongoing case handling. Some of the voluntary resettlement agencies also operate foster care divisions. In serving referrals from such agencies, the Department must decide whether to refer the child for purchase of care, or to provide the service directly. If the voluntary resettlement agency does not have a foster care division, the Department caseworker will decide whether to refer the child to a voluntary agency which has a foster care contract with the Department, or to plan for the child directly.

The majority of unaccompanied minors have been residing with refugee families. In those instances an assessment must be made of the child's adjustment in the home and the family's willingness and ability to be licensed as a foster home.

VI. Payment for Services

All of the Department's expenses involved in providing the necessary room and board, medical care, social services and administrative cost are 100% reimbursable by the Federal Government. When the Department has been awarded guardianship of an unaccompanied minor, the caseworker shall complete the following steps in order to assure that the cost of care will be charged to the appropriate account:

- A. Open a service case, but do not make an entry in the payment section of the Module.
- B. Call Pete Pirrera in the Office of Financial Management (217/785-3091) to secure a child's I.D. number. Unaccompanied Minors I.D. numbers carry a V prefix.
- C. Submit all vouchers for services provided to Pete Pirrera who will arrange for their payment from the Refugee Assistance Fund.

If it is decided that service will be provided by a private agency with whom the Department has an approved contract for regular foster care, that contract will need to be amended to provide for service to either Refugee Unaccompanied Minor or Cuban/Haitian Entrant Unaccompanied Minors.

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VII. Payment for Administrative Costs

Federal Regulations and the Inter-Agency Agreement provide for the reimbursement of all administrative expenditures incurred in the process of serving Unaccompanied Minors. The following procedures shall be followed in the recovery of expenditures for specific line items:

A. Personal Services

1. An employee whose job description reflects full-time service to Unaccompanied Minors shall be paid from Fund 684.
2. An employee whose job description reflects some service to Unaccompanied Minors shall keep a daily log of time to the nearest one-half hour that is devoted to this client population. The log shall be turned in to the office timekeeper at the end of each month. At the end of each quarter, timekeepers shall forward the logs and a statement of the number of hours the employee worked during the quarter to Ralph Hanebutt in the Division of Program Operations. Employees will be transferred to the Fund 684 payroll for the equivalent number of full pay periods earned during the previous quarter. Any time not compensated in one quarter shall be carried over and added to the hours worked in the next quarter.

B. Retirement and Social Security

Employees who are compensated from Fund 684 shall also have their Retirement and Social Security charged to that fund during the same pay period.

C. Group Insurance

Group insurance for employees paid from Fund 684 shall also be charged to that fund during the same period.

D. Travel

Any travel expenses incurred in conjunction with services to Unaccompanied Minors shall be charged to Fund 684. The Appropriation Account Code number is 684-41817-1900-00-99.

E. Telecommunications

Employees who frequently need to place long distance calls in conjunction with services to Unaccompanied Minors shall be provided with telephone credit cards. Payment for credit card calls shall be vouchered separately and charged to Fund 684.

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F. Contractual - Commodities - Printing

Any verifiable expenditure which has a direct relationship to serving Unaccompanied Minors shall be charged to Fund 684.

G. Staff Development

Department staff who work directly or indirectly with Unaccompanied Minors may attend conferences, meetings, or courses which serve to enhance their understanding of the needs of this client population. Expenses for travel, meals, lodging and miscellaneous expenses shall be paid in accordance with State Travel Regulations. Registration fees may be paid upon submission of a paid receipt. Out-of-State Travel Regulations shall apply to any Out-of-State travel.

VIII. Payment Approval and Payment Processing

The Regional Administrator or his designee shall sign as Receiving Officer for the expenditure of all funds for direct service, purchase of service, and Regional administrative expenses consistent with Department Procedures. All required vouchers shall be typed in the Region and submitted to the Office of Financial Management for scheduling and payment processing.

IX. Program and Budgetary Planning and Monitoring

The Division of Program Operations shall be responsible for program and Procedures development and compliance monitoring. Likewise, this Division shall be responsible for budgetary planning and liaison activities with the Department of Public Aid and the HHS Office of Refugee Resettlement. Any questions regarding these procedures shall be directed to Ralph Hanebutt.

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SUBPARTC: DEPARTMENT CHILD WELFARE SERVICES

APPENDIX E – SERVICES TO CHILDREN OF WOMEN AT DWIGHT CORRECTIONAL CENTER

I. Purpose

These procedures detail the process to be followed when children are born at the Dwight Correctional Center as well as the process for providing special support services to children for whom DCFS is legally responsible whose mothers are incarcerated at the Dwight Correctional Center. These procedures apply to all Regions.

II. Services for Infants Born at Dwight Correctional Center

- A. Dwight Correctional Center staff will coordinate arrangements for placing infants born to inmates.
- B. DCFS will be contacted only when relative resources are not available or appropriate. The mother's residence for DCFS service purposes shall be the community in which she lived immediately prior to her commitment to Dwight.
- // C. The DCFS region serving the mother's residence has total case responsibility (opening, payment and planning). In those instances where the Juvenile Court serving the mother's residence refuses to take venue, the region serving the mother's residence continues to have total case responsibility.
- // D. The DCFS Peoria Region, through its Ottawa Office, will provide specific services at the request of the mother's resident DCFS Region. Services to be provided by Ottawa Office staff will be negotiated with them and entered in the service plan. They may include, but are not limited to, securing court ordered temporary custody through the LaSalle County Juvenile Court and attending the shelter care hearing. Ottawa Office staff will not remove the child from the hospital, transport the child nor place the child unless services were specifically agreed and recorded in the service plan.
- E. Services to the child will be provided as they are for all other children for whom DCFS is legally responsible and shall include the special support services specified below.
- F. The following process applies when DCFS becomes involved for placement of an infant born at Dwight:
 - // 1. Dwight Correctional Center staff shall contact (2-3 months prior to delivery whenever possible) the appropriate Field Services Supervisor (Administrator, Residential Care Program in Cook County) who has administrative responsibility for the mother's residence to obtain assistance in arranging for placement of the unborn child;

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- // 2. The Field Services Supervisor (Administrator, Residential Care Program in Cook County) will assign the appropriate child welfare staff/unit to follow up on the referral. The assigned child welfare worker shall:
 - o notify the Ottawa Office supervisor of the impending birth and approximate delivery date. Ottawa Office staff will notify the LaSalle County State's Attorney of the impending birth.
 - o make the necessary plans for placement prior to the child's birth.
- 3. Dwight Correctional Center staff will immediately notify the worker of the child's birth;
- // 4. Upon receiving notification of the child's birth, the worker shall contact the Ottawa Office which in turn will petition for temporary custody of the child through the LaSalle County Juvenile Court, attend the shelter care hearing, and present the court order to the hospital;
- 5. The assigned worker shall make arrangements to pick the child up from the hospital, secure the temporary custody order from the hospital, and place the child as appropriate;
- // 6. The LaSalle County State's Attorney will be asked to process a "change of venue" to the county of the mother's residence or, where that is not possible, to the county where the child is placed; and
- // 7. The assigned worker shall notify the State's Attorney in the county of the mother's residence or, where applicable, the county where the child is placed, of the temporary custody order and arrange for an appropriate hearing.

III. Special Support Services for Incarcerated Mothers

When children meet the following requirements, the children and their mothers are eligible for special support services:

- o children under age 18 for whom the Department is legally responsible, and
- o whose mother is currently incarcerated at Dwight, and
- o whose permanency goal is RETURN HOME TO THE MOTHER upon her release from Dwight.

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A. Special Support Services Available

The following services are available to children and their mothers who meet the above criteria.

1. Monthly updates to inform the mothers how their children are progressing in substitute care.
2. One visit per month between the children and their mothers.

The services to be provided to the incarcerated mothers and children (phone calls and visits) shall be recorded on the CFS 497, Client Service Plan, Part II, Task/Objective Statement.

B. Support Service Implementation

1. Telephone Calls From DCFS Workers to Incarcerated Mothers

// DCFS workers shall call incarcerated mothers once per month if they do not accompany the child on their visits. DCFS workers shall call the Dwight Correctional Center's Clinical Services Supervisor, Jean Fairman, who will schedule a time for the workers to speak to the mother. Ms. Fairman can be reached at (815) 584-2806. The purpose of these calls to the mothers will be to:

- o update the mother on how her children are doing in substitute care.
- o make advance plans for family reunification--especially as the mother approaches her release date.

2. Visitations By Children To Their Incarcerated Mothers

DCFS workers shall offer to assist in arranging visitations. DCFS shall pay for one visit per month by the eligible children to their mothers at Dwight. The mother, or the child if the child is 12 years old or older, may decline to receive or to make visits. When this occurs, the DCFS worker shall verify the reason for non-participation and shall document that reason in the case record. In some situations the worker may wish to reevaluate the permanency goal.

Each Region can develop its own approach to arranging and paying for these visits.

- a) Supervisors or Supervisors of Field Services will decide the type of responsible adult who shall accompany the eligible children on the visits. Individuals include:

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Foster parents
Homemakers
Advocates
Volunteers
DCFS workers

- b) CFS workers will ensure that an adequate number of responsible adult(s) accompanies each DCFS child or group of DCFS children visiting Dwight to ensure that the children's physical and personal needs are met during the travel time and during the visit itself.
- c) CFS workers will telephone both the caretakers and the mothers and inform them that this special visitation support service is available. DCFS workers shall assist mothers and caretakers in making visitation arrangements as requested.

3. Visitation Travel Expenses

- a) When wards are transported on these visits by DCFS workers or by advocates or homemakers working under individual contracts, their regions shall pay for the visits from their travel lines.
- b) When wards are transported on these visits by advocates or homemakers working under agency contracts, then travel is part of the agency contract.
- c) When wards are transported on these visits by public transportation, then regions shall pay for these visits out of the children's personal and physical maintenance line.
- d) Under the terms of a special service contract with DCFS, the CAUSES (Child Abuse Unit for Studies, Education and Services) is currently providing direct services to Dwight mothers--especially those whose children are in placement with DCFS. The coordinator can be reached at (312) 883-7169.

C. Record of Visits and Telephone Calls

Staff are to maintain a record of parent-child visits on the CFS 497, Part V, Visiting Record and telephone calls to the mothers on the CFS 492, Case Entry.

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302.APPENDIX F - Employment Incentive Program

a) Purpose

The purpose of the Employment Incentive Program (EIP) is to provide financial and supplemental services to support adolescent youth learning marketable job skills either through on the job work experience or job training programs. Youth that complete the EIP will have acquired the work skills and ethics necessary for the successful transition to independence.

b) Program Eligibility Requirements

- 1) The youth must be 17 years of age but not yet 21.
- 2) The Department must have court-ordered legal responsibility for the youth.
- 3) The youth must have received independent living skills training and adhere to the life skills assessment and training requirements of Appendix M. If an adaptive skills assessment is appropriate for assessing the youth's skill level, program readiness will be determined on an individual basis. The assessment must be current within six months of the youth applying for the EIP.
- 4) The youth must have a high school or General Educational Development (GED) certificate.
- 5) The youth must be receiving job training through a certified job skills-training program (e.g., Job Corps, apprenticeship, internship), or the youth must be employed for a period of at least one month prior to applying for the EIP and working a minimum of 20 hours per week.

c) Benefits

1) Monthly Grant

Youth approved for the EIP will receive a grant of \$150.00 per month for a maximum of 12 months. The youth may receive the monthly grant in consecutive or non-consecutive payments depending on the youth's sustained or intermittent participation in the program. Monthly grant payments cease when a youth turns 21 years of age regardless of whether the youth completed 12 months in the EIP.

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Caseworkers must provide youth with an explanation of the financial and security benefits of having their grant checks directly deposit and assist youth in completing the C-95, Authorization for Deposit of Recurring Payments. Youth that do not choose direct deposit will have their grant checks mailed directly to them.

2) Living Arrangement

Youth may live in a Department funded placement while in the EIP.

3) Start Up Funding

Start up funding is need based, work related (e.g., tools, work clothing, etc.) and limited to a one-time disbursement of up to \$200.00. Documentation for this funding is required, and receipts or an itemized list of work required items should be attached to the EIP application forwarded to the regional Transition Coordinator.

4) Medical Services

Medical services are available to youth in the EIP through the Department of Healthcare and Family Services Medical Assistance Program via the DCFS issued medical card. Youth are eligible for a medical card up to the age of 21 or case closure, whichever occurs first. The medical card may be used for:

- Preventative health care (i.e., physical, dental, hearing and vision exams and immunizations); and
- Specialty medical care, acute medical care and prescriptions.
- Medical case management services are provided to pregnant/parenting youth and their children, birth through five years of age, through the Department of Human Services.

Questions concerning the medical card may be directed to the Medical Card Hotline during normal business hours at 800/228-6533.

The youth's caseworker shall assist the youth in identifying Medicaid-enrolled providers for his or her ongoing health care services. The youth's caseworker shall also assist the youth to identify community-based health care services that are provided on a sliding fee scale or free if the youth will not have health insurance after case closure. The KidCare Hotline (800/226-0768) and the DCFS Office of Health Services (217/557-2689) can provide assistance in identifying Medicaid enrolled providers.

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d) Referral Information Requirements

Referrals for the EIP shall include the following:

- 1) A completed **Employment Incentive Program Application, CFS 449-2**;

Note: All sections of the application must be completed. The youth's budget, Part D, must include the youth's plan to meet his or her daily financial obligations if there is a loss of income or financial emergency. Part F, EIP Service Agreement, must be signed by the youth and caseworker.

- 2) The youth's current **CFS 497, Client Service Plan**;
- 3) Documentation of enrollment in a job training program; or
- 4) Verification (i.e., pay stub, written statement from employer) that the youth has been employed for at least one month and working a minimum of 20 hours per week; and
- 5) If the youth chooses to have his or her monthly grant directly deposited in their checking or saving account, a completed C-95, Authorization for Deposit of Recurring Payments.

e) Approval Process

- 1) Caseworkers

The youth's caseworker shall ensure that the EIP referral is complete and that it is in the best interest of the youth to participate in the program before forwarding the referral to the Office of Education and Transition Services (OETS) Transition Coordinator.

Cook North Transition Coordinator

Department of Children and Family Services
Division of Service Intervention
Office of Education and Transition Services
100 West Randolph, 6th Floor
Chicago, Illinois 60601

Cook Central Transition Coordinator

Department of Children and Family Services
Division of Service Intervention
Office of Education and Transition Services
100 West Randolph, 6th Floor
Chicago, Illinois 60601

Cook South Transition Coordinator

Department of Children and Family Services
Division of Service Intervention
Office of Education and Transition Services
100 West Randolph, 6th Floor
Chicago, Illinois 60601

Northern Region Transition Coordinator

Department of Children and Family Services
Division of Service Intervention
Office of Education and Transition Services
5415 N. University, Room 103
Peoria, Illinois 61615

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Central and Southern Regions Transition Coordinator

Illinois Department of Children and Family Services

Division of Service Intervention

Office of Education and Transition Services

406 E. Monroe, Station #22

Springfield, Illinois 62701

2) Transition Coordinators

Transition Coordinators shall review referral documents for completeness and to determine if it is in the best interest of the youth to participate in the EIP. If the coordinator approves the referral, he or she shall sign the EIP Service Agreement and forward the referral documents to the Employment Incentive Program Coordinator for Cook County or downstate.

3) Employment Incentive Program Coordinator

The Employment Incentive Program Coordinator shall complete the final review of each referral and forward accepted referrals to the OETS Business Office for payment processing.

4) Office of Education and Transition Services

The Office of Education and Transition Services will send a letter to the youth and the youth's caseworker notifying them that the referral has been accepted and that the initial monthly grant payment has been processed.

f) Transitional Services Contract Planning

In accordance with Department client service planning procedures a separate service plan is developed for each youth no longer considered part of his or her parents' family. The youth's caseworker shall actively involve the youth in the development of his or her service plan and shall review the plan with the youth prior to each administrative case review. The **Client Service Plan** completed for EIP youth shall include:

- The youth's EIP projected start and completion dates;
- An employment objective;
- The youth's level of functioning and employment skills or job training skills needs;
- A defined time frame for the youth to achieve the employment objective;

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- Clearly defined and measurable tasks (e.g., youth will remain employed for a minimum of 20 hours per week for six months, youth will become employed full-time; youth will successfully complete the job training program; youth will develop the job seeking and maintenance skills) the youth will need to complete to achieve the employment objective; and
- A schedule of in-person caseworker/youth contacts that should be established with input from the youth. In-person contacts may occur weekly, monthly or every other month if the youth is in a placement over 50 miles from the worker's headquarters.

g) Monitoring

1) Verification of Continued Eligibility

The youth must provide his or her caseworker monthly verification (i.e., check stubs or certified job-training program progress reports) of continued eligibility for the EIP, which the caseworker will forward to the Employment Incentive Program Coordinator.

Employment Incentive Program Coordinator – Cook County
Illinois Department of Children and Family Services
Division of Service Intervention
100 W. Randolph
Chicago, Illinois 60601
Phone: 312/814-5509
Fax: 312/814-2656

Employment Incentive Program Coordinator – Downstate
Illinois Department of Children and Family Services
Division of Service Intervention
406 E. Monroe Street, Station #22
Springfield, Illinois 62701
Phone: 217/524-2425
Fax: 217/782-5076

Failure to submit the documentation monthly will result in the youth being discharged from the EIP. Youth that become unemployed must contact the Employment Incentive Program Coordinator for employment assistance within 30 days of becoming unemployed.

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2) Schedule of In-Person Caseworker/Youth Contacts

Caseworkers are required to maintain the established schedule of in-person contacts with the youth that is documented in the youth's service plan. Supplemental contacts with the youth via the telephone and mail may be appropriate.

3) Evaluation of Youth's Progress

The youth's progress shall be evaluated every six months in accordance with **Procedures 305.60(b)**. The caseworker will communicate with the Transition Coordinator regarding any issues that may occur concerning the youth's participation in the EIP. The caseworker shall also obtain a copy of the youth's annual employment evaluation and provide a copy of the evaluation to the OETS Business Office.

4) Client Satisfaction Survey

Youth that have finished 12 months in the EIP shall be provided a client satisfaction survey to complete.

h) Suspension or Discharge From the Employment Incentive Program

Youth may be suspended or discharged from the EIP for any of the following reasons. Youth that are suspended or discharged from the EIP for reasons three through five have the option of appealing the Department's decision in accordance with **Rules 337, Service Appeal Process**.

1) The youth becomes 21 years of age; or

2) The youth completes 12 months in the EIP; or

3) The youth has been unemployed for thirty consecutive days and has not contacted the Employment Incentive Program Coordinator and/or has not submitted job search documentation; or

4) The youth has failed to complete service plan tasks within established time frames; or

5) The youth has failed to provide monthly verification of continued eligibility (i.e., current check stub or certified job-training program progress report).

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i) Living Arrangements

Youth may remain in a Department funded living arrangement while they are in the EIP. The placement type must be appropriate to the needs of the youth and may include foster care, supervised independent living, group home or institutional placements.

j) Reinstatement in the Employment Incentive Program

Youth that have completed 12 months in the program or reached age 21 are not eligible to apply for reinstatement. Youth approaching the age of 21 must apply for reinstatement a minimum of six months prior to their 21st birthday.

To apply for reinstatement, the youth's caseworker must submit an updated referral package to the regional Transition Coordinator. Youth reinstated in the EIP will be eligible to participate in the program for those months he or she has not used. The youth's eligibility will cease at age 21 regardless of whether he or she has used the allotted 12 months.

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302.Appendix G - Youth in College/Vocational Training Program

[Moved to Procedures 314.75, Post High School Education Programs]

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302.APPENDIX H SUPERVISED INDEPENDENT LIVING PROGRAM

a. Description and Purpose

The Supervised Independent Living Program (SILP) provides supportive services and living maintenance to adolescent youth for whom the Department is legally responsible. The purpose of SILP is to assist youth who have demonstrated the minimum requirements for living independently to progress toward their goal of independence. SILP is a totally purchased service from licensed child welfare agencies having contracts with DCFS to provide SILP.

b. Eligibility Requirements

Adolescents considered for entrance into SILP must meet the following criteria:

1. Youth must be sixteen (16) years of age but not yet 21 of age and
2. The Department must have court ordered legal responsibility for the adolescent or must have transferred legal responsibility to a successor guardian in accordance with 89 Ill. Adm. Code 302 (Section 302.400) and
3. The permanency goal for the youth must be independence and the time limit for goal achievement shall be established upon date of entry into the program and
4. The youth must have some money management skills and
5. The youth must be able to live in the community without continuous adult supervision and
6. The youth must be willing and able to cooperate with the supervising agency to further develop independent living skills and
7. The youth must have the ability and motivation to complete a training or educational program designed to assist financial independence and
8. The youth must have the ability to manage day-to-day living skills in an apartment or board and room living arrangement such as meal preparation, maintaining proper nutrition, purchasing and caring for appropriate clothing and maintaining a reasonable degree of cleanliness and
9. The youth must be reasonably expected to attain total independence within one year, progress into another youth development program, or continue in SILP for an additional year with prior approval by the Regional Administrator/Cook County designee.

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c. Approval

Prior to acceptance into the program, the youth's worker shall submit the following materials to the Regional Administrator/Cook County designee:

1. Documentation of the youth's abilities as they relate to the eligibility requirements including observations from the worker and past caretaker(s) and current medical and dental examination results.
2. Current CFS 497 series which demonstrates the permanency planning goal of independence which identifies the specific planned SILP services and discharge date.

The Regional Administrator/Cook County designee shall determine the appropriateness of the referral and the availability of slots in SILP. The worker shall be notified of the decision within two (2) weeks of receipt of the material by the Regional Administrator/Cook County designee. When the request is denied, the basis for denial, as well as alternatives, are to be provided by the Regional Administrator/Cook County designee. When the request is approved the worker shall:

1. Initiate a referral to an agency with whom DCFS has a SILP contract, and
2. Upon acceptance by the agency and placement in SILP ensure that the agency completes a CFS 906-1 to reflect SILP (Service Code 0204) at the negotiated payment rate.

d. Service Planning

Upon initial entry into SILP a service plan (CFS 497) will be developed for the youth by the DCFS and supervising agency worker. The CFS 497 will be reviewed at six (6) month intervals in accordance with procedures 305, Client Service Planning. The CFS 497 shall include:

1. statement of a permanency goal of independent living and planned goal achievement date.
2. Specifications of services to be provided which include monthly living maintenance for the youth provided by the agency and individual or group counseling. Services which may additionally be included are: assistance in locating appropriate educational or vocational programs; assistance in improving competence in daily life skills; and employment related services (e.g., developing job interview skills, job finding).
3. A schedule of a minimum of twice monthly meetings between the youth and service provider; at least one meeting per month shall be in the youth's residence.

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e. Medication Administration Transitional (TLP) and Independent (ILO) Living Arrangements

1. Definitions

“Licensed prescriber” means a physician, dentist, podiatrist, or optometrist. Licensed prescriber also means a physician assistant licensed in accordance with the Physician Assistant Practice Act of 1997, and an advanced practice nurse in accordance with a written collaborative agreement required under the Nursing Practice Act.

“Medication” means any substance placed on or into the body for therapeutic purposes.

“Psychotropic medication” means medication whose use for antipsychotic, antidepressant, anti-manic, antianxiety, behavioral modification or behavioral management purposes is listed in American Medical Association Drug Evaluations, latest edition, or Physician’s Desk Reference, latest edition, or which are administered for any of these purposes. [405 ILCS 5/1-121.1] Consent of a parent or legal guardian is required for administration of psychotropic medication to a youth under age 18.

“Sharps container” means a sturdy plastic bottle or jar with a closeable lid that is used for disposal of used syringe needles and other sharp objects used in the medication administration process. The container should be heavy enough so that it will not puncture when thrown away (e.g., an empty laundry detergent container). The container should be clearly labeled (e.g., “Sharps Disposal”) and stored out of the reach of children.

2. Introduction and Prerequisites

This policy establishes minimum standards for staff that help youth become more independent in administering their medication. The policy requirements take into account the different program levels in transitional (TLP) and independent (ILO) living arrangements. Those applicable to TLP House Models are the most prescriptive. Those applicable to TLP Apartment Models and ILOs are progressively less stringent. TLP and ILO programs may implement additional policies that are more restrictive than this policy; however, under no circumstances shall their policies be less restrictive.

The term “TLP House Model” includes the following: dormitory-style TLPs; all house model TLPs regardless of resident youths’ program levels; and any TLP model for youth who are developmentally disabled or youth who are mentally ill, have an adult sustainable diagnosis and can be managed in the community without support. “TLP Apartment Model” refers to all other TLP living arrangements.

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Youth entering TLP and ILO programs should be able to self-administer their medications. If a youth entering TLP is unable to self-administer his/her medications, the TLP staff shall determine whether it is appropriate to support and train the youth to do so, or to deny placement. If a youth entering ILO is unable to self-administer his/her medications, the intake worker shall deny admission.

Youth moving to TLP or ILO should be able to:

- purchase prescription and over-the-counter medications from a pharmacy;
- recognize and distinguish his/her medications;
- know the reason for taking the medications;
- understand the potential adverse reactions and side effects of each medication;
- know how much and when to take the medications;
- know how to properly store medications;
- know how to check for each medication's expiration date and properly dispose of expired or unused medications;
- when medication administration requires more than the ability to swallow a pill, the youth shall be required to demonstrate the ability to self-administer that medication; and
- demonstrate to TLP/ILO staff upon placement the ability to take his/her medication properly. A parenting youth may be asked to demonstrate how to properly medicate his/her child and explain the reason the child is taking each medication.

Each youth age 18 and over entering TLP or ILO shall be asked to sign a consent authorizing TLP staff to obtain information from the youth's medical and psychiatric providers. In addition to the guardian's consent, youth under age 18 shall be asked to sign a consent authorizing TLP staff to obtain information from the youth's psychiatric provider. If a youth refuses or is reluctant to sign a consent, the caseworker shall be contacted. The caseworker shall explain to the youth that TLP/ILO staff need this information to help the youth learn to meet his/her medical and mental health needs. If a youth under age 18 still refuses to sign a consent, the caseworker shall contact the Department's Division of Guardian and Advocacy for assistance.

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3. Medication Policy

TLP and ILO programs shall have written policies for medications and medication management. These policies shall be approved by the program's governing body and medical director or a consulting licensed physician.

A. **TLP House Model.** At a minimum, the policy shall require the following:

Each youth must purchase and obtain his/her own prescription medication (or his/her child's medications) from a pharmacy and give the medication and pharmacy information sheet to a staff person authorized to handle medications. (This includes any medication samples obtained from the physician's office.) Authorized staff shall keep all prescribed medications, including refrigerated medications, in locked storage.

Advance authorization from the legal guardian or authorized agent is required for psychotropic medication for all youth under age 18.

When a youth (or the youth's child) is taking HIV/AIDS medications, the youth shall be allowed to store these medications in his/her living quarters. Each youth is responsible for taking these medications (or giving medications to his/her child) as instructed by his/her physician.

A youth who requires an emergency/rescue medication may carry that medication with them at all times. Staff shall review with the youth how to safely carry emergency/rescue medications, such as insulin syringes or Epi-pens, before and after use, and to return used syringes or needles for disposal in the program's sharps container. If a youth requires but does not have a syringe "travel bag", the program will assist the youth in getting one.

Each youth must purchase his/her own over-the-counter medications for general use. The youth shall be responsible for storing his/her own (or his/her child's) over-the-counter medications.

Staff shall remind each youth of the importance of storing medications so that it cannot be accessed by children or visitors. The program shall provide a locked drawer/cabinet or a lockbox in the youth's private living quarters for this purpose.

When receiving medications and pharmacy information sheets from a youth or handing a youth his/her medications, the staff shall:

- verify that the youth is the intended recipient of the medication. Prescription medications shall not be shared;

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- verify that a medication appears stable from a visual inspection for deterioration, discoloration and expiration date;
- store the pharmacy information sheet in a notebook or in a way that is immediately accessible to staff;
- verify that there is no known contraindication for administering the medication, identified from information provided by the pharmacy (e.g., known allergies, medical condition, apparent intoxication);
- make medication available to each youth at the proper time in the prescribed dose;
- document that a youth takes his/her medication at the proper time in the prescribed dose;
- monitor the youth's self-administration of medication in a manner that is considerate of the sensibilities of the youth. As a general rule, prescribed oral medications shall be taken in the presence of staff;
- provide on-going training for parenting youth regarding administering medication to their children. This includes understanding why the child needs an over-the-counter or prescribed medication and the importance of following the doctor's orders completely. Staff should also encourage the youth to carry the child's medical card at all times;
- account for and control all controlled substances, syringes and needles. All needles and syringes shall be disposable and may not be reused;
- ensure that used needles and syringes are placed in a sharps container that is maintained in locked storage accessible only by authorized staff. The policy shall include instructions for disposal of sharps containers;
- account for, control and dispose of unused, returned, discontinued or expired medications. The policy shall include instructions for disposal of unused medications, the prevention of diversion of medication, and documentation that medication is destroyed; and
- thoroughly wash their hands before handling medication containers. Gloves may be used in addition to hand washing.

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The program shall post the following information in such a way that protects the confidentiality of the youth but allows ready access by staff:

- the names of all staff who have successfully completed the training described in Section VII below;
- the names of youth who have known allergies, anaphylaxis and asthma action plans, and the prescribed remedy. All staff shall be trained to recognize the symptoms of allergies and asthmatic reactions, and shall receive training on Policy Guide 2002.01, Case Management Guidelines for Children's Asthma Management;
- the names of all youth with life-threatening conditions or allergies. If a youth requires but does not have a medical ID bracelet or necklace, the program will assist the youth in getting one; and
- emergency phone numbers.

A separate medication log shall be maintained for each youth listing all medications prescribed for that youth (and his/her child). The medication log shall be approved by the governing body and the medical director or a consulting licensed physician. Staff shall record all medications taken, missed or refused by the youth. Staff shall sign the medication log. If the youth is cooperative, he/she shall also sign the medication log.

Staff shall strongly encourage youth who store HIV/AIDS medications or who carry emergency/rescue medications for themselves or their children to maintain a medication log for those medications. Staff shall offer the youth the CFS 534, Medication Administration Log, for this purpose and/or describe other methods for documenting daily medication.

The policy shall require documentation of all medication errors and adverse reactions, and shall address, at minimum, the following situations:

- the wrong medication was given to/taken by a youth;
- the wrong dosage was given to/taken by a youth;
- a medication was given to/taken by a youth at the wrong time;
- a medication was not given at all;
- any amount of a controlled substance, syringe or needle is missing; or
- any medication delivery problem not specified above that has the potential to negatively affect the youth.

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The policy shall specify who staff shall call if a trained staff person is not available to determine whether a medical error or adverse reaction may jeopardize the youth's health or well-being. In the event of a significant adverse reaction, staff shall immediately call 911 for emergency assistance.

Staff shall document on the medication log when a youth refuses to take a medication (or medicate his/her child) and the reason given. Staff shall sign the medication log. If the youth is cooperative, he/she shall also sign the medication log. Staff must also complete a **CFS 119, Unusual Incident Report Form** when required by Rule and Procedures 331, Unusual Incidents. (Note: Staff may request that the Department waive the requirement to submit a UIR when the incidents are a repetitive behavior of a specific youth, and that behavior is not potentially harmful. Waiver of the reporting requirement requires the express approval of the Department. See Procedures 331-Appendix C, Request to Waive Reporting Unusual Incidents.)

TLP staff shall ask the youth why he/she is refusing the medication (or refusing to medicate his/her child) and discuss the reason for taking that medication. Staff shall contact the youth's caseworker to discuss the youth's refusal to take medication, refusal to medicate his/her child, or other unresolved significant concerns about medication involving the youth.

Visitation, Work, School and Off-Ground Activities

To the extent possible, the youth shall take his/her medication at the program before or after an off-site activity.

When it is necessary for a youth to take medication while off-site, the youth may carry that medication.

The youth and the staff person will determine the best way for the youth to carry his/her medications while away from the program. In school settings with medication guidelines, the youth and staff will develop a system for carrying medication that meets those guidelines. The youth shall complete the medication log for medications taken while away, and shall return any unused medication upon return to the program.

Runaways

If, despite counseling by staff, a youth indicates that he/she is going to run away, staff on duty shall encourage him/her to come back to the residence, contact the licensed prescriber or go to an emergency room to obtain his/her prescription medication.

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The program shall have a written policy approved by the governing body and the medical director or a consulting physician addressing the circumstances, if any, in which staff may give prescription medication to youth who have indicated their intention to run away.

Staff shall indicate on the medication log that the youth has run away. If medication was given to the youth, staff shall note the name and amount of medication given, and the date and time.

Staff shall immediately notify local law enforcement, the caseworker, and the Helpline for the Child Location and Support Unit for Missing Children, as required in Procedures 329, Locating and Returning Missing, Runaway and Abducted Children. At the time of notification, staff shall share information about any urgent medical issues. The caseworker shall be told of any medication changes since the last contact.

The program shall dispose of medications for runaways after 30 days.

Monthly Review of Medication Logs and Medication Errors

The program's written policy shall require a monthly review of all medication logs and medication errors to ensure that all medications are being given as prescribed, and to find and correct underlying causes of medication errors. This review shall be conducted by a program director or site director who has successfully completed the training described in Section VII below.

B. TLP Apartment Model and ILO

Youth living in apartments are expected to be able to assume greater responsibility for storing and taking their medications as directed. At a minimum, the policy shall require the following:

For youth in a TLP apartment, staff shall do an initial assessment of the youth's skill level regarding management of his/her medications. Staff shall assess a parenting youth's ability to manage and administer his/her child's medication. When needed, staff may accompany youth to a medical appointment to help the youth explain symptoms, ask questions or obtain information from the provider. Staff may also assist youth in obtaining medication from a pharmacy.

ILO staff shall require documentation of an assessment of the youth's skill level regarding management of his/her medications. The caseworker/site manager shall assess a parenting youth's ability to manage and administer his/her child's medication. A parent who cannot reliably give medication to his/her child shall not be placed or remain in ILO.

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Staff shall:

- follow up on the youth's management/self-administration of medications if a youth entering TLP or ILO is unable to manage or self-administer his/her medications (or his/her child's medications) until the youth demonstrates proficiency. Staff shall either train the youth to manage and administer those medications or contact DCFS to have the youth moved to a more structured setting;
- educate youth about safe storage of prescription and over-the-counter medications within their apartments, including storage and disposal of discontinued or expired medication, and needles and sharps, and the importance of storing pharmacy information sheets in a place that is easily accessible;
- ensure that youth know how to locate and purchase prescribed medications from a pharmacy, and ask the pharmacist questions regarding prescribed medication. They should be encouraged to read medication information sheets provided by the pharmacy to learn about side effects and adverse reactions;
- emphasize the need to plan ahead to obtain prescription refills so that the youth does not miss taking any prescribed medications. This is especially important for youth who are prescribed psychotropic drugs, insulin and emergency/rescue medications;
- advise or direct youth to call the licensed prescriber if they suffer any adverse reactions to prescribed medication. At the youth's request, staff may assist the youth in doing so;
- ensure that youth know how and where to purchase over-the-counter medications;
- encourage youth to always carry his/her medical card (a parenting youth should also carry his/her child's card);
- encourage youth to carry medications with them, including emergency/rescue medications, when they must take medication while away from their apartments;
- review with the youth how to safely carry insulin syringes before and after use, and to return used syringes for disposal in a sharps container. Staff shall verify that the youth is using a sharps container properly at least quarterly;

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- if a youth requires but does not have a syringe “travel bag”, the program will assist the youth in getting one;
- provide on-going oversight of youth with chronic diseases (e.g., diabetes, asthma) and those taking psychotropic medications;
- strongly encourage each youth to keep a daily medication log using the CFS 534, Medication Administration Log, or another method or checklist for documenting daily medication;
- prohibit youth from sharing prescription medication with other youth; and
- document their conversations with youth regarding medication management. TLP program staff shall share concerns regarding a youth’s medication management with the youth’s caseworker in a timely manner.

The TLP program shall post the following information in such a way that protects the confidentiality of the youth but allows ready access by staff.

- the names of all staff who have successfully completed the training described in Section VII below;
- the names of youth who have known allergies and asthma action plans, and the prescribed remedy. All staff shall be trained to recognize the symptoms of allergies, anaphylaxis and asthmatic reactions, and shall receive training on Policy Guide 2002.01, Case Management Guidelines for Children's Asthma Management;
- the names of all youth with life-threatening conditions or allergies. If a youth requires but does not have a medical ID bracelet or necklace, the program will assist the youth in getting one; and
- emergency phone numbers.

ILO caseworkers must include the following information in the each youth’s case record: known allergies or life-threatening conditions, asthma action plan/emergency action plan and prescribed remedy. If a youth requires but does not have a medical ID bracelet or necklace, the ILO program will assist the youth in getting one.

The policy shall address handling a youth’s refusal to take a prescribed medication, or to give a prescribed medication to his/her child. The TLP/ILO caseworker must complete a **CFS 119, Unusual Incident Report Form** when required by Rule and Procedures 331, Unusual Incidents. (Note: Staff

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may request that the Department waive the requirement to submit a UIR when the incidents are a repetitive behavior of a specific youth, and that behavior is not potentially harmful. Waiver of the reporting requirement requires the express approval of the Department. See Procedures 331-Appendix C, Request to Waive Reporting Unusual Incidents.)

The caseworker shall discuss refusal to take medication, administer medication to his/her child and/or other unresolved significant concerns about medication with the youth, and, when necessary, the primary care physician (or the licensed prescriber, if different). TLP staff also contact the youth's caseworker.

4. Hospitalization, Detention, Residential Substance Abuse Programs, etc.

When a youth is temporarily hospitalized or placed in a detention center, residential substance abuse program, or other temporary residential program, the caseworker shall contact the hospital, detention center, or program to determine whether it will accept the youth's prescription medication or will provide medication.

If medication is accepted, the caseworker shall give the hospital, detention center or program the medications for that youth in the original containers. The hospital, detention center or program shall be asked to return any unused medications to the youth at discharge, if the youth will still be taking that medication.

When medication is not accepted, the caseworker shall a list of the youth's prescription medications and the licensed prescriber, a list of the youth's over-the-counter medications, if known, and the reason each medication is taken by the youth, if known.

The caseworker or other appropriate program representative shall notify the Department's Division of Guardian and Advocacy when a hospital, detention center or program does not administer all prescribed medications. The Division of Guardian and Advocacy shall facilitate a discussion between the prescribing physician and the facility's physician to discuss the medical basis for giving or withholding those medications.

Upon return to the program, the caseworker shall instruct the youth to contact the licensed prescriber or his/her primary care physician to discuss any written discharge instructions and whether there are any contraindications for taking his/her prescribed medications.

TLP House and Apartment Models: The caseworker shall contact program staff to discuss the discharge instructions and any medication changes.

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TLP House Model: The program's medication log shall note that the youth is absent at these times.

5. Change of Placement

A. **TLP House Model:** When a youth moves to a new placement, the program shall give the youth his/her medications in the original containers, unless the new placement requires hand-off of medications to staff or provides other written instructions.

Staff shall also provide copies of written authorizations for administration of psychotropic medications for youth under age 18 and copies of all medication logs for the youth.

B. **TLP Apartment Model and ILO:** When a youth moves to a new placement, the youth shall be responsible for taking his/her medications to the new placement, unless the new placement requires hand-off of medications by staff or provides other written instructions.

6. Preparations to Transition from TLP or for Emancipation to Adulthood

A youth preparing to transition out of TLP into a less restrictive and independent living arrangement, or preparing to emancipate to adulthood shall be proficient in following skills:

- purchasing prescription medications from a pharmacy, and obtaining refills in a timely manner;
- taking his/her medication as required;
- understanding the reason for taking each medication;
- understanding the potential adverse reactions and side effects;
- proper storage of medications (and when appropriate, needles and sharps);
- checking for each medication's expiration date and proper disposal of expired or unused medications. (When appropriate, know how to safely dispose of used needles and sharps);
- (for a parenting youth) demonstrating that he/she can properly medicate his/her child and understanding the reason for giving medication to the child;
- carrying a copy of his/her medical card at all times. A parenting youth also carries a copy of his/her child's medical card.

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If a youth cannot proficiently demonstrate these skills when transition planning begins, TLP/ILO staff shall convene a staffing to address the youth's deficiencies in managing his/her medications. A DCFS representative shall be invited to attend the staffing. TLP/ILO staff shall document in the record all the efforts, resources and referrals that will be provided to the youth to manage these issues in preparation for emancipation.

7. Training for Staff – TLP and ILO

Each program shall develop a written training plan for staff that includes, at a minimum, the requirements of this subsection. The training plan shall be approved by the program's governing body and the medical director or a consulting licensed physician.

The program shall keep a log of all staff that have successfully completed this training, and shall also note the completion of this training in each staff person's personnel file.

Staff shall receive additional training specific to youth with chronic illnesses (e.g., diabetes, asthma, HIV/AIDS, kidney disease that requires dialysis, etc.).

A. Reporting and Observation Skills

All staff should be trained in observing and reporting changes in physical appearance, emotional adjustment and behavioral activity, and trained to recognize common reactions to medications. Staff should understand and be able to recognize through observation skills, the desired, unwanted (both expected and unexpected), or absence of desired effects of medications including potential medication interactions.

TLP House and Apartment Models: Staff shall report significant changes to the youth's caseworker within the appropriate time frames as set out in policy.

B. Staff Responsibilities in the Medication Process

Staff shall be trained to support and assist the youth in self-administration of medications. Staff should help the youth learn the name and reason for taking medications. Staff should know how to teach youth to self-administer medication if the youth comes to the program without that skill or receives a new medication after entering the program, how to locate and purchase a prescription from a pharmacy, and how to safely store medications.

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Staff shall know the program policy specific to the medication administration process. They should understand the difference between controlled and non-controlled medicines. They should be trained to recognize side effects and reactions to medications.

When asked, staff should help a youth contact his/her doctor (or child's doctor), and should know how to work with doctors and hospitals with regard to medications.

Staff should know how to use and safely carry emergency/rescue medications and safely dispose of sharps and sharps containers and unused, returned, discontinued and expired medications.

Staff shall be able to determine when a medication error has occurred and what action should be taken.

TLP House Model: Although youth are required to self-administer medication, staff should be able to recognize and distinguish a youth's medication. They should know how to monitor that the youth is taking the proper dosage of medicine at the proper time. They should know when to contact the licensed prescriber with questions regarding the administration of medications.

C. Handling Emergency and Health-Threatening Situations

All staff should know how to handle both emergency and non-emergency conditions, and they should teach youth how to handle these conditions. They need to know how to access immediate and direct care in an emergency situation (e.g., call 911). They also need to know how to access medical support in a non-emergency situation.

f. Monitoring

The service provider shall submit reports as required by the contract.

g. Financial Provision

1. Payment to the Youth. The supervising agency will provide the adolescent with a monthly allowance in accordance with contractual stipulations. The amount shall not exceed \$200 monthly.
2. Start-up Expenses. Initial expenses related to setting up a household may be partially subsidized by DCFS. The adolescent will present an itemized list to the private agency who will request DCFS payment. An amount up to \$100 may be authorized.

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3. Medical and Dental Payments. Youth in SILP are eligible to receive a Medicaid card for medical and dental needs.

h. Discharge from SILP

The service provider shall terminate the youth from SILP:

1. Upon demonstration by the adolescent that he is able to live independently without supervision.
2. When circumstances indicate that the adolescent could better be served in another youth development program.
3. When the adolescent, over the age of 18, fails to complete the tasks as agreed upon and identified on the CFS 497.
4. No later than 24 months after entry into SILP. The Regional Administrator/Cook County designee must give prior written approval to continue an adolescent in SILP beyond 12 months.

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APPENDIX J PREGNANT AND/OR PARENTING PROGRAM

I. Purpose

The Pregnant and/or Parenting Program provides supportive services and living maintenance to pregnant and/or parenting children and youth for whom the Department is legally responsible. The Department recognizes that these wards and their child(ren) are a family and this program is designed to ensure that the ward's role and responsibility as a parent is respected and supported. This program applies not only to pregnant wards but also to parenting wards, male or female, who are caregivers for their child(ren) or whose service plan calls for them to take an active role in parenting their child(ren) and to those whose child(ren) have been removed due to reported child abuse or neglect and for whom a service plan has not been developed for their child(ren).

Basic Assumptions of the Pregnant and/or Parenting Program

Pregnancy and childbearing in adolescence are generally untimely events, out of sequence with societal expectations and developmental norms, and should be delayed whenever possible.

- A comprehensive array of services should be made available to those adolescents who are at risk of early sexual activity, those who are sexually active, and those who become pregnant and parenting.
- Case management and service delivery should be adapted to the developmental stage, abilities and particular needs of the adolescent.
- Pregnant and parenting wards have the right to receive services without regard to race, religion, ethnicity, economic status, marital status, or plans regarding the resolution of pregnancy. Services should be delivered in the context of the client's community, cultural and ethnic background.
- Pregnant adolescents should be fully informed about all options for resolution of the pregnancy.
- The needs, rights and responsibilities of young fathers (acknowledged, adjudicated, putative) are equally important and should also receive full attention in the provision of services.

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- The responsibilities and legal rights of fathers of children born to adolescent mothers extend beyond the obligation of financial support. The father should share responsibility with the mother for the child's overall welfare, including health, personal development and support. Regular contact between fathers and child(ren) should be encouraged whenever appropriate.
- Services must continue after the birth of the child when the teen elects to keep her/his baby.
- The families of pregnant and parenting adolescents are often their main source of support, and those relationships should be encouraged.

Consistent with the above-cited assumptions, the Pregnant and/or Parenting Program shall be maintained in accordance with the following DCFS policies:

Non-Discrimination

Pregnant and/or parenting wards shall not be retaliated against, discriminated against nor penalized because they are pregnant or parenting or because they have had successive pregnancies.

Consultation With Legal Counsel

Department employees, private agencies and foster parents shall not intentionally interfere or impede the ability of a pregnant/or parenting ward to communicate with her/his legal counsel. In addition, pregnant and/or parenting wards should not be questioned about their conversations with legal counsel nor should they be threatened or punished for asserting their legal rights through counsel.

Use of Coercion

Caseworkers and private providers shall use non-coercive measures of informing, educating and training pregnant and/or parenting wards on issues concerning pregnancy resolution and on the care of their child(ren). Pregnant and/or parenting wards shall not be threatened with release from DCFS custody or guardianship, with termination of their parental rights of their child(ren) or with false reports of abuse or neglect of their child(ren) in order to coerce the ward into cooperating with the ward's placement or service plan or to punish the ward for complaining about the quality of her/his placement or services. (It should be noted however, that in appropriate circumstances, DCFS can release a ward from custody or guardianship or take action to terminate the ward's parental rights of her/his child in accordance with state and federal law.)

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Appropriate DMHDD Placements

Pregnant and/or parenting wards who are placed in a mental health facility operated by the Department of Mental Health and Developmental Disabilities (DMHDD) and are clinically ready for discharge shall not remain in that facility unless otherwise permitted by law. The caseworker must make every effort to find the pregnant and/or parenting ward a suitable placement as soon as possible so that she or he can be discharged from the facility.

II. Eligibility Requirements

- a) In order to qualify for the specialized services and placements available through this Program a ward must meet one or more of the following criteria:
 - 1) Be a pregnant youth for whom the Department is legally responsible or for whom legal responsibility has been transferred to a successor guardian in accordance with 89 Ill. Adm. Code 302 (Section 302.400); or
 - 2) Be a parenting ward, female or male, who is the caregiver for her/his child(ren); or
 - 3) Be a parenting ward, male or female, who is not the caregiver for the child(ren), but whose service plan does not contraindicate the parenting ward pursuing an active role in parenting her/his child(ren); or
 - 4) Be a parenting ward, male or female, whose child(ren) has been removed from her/his custody by DCFS due to neglect or abuse and the service plan for the child(ren) has not yet been developed.
- b) Within 14 days of the caseworker determining that a pregnant and/or parenting ward meets one of the criteria listed above, the caseworker shall complete an Unusual Incident Report (UIR) to document the pregnancy and subsequent birth of the child(ren). The UIR must contain the following information:
 - (i) the ward's name and gender;
 - (ii) ward's date of birth;
 - (iii) name, type and location of current placement or whether the ward is on runaway status;
 - (iv) whether the ward is pregnant and, if so, her due date;

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- (v) the name(s) and birth date(s) of any child(ren) born to the ward;
- (vi) whether the ward's child(ren) reside with the ward; and
- (vii) any special needs the ward may have.

If a ward is pregnant, an additional UIR must be completed after she gives birth which contains information about the child born to the ward, or, if she does not give birth, specifies information regarding pregnancy resolution. (Also, when a male ward expresses an interest in taking an active role in parenting his child the caseworker must complete a UIR.)

- c) A pregnant and/or parenting ward remains eligible to receive appropriate services as long as she/he remains in the care of DCFS and the ward cooperates with the service plan - until age 21 if necessary.
- d) In accordance with Rules and Procedures 305, Client Service Planning, any ward who is not currently actively involved in the parenting of her or his child(ren) may request that her/his service plan be amended to permit her/him to do so. A caseworker receiving such a request shall notify the Teen Parent Coordinator (see Section V below), in writing, within 21 calendar days of receiving the request to make changes in the service plan. If the service plan is not amended, the youth is entitled to appeal the denial decision through the service appeals system.

III. Service Planning

Service planning for pregnant and/or parenting wards requires consideration of the unique needs of the specific ward, both generally and as they relate to pregnancy or parenting. Special consideration must be given to the needs of wards who are developmentally delayed or at high risk (e.g. those wards under age 14). When a caseworker is attempting to locate a resource for a pregnant and/or parenting youth the caseworker should secure consultation from the Teen Parent Coordinator, when necessary, in order to identify the community resources available to serve pregnant and/or parenting youth.

Some of the service needs which apply to all wards in the pregnant and/or parenting program are listed below.

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a) Discussion Of Parental Options

Upon learning that a ward is pregnant and/or desires to parent her/his child, the assigned caseworker shall counsel the ward or refer the ward for counseling on the following available alternatives: keeping and raising the child, including the risks associated with childbirth; relinquishing the child for adoption; transferring guardianship to other family members; terminating the pregnancy, including the risks associated with abortion. (See Procedures 327, Guardianship Services.)

b) Counseling

Counseling shall be provided to help the ward address and manage the responsibilities and tasks of pregnancy and parenting. Counseling needs should be addressed on an individual, couple, or group basis, depending on the circumstances of the pregnant and/or parenting ward.

c) Health Care

A pregnant ward has prenatal and postnatal nutritional and medical needs which must be addressed on a regular and consistent basis. Primary care for the parent must also be addressed. Prenatal care should begin as soon as the pregnancy is identified. Medical care is essential to ensure the health and welfare of the parent as well as the child. Pediatric care for the ward's child should be facilitated. (See Section VI, Financial Provisions (b) and (c) below.)

d) Parenting Training

The ward will need to receive broad, comprehensive training regarding her/his child rearing responsibilities. At a minimum this training shall address the following: proper care of the child (including appropriate nurturance and stimulation); financial management; ways that the parent can provide for her/his health care needs as well as those of the child(ren); emergency care (including infant-child CPR); proper nutrition; and appropriate clothing and hygiene. A pregnant or parenting ward must be taught day to day living skills which include those related to parenting and maintaining a family. (See Procedures 302, Appendix H, Supervised Independent Living Program.)

e) Parenting Responsibilities

The authority of the Guardianship Administrator and Authorized Agents to consent to certain procedures and services on behalf of wards does not extend to the minor's medical care during pregnancy. Nor does the consent authority extend to the child of a ward unless the Department has been made legally responsible for the child of the ward through a separate court proceeding. The parenting ward must be informed of her/his responsibility to

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authorize medical care for the child(ren) and to keep the child(ren)'s medical records. The parenting ward also has a responsibility to obtain and retain birth certificate(s) of the child(ren) as well as other pertinent information.

f) **Paternity and Outreach to Fathers**

The caseworker shall provide information and support to fathers, including information about rights and obligations with respect to the Putative Father Registry, child support and the establishment of paternity.

It is usually in the interest of the child, **both** parents and society at-large that the non-caregiving parent participate in the emotional and financial well-being of a child. Therefore, service planning should include outreach to fathers where appropriate.

When a parenting ward has a steady relationship with her child's father and his family, family conferences should be convened periodically to discuss safety and child well-being issues with the father and his family.

Placement and services shall be made in consideration of a policy to actively encourage fathers for whom the Department is legally responsible to engage in child rearing. Parenting fathers and fathers expressing an interest in parenting need the same supports extended to parenting mothers. These supports include, but are not limited to placements that support and encourage the care of their child(ren), day care services so the parenting wards may attend school and/or work, counseling, and parenting classes.

Note: Information regarding the Putative Father Registry and registration forms may be obtained from:

The Illinois Putative Father Registry
Department of Children and Family Services
160 North LaSalle Street - 6th Floor
Chicago, IL 60601
Telephone: 1- (800) 420-2574

g) **Education**

Rules and Procedures 314, Educational Services, detail the rights of children and youth for whom the Department is legally responsible to a free, appropriate education. The caseworker is responsible for assisting each pregnant and/or parenting ward to enroll or obtain appropriate elementary or secondary schooling. Wards shall not be prevented from attending school solely because they are pregnant and/or parenting. Supportive services should be used where necessary to enable pregnant and/or parenting wards to attend and achieve in elementary

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and secondary school (e.g. tutoring). Pregnant and/or parenting wards should also be provided with available services to compensate for any elementary or secondary school missed due to pregnancy or due to any placement disruption related to the ward's pregnancy or birth of her/his child(ren).

The caseworker must ensure that pregnant and/or parenting wards are not classified as being in need of special education or having behavioral disorders solely because they are pregnant and/or parenting. The assistance of the Statewide Education Coordinator shall be sought if the caseworker determines that the pregnant and/or parenting ward has been inappropriately classified for educational purposes. (See Procedures 314.)

In accordance with Procedures 314, the caseworker should arrange transportation for the pregnant and/or parenting ward to and from school - including any necessary transportation for the ward's child(ren) to attend child care to enable the ward to attend school. Transportation is necessary when it is a barrier which will prevent the ward from attending school if it is not provided. Arrangement of transportation may include, for example, tokens for public transportation or arrangements for transportation with the school or the ward's placement.

Pregnant and/or parenting wards should be encouraged, where appropriate, to participate in post-secondary educational or vocational programs. Such encouragement may include assisting the ward in applying for scholarships or student loans and assisting with the school's application process.

Although DCFS is not legally or financially responsible for the parenting ward's child(ren) (unless the Department has been made legally responsible for the ward's child through court action due to abuse, neglect or dependency), the caseworker should assist the parenting ward in enrolling her/his own child(ren) in any appropriate and available educational or pre-educational programs and making application for financial assistance. (See Rules and Procedures 314, Educational Services, for a description of available early intervention and preschool programs.)

h) Preventive Services

Pregnant and parenting wards shall receive a range of preventive services including family life education, family planning services, family counseling, and sex education (including information on the prevention and treatment of disease as well as the prevention of pregnancy.)

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i) Respite

Availability of respite time is critical to the maintenance of a ward's healthy development. Service planning for a ward in the Pregnant and/or Parenting Program should include the consideration of recreational activities and means by which the ward's interest in such activities may be engaged and sustained.

j) Day Care

Parenting wards shall be provided with child care services as allowed by Procedures 359, Authorized Child Care Payments, including transportation to and from the day care facility, where necessary to enable the ward to attend elementary and secondary school or receive other services such as training, vocational education, and counseling as identified in the ward's service plan.

k) Review Appropriateness of Placement

The caseworker shall review the pregnant and/or parenting ward's current placement to ascertain the feasibility of the ward remaining in her/his current placement while pregnant and/or parenting. Efforts must be made to maintain the placement if at all possible. Such efforts might include securing necessary supportive services, conducting emergency staffings and family conferences, and/or obtaining crisis intervention services to stabilize and maintain the current placement. The Teen Parent Coordinator is available to assist with crisis management.

l) Special Needs

Whenever a mental health or developmental disabilities facility operated by DMHDD learns that a ward in its care is pregnant and/or parenting, the facility is required to notify the ward's caseworker and the Teen Parent Coordinator within seven days. Upon receiving such information, the assigned caseworker shall ensure that pregnant wards receive counseling about their pregnancy options, appropriate pre-natal care and other appropriate and adequate services discussed above if they choose to keep the child.

Whenever a mental health or developmental disabilities facility operated by DMHDD determines that a pregnant or parenting ward is clinically ready for discharge, the facility is required to notify the caseworker, in writing, of its intent to discharge the ward. The facility is required to issue such notice at least seven days prior to the intended discharge date, and provide copies of the notice to the Teen Parent Coordinator and the ward's attorney. The caseworker shall

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make every effort to secure an appropriate placement for the ward by the intended discharge date.

Core services shall be made available to all parenting wards regardless of placement. Core services include counseling, education assistance, day care, parenting training and sex education.

IV. Placement Options

Should it become necessary to seek a different placement for a pregnant and/or parenting ward, the assigned caseworker must carefully assess the youth's ability to care for herself/himself and her/his child(ren) when deciding which placement would be appropriate. All placements should be made consistent with the basic assumptions of the Pregnant and/or Parenting Program. (See Section I, Purpose.)

Parenting wards should be placed with their child(ren) unless separate placement is necessary for the safety or treatment of the parenting ward or the child(ren). If the parenting ward requires medical or mental health treatment, parent and child should be separated only if in-patient treatment is required or if it is determined that remaining with the parent(s) puts the child(ren) at risk.

If the caseworker proposes to separate the parenting ward from her/his child(ren), the caseworker shall notify the Teen Parent Coordinator prior to effecting the change in placement. If the caseworker and the ward are unable to identify a mutually agreeable plan, then the caseworker shall advise the ward that she/he has the right to appeal any final placement decision, and shall direct the ward to the proper channels for making a service appeal.

The assigned caseworker may secure consultation to help make a determination regarding an appropriate placement for the pregnant or parenting youth. Consultation with the Teen Parent Coordinator may also be sought regarding the programs private purchase of service providers may have for wards who are pregnant and/or parenting.

In accordance with Rules and Procedures 301, Placement and Visitation Services, children and youth for whom the Department is legally responsible shall be placed in the least restrictive setting possible which is consistent with their needs and best interests. The available placement options in the continuum of care follow. As stated above, core services shall be made available to all parenting wards regardless of placement. The following descriptions highlight various services upon which the specific placements focus.

- **Home of Relative/Foster Care** - For wards who can benefit from a family setting and need the nurturing through modeling to learn effective parenting skills.

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Foster parent(s) must be able to assist rather than "take over" child care responsibilities. Services include day care, in-home support services, high risk pregnancy services, and informal recreation.

- **Group Homes/Residential** - For wards who exhibit dysfunctional behavior and need structure, but are also ready to begin formal independent living and parenting skills training. Services include individual and group therapy, behavior management, specialized educational services, day care, medical care for wards and their children, sex education and family planning, and parenting and independent living skills classes.
- **Independent Living** - Youth considered for this living arrangement are wards aged 16-21 who have demonstrated some basic independent living/life skills and parenting skills prior to this placement. Age is not the sole criterion for entering an independent living program. The ward must have demonstrated that she/he is capable of caring for herself/himself and the child(ren). See Procedures 302, Appendix H, Supervised Independent Living Program. Services include individual counseling, monthly home visits, day care, medical care referral, parenting classes, and job support.

In addition to the above, the caseworker should consult with the Teen Parent Coordinator and regional resource staff regarding placement resources and services for pregnant and or parenting youths who have special needs due to high-risk pregnancy, developmental disability, mental illness or similar conditions.

V. Teen Parent Coordinator

The Department has appointed a Teen Parent Coordinator to coordinate the development of programs and services for pregnant and parenting wards and to provide expertise concerning this population to other staff.

Any questions or concerns of caseworkers or private providers regarding pregnant and parenting wards should be referred to the Teen Parent Coordinator. The Teen Parent Coordinator can be reached as follows:

Teen Parent Coordinator
Department of Children and Family Services
100 West Randolph Street- Suite 6-200
Chicago, IL 60601
Telephone: (312) 814-5991

For monitoring purposes, caseworkers must notify the Teen Parent Coordinator when any of the following events occur:

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1. Whenever a caseworker determines that a child or youth for whom the Department is legally responsible is pregnant or parenting and meets the eligibility requirements specified in Section II (a), Eligibility Requirements of this Appendix J - P302. If a ward is identified as pregnant, a follow-up notification must be submitted which provides information about the child born to the ward, or, if the ward did not give birth, specifies other information regarding pregnancy resolution.
2. Whenever a ward who is a parent decides that she/he would like to pursue an active role in parenting her/his child(ren) and requests that her/his service plan be amended to provide for the parenting ward to do so. The caseworker must notify the Teen Parent Coordinator of the request within 21 days of the date the request is made.
3. Whenever a parenting ward who has custody of her/his child is placed separately from that child because the separate placement is necessary for the safety or treatment of the ward or the ward's child(ren).

These notifications shall be provided in the form of an Unusual Incident Report (UIR). The UIR should contain the information specified in Section II (b) of this Appendix J - P302. Additionally, the UIR should specify the reason for the notification:

- 1) pregnant or parenting ward identified;
- 2) pregnant or parenting ward seeking an active role in parenting her/his child(ren); or
- 3) placement of a ward's child in a separate placement from the ward.

VI. Financial Provisions

- a) **Living Maintenance.** Pregnant and/or parenting wards shall be provided with the type of living arrangement appropriate to their needs (foster family or relative care, residential care in a child care institution or group home, or supervised independent living program (SILP), and may receive special payments in accordance with their needs or the needs of the child(ren). See Procedures 359, Authorized Child Care Payments.
- b) **Medical Care.** All wards, including those who are pregnant and/or parenting, are eligible for enrollment in the Department's statewide health care provider network, Healthworks of Illinois. The ward's non-ward children may also be eligible for medical coverage through Healthworks. **As a result of welfare reform, parenting wards will no longer be sent to the Department of Public Aid (DPA) for financial assistance and their children's medical coverage.** To obtain medical coverage for all non-ward children living with the ward parent, the

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caseworker shall contact the **Federal Financial Participation, Technical Support Unit (217) 524-1974**.

- c) **Financial Assistance.** When a caseworker learns that a baby has been born to a ward (and the baby will be living with the ward), the caseworker shall contact the **Federal Financial Participation Division, Technical Support Unit (217) 524-1974**. FFP-TSU will register (but not open) the non-ward child(ren) under a new CYCIS family ID, with the parenting ward as Head of Household (H) in the new family and Both (B) in the original family. The other natural parent will also be registered to the new family. The non-ward child now has a permanent CYCIS ID. The child would retain this ID should the case be opened in the future. TSU will also open a medical (98) case for the non-ward child baby and assign a special service fee that replaces the financial assistance previously provided by DPA. This special service fee and others that a worker can authorize are described in Procedures 350.40, Authorized Child Care Payments. The caseworker will receive a **CFS 1410, Case Registration Case Opening**, turnaround document to be placed in the ward's family file.

The Technical Support Unit will need the following information to initiate a Medical Card and the financial assistance Special Service Fee:

- 1) Caseworker name, region/site/field
- 2) Ward's name
- 3) Ward's ID number
- 4) Ward's birth date
- 5) Ward's social security number
- 6) Non-ward child(ren)'s name
- 7) Non-ward child(ren)'s birth date
- 8) Non-ward child(ren)'s race
- 9) Non-ward child(ren)'s social security number or applied-for date
- 10) Any information regarding the other natural parent.

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The special service fees should be used by the ward for care of her/his child(ren). The money can be used for diapers, clothing, food or other needs identified by the teen parent. Because learning how to budget the use of money is an important step toward independence

for a young parent, the responsibility for spending the special service fee is the ward's, not the caregiver's. However, if the ward parent does not have experience in managing money or has demonstrated a general immaturity or irresponsibility, the foster parents or the responsible individual may assist the ward with budgeting.

If DCFS obtains legal responsibility for a ward's child because of abuse, neglect, the child's living conditions with the ward parent shall be assessed according to Procedures 300 Appendix G. The CYSIS ID number for the child shall be the same number assigned when receiving medical and financial assistance.

VII. Transitioning Out

At least twelve months prior to the pregnant and/or parenting ward's eighteenth birthday, the caseworker and her/his supervisor shall conduct a staffing with the ward to review her or his plans for the care of the child(en) and themselves as the youth enters adulthood. In attendance at the staffing should be any current service providers, foster parents, and any relatives or friends invited by the ward.

At the staffing, caseworker and the ward will discuss, at minimum:

- a) child care for the ward's child(ren);
- b) education for the ward and her or his child(ren);
- c) employment opportunities and difficulties;
- d) housing options;
- e) available public benefits; and
- f) community services and support networks available to the ward.

The caseworker must assist the ward in developing a transition plan, which addresses these issues and others unique to the youth's circumstances. The caseworker will also refer the ward to community organizations linked with the Children & Adolescent Local Area Network (LAN) in the youth's residential area.

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Not more than three months after the staffing and at three-month intervals, the caseworker and his/her supervisor shall meet with the pregnant and/or parenting ward to review implementation of any plans developed at the prior transition meeting. If necessary, the transition plan shall be refined and additional referrals provided to community organizations in the ward's residential area.

Transition planning is intended to prepare a youth to be on her or his own when discharged from the guardianship of DCFS - usually at age eighteen. A court may continue guardianship of a ward until the age of 21 when the court determines that it is in the best interest of the youth and the public to continue wardship. The youth remains eligible for services under the Pregnant and/or Parenting Program during that time.

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302. APPENDIX K Support and Well-Being of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Children and Youth

a) Purpose

Procedures 302, Appendix K provides DCFS staff, POS staff, and foster parents, with direction and information that sets mandatory minimum standards to promote the safety, adjustment and well-being of Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) children and youth in the Department's care. Anybody in contact with children/youth in DCFS care, who is acting under DCFS/POS authority or control, whether or not directly employed by DCFS or a POS, is prohibited from engaging in the discrimination, bias, or harassment prohibited by Appendix K. These procedures provide information and guidance to all staff working with LGBTQ children, youth and their families. Anyone working with DCFS involved LGBTQ children and youth should contact the DCFS LGBTQ Coordinator through the Office of Specialty Services at 855-814-8421 under the Division of Clinical Practice & Development for information and guidance or to report concerns or questions regarding conduct in violation of Appendix K or otherwise discriminatory or harmful to LGBTQ children, youth and their families. Contact can also be made by completing a CFS-399-1 Clinical Referral Form and sending it to ClinicalRef utilizing the DCFS Outlook.

Children and youth who are lesbian, gay, bisexual, transgender, queer and questioning are protected by the Illinois Human Rights Act [755 ILCS 5] <http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=2266>. Children and youth have many legal rights while in care, including the right to be free from verbal, emotional and physical harassment in their placements, schools, and communities. The adults involved in their care have a legal and ethical obligation to ensure that they are safe and protected. These children and youth also have the right to be treated equally, to express their gender identity, and to have the choice to be open or private about their sexual orientation, gender expression and gender identity.

The Department's policy is to maintain and promote a safe and affirming environment for LGBTQ children and youth in DCFS care, including children/youth who are in DCFS contracted residential facilities and programs, foster care and any other substitute care settings. Like all other children, LGBTQ children/youth are to be placed in the least restrictive setting appropriate for their needs, and LGBTQ status is not an indicator, much less a justification, to place a child in a more restrictive setting. All staff are prohibited from engaging in any form of discrimination, bias or harassment against LGBTQ children, youth and their families. Staff may not impose personal, organizational or religious beliefs on LGBTQ children, youth and families, and in no way should personal beliefs impact the way individual needs of children/youth or families are met. DCFS staff can be disciplined for violating this policy up to and including discharge, per the Employee Handbook and CMS Personnel Rules. See http://dnet/DCFS_Employee_Handbook/Illinois_Department_of_Children_and_Family_Services_Employee_Handbook.pdf. DCFS will not accept the services of volunteers who fail to abide by Appendix K, and will not contract with private agencies who fail to adopt

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LGBTQ policies that are at least as extensive as Appendix K (including, without limitation, policies providing for employee discipline, up to and including termination, for conduct in violation of the non-discrimination policy.

It is important for DCFS/POS staff, providers and foster parents to understand that when children and youth (including DCFS children and youth) explore/express a sexual orientation other than heterosexual and/or a gender identity that is different from the child/youth's sex assigned at birth, those children and youth are to be supported and respected without any effort to direct or guide them to any specific outcome for their exploration.

DCFS is committed to supporting the physical and emotional health and well-being of all children and youth, including LGBTQ and specifically transgender/gender expansive child/youth that are in DCFS care. DCFS requires that all LGBTQ children and youth be placed in an affirming safe housing, receive LGBTQ competent medical and mental health services, and have equal opportunity and access to care. All DCFS/POS staff, providers, and foster parents shall treat LGBTQ children and youth in an affirming manner and proactively work to create a respectful space. All DCFS/POS staff, providers and foster parents are required to be culturally competent in serving the needs of LGBTQ children and youth, including understanding the challenges that LGBTQ and particularly transgender/gender expansive child/youth face in foster care and congregate care. Therefore, any person who is involved with DCFS children/youth will complete mandatory training in LGBTQ competency. Specifically, LGBTQ training will be part of the retraining Child Welfare license, will be included as part of PRIDE training, and will be included in DCFS core training. DCFS and POS staff must complete additional, mandatory standalone LGBTQ training at least once per year. Agencies must include LGBTQ training in their training of volunteers. Annual training in LGBTQ competent care is required for all child welfare providers; whether or not they believe they have care for or currently care for any LGBTQ child/youth.

It is critical that we always speak and behave in ways that are respectfully to LGBTQ children and youth even if we don't know that a LGBTQ child or youth is present. We must model respect and value all children, youth and families regardless of their sexual orientation, gender identity and/or gender expression. Staff in congregate care facilities must be especially sensitive to the needs of, and be culturally aware in serving LGBTQ children and youth in care. This degree of professionalism is exceptionally crucial and especially critical in emergency facilities given that they are an important entry point for children and youth in care.

Early consultation with DCFS LGBTQ Coordinator improves the delivery of services for children/youth and their caregivers. This prepares and stabilizes placements, preventing unnecessary disruptions. DCFS will require all staff to attend ongoing training and education regarding sexual orientation, gender identity and gender expression.

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- b) **Definitions:** It is important to allow all children and youth to self-identify with these terms. The language expressing gender/sexual identities is constantly evolving but this policy is a static document. Children/Youth may be same sex practicing or gender expansive with or without claiming a LGBTQ identity. Language associated with being LGBTQ varies greatly across communities. The use of identity categories (gay, lesbian, queer, transgender), and gender pronouns may be fixed or fluid. Please seek LGBTQ competent consultation if you have questions.

Affirming: Acknowledge and support the individual's rights to self-determination of gender and sexual orientation.

Asexuality: Is the lack of sexual attraction to anyone, or low or absent interest in or desire for sexual activity. It may be considered the lack of a sexual orientation, or one of the variations thereof, alongside heterosexuality, homosexuality and bisexuality.

Bisexual: A person who is emotionally, romantically, and sexually attracted to both men and women.

Cisgender: Term used to describe people whose gender identity is congruent with sex assigned at birth.

Coming-Out: There may be a gradual process of becoming aware of one's sexual orientation and gender identity that includes a personal sense of when to safely disclose this information to others. There is also a gradual coming out process for family, friends, and caregivers as they learn to understand and accept the LGBTQ children and youth. Not all people who identify as LGBTQ choose to or are able to come out.

Congregate Care: Is defined as an entity which consists of 'group living', i.e. Residential Treatment Facility, Group Homes, Transitional Living Programs and Emergency Shelters. These facilities must also be licensed as a child care institution by DCFS.

Culturally Competent: (Culturally Informed) Cultural competence in terms of this population is having fundamental respect for children and youth and meeting their individual needs. Also, it is a lifelong project. Competence with one group doesn't mean you're competent with another. We're an increasingly culturally complex country. Training in cultural competence should include race and ethnicity, sexual orientation, age, gender expression, gender identity, disability status and other demographic characteristics.

Gay: A person whose emotional, romantic, and sexual attractions are primarily for individuals of the same sex, typically in reference to men. In some contexts, the term is used as a general term for gay men and lesbians.

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Gender Dysphoria: Replaces the obsolete diagnosis of gender identity disorder. Gender Dysphoria emphasizes distress, not disagreement, between birth-assigned gender and gender identity. Disagreement between birth-assigned gender and gender identity is not pathological and does not need diagnosis. Gender Dysphoria may be diagnosed when a transgender/gender expansive person is seeking medical interventions such as hormones and/or surgery. Not all transgender people experience gender dysphoria.

Gender Expansive: Having or being perceived to have gender expression and/or behaviors that do not conform to traditional or societal expectations. Gender-expansive individuals may or may not identify as LGBTQ.

Gender Expression: A person's way of communicating gender identity to others through behavior, dress, and physical characteristics. Most people express a range of masculine and feminine characteristics.

Gender Identity: One's innermost concept of self as male or female or both or neither; how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different than the sex assigned at birth. Gender Identity is distinct from sexual orientation. For example, a transgender girl (identified as male at birth but whose identity is female) may identify as heterosexual, meaning she is attracted to boys.

Intersex: A general term used to describe a person born with the sex characteristics (including genitals, gonads hormones and chromosome patterns) that do not fit typical binary notions of male or female bodies. While a person who is transgender has a gender that is different from the one traditionally associated with the sex they were assigned at birth, an intersex person is born with a variation in their sexual or reproductive anatomy such that their body does not fit typical definitions of male or female. Some intersex conditions are visible at birth while others do not become apparent until puberty or later and some differences may not be apparent at all. Upper estimates of the amount of intersex people are approximately 1.7 percent. The term "hermaphrodite" is outdated, stigmatizing, and used to sensationalize intersex people. An intersex person may or may not identify as LGBTQ.

Lesbian: A woman whose emotional, romantic, and sexual attractions are primarily for other women. Some women prefer to call themselves gay.

LGBTQ: Lesbian, Gay, Bisexual, Transgender and Queer/Questioning. This is a common acronym for lesbian, gay, bisexual, transgender, and questioning/queer persons who despite their differences are often discriminated against in similar ways. LGBTQ is sometimes written to include "I" for intersex, and/or "A" for ally. It is also, written LGBTQ+ to identify the many possible additions to the basic "LGBTQ."

Preferred Gender Pronoun (PGP): The pronoun or pronouns that an individual prefers others to use when speaking about them. Single use pronouns may include but are not limited to; he, she, he gender neutral they and ze.

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Queer: Historically, this was a derogatory slang term used to identify LGBTQ+ people but is now a term that has been embraced and reclaimed by the LGBTQ community and academia as a symbol of pride, representing individuals who may fall out of “norms” for gender and sexuality.

Sex Assigned at Birth: Birth-assigned male or female sex typically based on reproductive anatomy (external and internal genitalia, e.g. penis, vagina, gonads, reproductive tracts, and so forth.).

Sexual Orientation: Sexual behavior does not necessarily determine sexual orientation. Sexual orientation refers to one’s enduring emotional, romantic, and/or sexual feelings to another person.

Transgender: A broad term describing the state of a person’s gender identity/expression, when their identity/presentation does not necessarily match those characteristics associated with sex assigned at birth. Associated terms may include female to male (FTM) male to female (MTF), transsexual, and gender queer.

c) **Background Information**

For many children and youth, understanding their sexuality, sexual orientation and gender identity can be a time of reflection, questioning, as well as turmoil and stress. For LGBTQ children and youth, understanding these matters is often more difficult, as LGBTQ children/youth may face prejudice and discrimination from their family, friends, professionals and community. LGBTQ children and youth of color and diverse cultural backgrounds may experience added bias.

Unfortunately, America’s children and youth bear much of the fallout from anti-LGBTQ prejudices. Our DCFS children and youth are more highly impacted than the general population of LGBTQ children and youth.

According to the Child Welfare League of America, LGBTQ children/youth are at higher risk than their heterosexual cisgender counterparts for emotional and physical abuse from family members and/or peers, failed out-of-home placements, homelessness, emotional/physical victimization, and/or institutional neglect or abuse. LGBTQ youth, as a group, have a higher incidence of suicide attempts, runaway behavior, substance abuse, high-risk sexual behaviors, sexually transmitted infections, HIV and pregnancy. In school, LGBTQ youth are at greater risk than their heterosexual counterparts for academic failure, school truancy and premature withdrawal, often as a result of fear, intimidation or threats from other students or staff. Consequently, many LGBTQ children and youth are unlikely to reveal their sexual orientation or gender identity, particularly to people in perceived positions of authority or power (e.g., social service staff, family members, caregivers, teachers, church members, etc.).

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d) Identifying a Need

A child or youth may self-identify as having questions surrounding their sexual orientation or gender identity, or may be identified as LGBTQ by child protection or child welfare staff, school personnel, a birth or foster family member, a therapist, or others from within the community. The caseworker and supervisor are responsible for respecting the children's and youth's sexual orientation, gender identity and expression; informing all children and youth about their legal rights and protecting the child/youth's privacy in the coming out process. It is the caseworker and supervisor's responsibility to ensure that all DCFS youth know that discrimination on the basis of sexual orientation or gender identity is unlawful in Illinois.

Sexual orientation, gender identity, and gender expression are critical components of each individual's development. *These components may or may not be factors in the emotional or behavioral concerns of the LGBTQ child/youth.* It is important to recognize that these are developmental milestones, not problematic behavior. The LGBTQ Coordinator can provide information, clinical consultation, training, and resources to staff and participate in case staffing.

The caseworker shall notify their supervisor and contact the DCFS Clinical Specialty Services LGBTQ Coordinator immediately when there are concerns regarding the child/youth's safety and well-being. Caseworkers and supervisors are responsible for ensuring that recommendations from the consultation are implemented to protect the safety and well-being of the children and youth.

e) Meeting the Need

Placement and Support Services: A child or youth's LGBTQ status is not a reason to place them in congregate care. Most needs of LGBTQ children and youth can be met through positive caregiver, family support and community peer educational support groups. Placement decisions, such as the decision to place a child with kin or fictive kin, must be guided by the caregiver's capacity to meet the unique and diverse needs of the individual. If a child or youth is known to be LGBTQ, the caseworker is responsible for determining prior to placement, the caregiver's attitudes and beliefs regarding sexual orientation, gender identity/gender expression. **In no instance should LGBTQ children/youth be placed with a non-affirming caregiver who is opposed to sexual orientations that differ from the caregiver's own. Nor should LGBTQ children and youth be placed with caregivers who are unwilling/unable to support children and youth whose gender identity or gender expression differs from traditional expectation.** It is critical that children and youth be in a safe, supportive and affirming environment that is safe and promotes physical and emotional well-being the assessment is ongoing. If a caregiver is found to be non-affirming or is otherwise in violation of the nondiscrimination requirements in Appendix K, the youth's DCFS caseworker must take immediate action to intervene and take appropriate corrective action and contact the LGBTQ Coordinator.

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The children's and youth's worker, family, foster family members, or placement caregivers and peers may themselves need assistance in supporting the LGBTQ children and youth. The LGBTQ Coordinator can provide education and identify resources that will assist the caregiver, and support the children and youth in placement. Participation in education and support groups, such as, PFLAG <https://www.pflag.org/> for Parents, Families, Friends, and allies united with people who are LGBTQ, shall be encouraged.

LGBTQ children and youth may also experience difficulty in school. For example transgender students have the right to use the gendered school facilities (e.g., restrooms and locker rooms) that correspond to the student's gender identity. Caseworkers and caregivers should assist children/youth in obtaining their school's permission to use these facilities. Organizations such as the ACLU of Illinois www.aclu-il.org/ are resources to go to should issues in this area arise. Agencies such as the Illinois Safe Schools Alliance <http://illinoissafeschools.org/> promote safe and respectful schools for LGBTQ and allies, for children/youth throughout Illinois by providing professional development to school personnel, supporting children/youth in organizing Gay-Straight Alliances, advocating for inclusive school policies, and providing crisis intervention to child/youth and families in need. Consult educational advisor and DCFS LGBTQ Coordinator if school is impacted.

As with any child/youth, LGBTQ children and youth experiencing emotional and/or behavioral problems may require specific services, such as short-term outpatient counseling or psychotherapy. For example, when a child/youth is having a severe emotional reaction to their sexual orientation, gender expression or gender identity (e.g., persistent depression or anxiety, engaging in substance use or dangerous, high-risk behaviors, social withdrawal, rejection of child/youth, placement disruption), more intensive services may be required. These services might include, but are not limited to, individual, group or family therapy. For any and all services, staff should refer children and youth who identify as LGBTQ only to community-based providers who demonstrate cultural competence in working with LGBTQ children and youth.

All staff should recognize that many adolescents are still exploring their sexual orientation, gender identity, and/or gender expression. Staff should also recognize that children and youth may not be aware of the relevant terminology related to sexual orientation and/or gender identity.

Caseworkers and caregivers should facilitate exploration of any LGBTQ matters through an affirming approach with children and youth by being open, non-judgmental, and empathic. Caseworkers, caregivers and clinicians should allow children and youth to guide the process of choosing language with which they feel most comfortable while discussing their sexual orientation and gender identity and/or expression. Caseworkers, caregivers, and clinicians should recognize that this language may change over time, and affirm and support children and youth in their process of identity formation and expression.

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In some situations, the sexual identity or orientation of LGBTQ children and youth may not be respected. They may not feel safe from harassment, stigma, or discrimination. The LGBTQ Coordinator may be able to assist through education or support services. However, when the risk of harm cannot be mitigated and placement stabilization is no longer in the best interest of the child/youth, the caseworker shall immediately make every effort to seek an alternative placement that is LGBTQ affirming and respectful of the child/youth's right to self-determination. The LGBTQ Coordinator can also assist with identifying resources. It is important to note that staff should continue to carefully consider the parent/caretaker's attitude towards the child/youth's sexual orientation, gender identity/expression and other related behaviors throughout the life of the case when assessing possible safety factors.

f) Expectations of DCFS/POS Direct Services, Foster Parents, Congregate Care (Residential, TLP, Shelter, Group Home Staff)

Respect and Privacy: It is critical to respect the child/youth's gender expression and self-determination, including the child/youth's choice of clothes, make-up, hairstyle, friends, and activities within appropriate boundaries (e.g. if a caregiver permits a cisgender heterosexual child/youth to date at a certain age, the caregiver may not prohibit a gay or transgender child/youth from dating). The child/youth's chosen name and preferred gender pronoun (including gender-neutral pronouns such as "they" or "ze/hir") must be respected. While records must also identify the child/youth's legal name, use the chosen name when communicating directly to the child/youth.

Some children and youth choose privacy. "Respect" refers to protecting the children's and youth's right to confidentiality about sensitive and private information such as their sexual orientation and gender identity. Child welfare staff must be sensitive to the timing and nature of the child/youth's coming-out process and must obtain the child/youth's explicit oral or written permission ([CFS 600-3, Consent for Release of Information](#), or on the D-Net at: [Forms](#)) prior to disclosing this information. Moreover, permission is not "universal" once given. Rather, the caseworker must request permission from the child/youth each time disclosure to a different individual is involved. If a youth requests that their preferred name, and/or gender neutral pronoun also be included in written documents, however, that request should be honored for all written records, including court documents, medical records, school records, and clinical or other service referrals.

When a child or youth requests the use of a preferred name and/or gender pronoun, the staff or provider should ask the youth how they would like to be referred to in conversations with family members and other service providers (e.g., community-based service providers, school officials, and so forth) and the court. As children/youth may experiment with different names and pronouns, this question may need to be repeated frequently. Remember to be flexible.

Reference to a child/youth's orientation or gender identity may be disclosed *without* permission *only* if there is reason to believe that the child/youth is in immediate danger of self-harm or is at risk of being harmed by others because of their LGBTQ identity.

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If a DCFS child/youth is to be body searched, cross-gender searches of transgender youth are prohibited. The child/youth must be searched by someone of the same gender as the child/youth's gender identity unless the child/youth requests otherwise.

If the child/youth feels they are being discriminated against or harassed, or that their service needs are not met, they should be advised to contact the LGBTQ Coordinator along with the DCFS or POS Administrator for assistance. Children and youth also have the right to contact their Guardian Ad Litem, Lambda Legal, or the American Civil Liberties Union (ACLU).

g) Documentation

Documentation and disclosure of LGBTQ matters shall be guided by the children's and youth's right to privacy, the scope of document distribution, and the children's/youth's informed consent. Most references should be limited to case notes. Permission to include explicit LGBTQ references in assessments shall be sought from the child/youth. If the child/youth does not or cannot consent, general references regarding "identity" and "relationships" may be substituted. Service plans shall incorporate the recommendations as they relate to specific daily living, emotional or behavioral concerns. These may include recommendations for counseling or support groups "to address identity and relationship matters" but there should be no explicit reference to LGBTQ services without the permission of the child/youth.

h) Sleeping Arrangements for Transgender/Gender Expansive Children and Youth:

No matter the type of placement, placing youth consistent with their gender identity, rather than their sex assigned at birth, is generally, the best way to protect youth. Accordingly, placement consistent with gender identity should be the presumptive placement. Moreover, a youth's perception of where they should be placed and would feel safest should be the primary factor informing housing decisions and placements should never be made before discussing the issue with the youth.

1) Foster Care Licensed, Foster Home, Home of Relatives and Home of Fictive Kin

When a transgender/gender expansive child/youth is residing in a foster home, the agency is expected to make sleeping arrangement decisions on an individualized basis, while following the general guidance detailed above. Decisions on bedrooms for transgender/gender expansive child/youth in foster homes should be based on the child/youth's **individualized needs and should prioritize the child/youth's emotional and physical safety**. The agency (DCFS/POS) should take into account the child/youth's perception of where they will be most secure, as well as any recommendations from the child/youth's health care provider. The child/youth's well-being as well as that of any other children/youth in the foster home should be taken into consideration when making this decision. It is important to consider the LGBTQ child/youth and other children/youth in the home in the decision making process. While this may take time and effort on the front end, there will be a higher likelihood that the placement will be stable over time.

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All LGBTQ children and youth are particularly vulnerable to failed placements. With this in mind, individualized placement decisions, as well as an increase and diversification of placement options available to LGBTQ children and youth is critical. Caregivers for LGBTQ children/youth must understand and support the LGBTQ children/youth's identity.

2) **Congregate Care: (Residential, Group Home, Shelter, Transitional Living)**

A child or youth's LGBTQ status is not a reason to place them in congregate care. For situations where a transgender/gender expansive child/youth is in congregate care for reasons other than because they are LGBTQ, every effort should be made so that transgender/gender expansive child/youth are housed in a facility that can provide transgender/gender expansive culturally competent staff, individual sleeping quarters (one person bedroom), as well as private bathroom and shower to allow for safety and privacy. Where shared sleeping accommodations are required, extensive consideration must be given to ensuring that assigned roommates are not a risk to the transgender/gender expansive child/youth's emotional/psychological well-being or physical safety. Transgender/gender expansive child/youth should not automatically be housed according to their sex assigned at birth. As in foster care setting, the agency should make housing/sleeping quarters decisions based on the child/youth's individualized need and should prioritize the child/youth's emotional and physical safety. Agency staff should take into account the child/youth's perception of where they will be most secure, as well as any recommendations from the child/youth's health care providers and remember to include the child/youth in the decision making process as to avoid alienating them.

Care must be taken to protect male identified children and youth who were labeled female at birth from aggressive peers/staff in congregate settings. If safe congregate housing cannot be found for transgender/gender expansive male identified people assigning them to female congregate facilities could be considered, but their transgender/gender expansive identity must be respected in the female facility. If a facility has both male and female residents, it could be considered to have the transgender/gender expansive child/youth sleep on the unit of their assigned gender and program on the unit of their preferred gender. Individualized decisions are needed and must place the safety/well-being of the transgender/gender expansive child/youth first, over institutional ease.

If a DCFS child/youth is to be body searched, cross-gender searches of transgender youth are prohibited. The child/youth must be searched by someone of the same gender as the child/youth's gender identity unless the child/youth requests otherwise. This should be reflected in the agency's Standard Operating Procedures (SOP) manual of the congregate care facility.

Designated staff should conduct ongoing check-ins with the LGBTQ child/youth to confirm that the placement continues to be one that is supportive of their identity and meets their needs.

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i) Expectations of the DCFS LGBTQ Coordinator

The DCFS LGBTQ Coordinator can help workers and supervisors in addressing the sensitive matters of sexuality and gender expression or emerging sexuality of children and youth for whom the Department is responsible. The Coordinator can help:

- consult about the Department's LGBTQ policy
- educate staff, caregivers, and child/youth about LGBTQ legal rights and matters
- raise self-awareness about attitudes or bias through consultation and training
- participate in meetings and staffings
- identify LGBTQ-**sensitive** resources and placements
- help with the preparation of a new placement
- consult about the preservation of the current placement
- distinguish problematic behaviors from identity development
- consult with children and youth about legal rights process, and resources
- advocate respect for diversity

j) Health Care:

Medical: LGBTQ appropriate and culturally competent medical care and sexual health education and resources shall be provided to all DCFS child/youth.

All DCFS child/youth receive a comprehensive health assessment at case opening which includes identification of existing medications being taken by child/youth. If the child/youth reports that they were prescribed hormones or puberty blocking medications by a licensed medical provider, these medications must be continued under appropriate medical supervision while the child/youth is in care. A referral to DCFS Nursing Services should be made to ensure there is continuity of care utilizing the CFS 531 and sending the referral to *NurseRef* via DCFS Outlook.

If a child/youth makes a request to begin puberty blocking/hormone therapy while in care, they should be referred to medical professionals who are recognized as medically competent in the care of transgender child/youth. The Statewide LGBTQ Coordinator should be contacted when transgender medical care is being considered, along with the DCFS Guardian's office.

Please refer to Procedures 327.5 Medical Consents Section (a)(5) for the new initiation of puberty blocking/hormone therapy. If the child/youth's Permanency Goal is to return home, and if the parent's whereabouts are known, they should be informed of the initiation of puberty blocking/hormone therapy. Two physicians or a physician and another licensed health care provider such as a licensed psychologist, LCPC, LCSW who is culturally competent in transgender health care, must agree that the child/youth is appropriate for the initiation of puberty blocking/hormone therapy. Definitions and information of these terms can be found through this link <http://transhealth.ucsf.edu/trans?page=guidelines-youth>.

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Intersex: For children and youth that are intersex, a referral to a health provider/specialist should be made. In addition, referrals to DCFS Nursing, utilizing the referral form CFS 531 should be sent to NurseRef via DCFS Outlook.

Mental Health:

LGBTQ children and youth commonly experience chronic stress related to harassment, the need for vigilance to protect against discrimination and abuse, coming out to family and friends, and having one's sexual orientation discovered. Chronic stress can lead to increased levels of depression and anxiety. Several studies, including population-based studies, indicate a higher risk of suicide ideation and attempts among lesbian, gay, and bisexual youth, compared with their heterosexual peers. LGBTQ children and youth are also at risk for inappropriate mental health treatment, including misdiagnosis of gender identity disorder, involuntary institutionalization, and reparative therapy or other interventions designed to change their sexual orientation or gender identity.

Transgender children and youth may present health concerns distinct from those common to lesbian, gay, or bisexual children and youth generally. Transgender children and youth experience very high levels of stigmatization, which may increase their feelings of depression and hopelessness. They may also experience significant distress because their body does not correspond to their gender identity. CWLA Best Practice Guidelines <https://familyproject.sfsu.edu/sites/default/files/bestpracticeslgbtyouth.pdf>

DCFS and POS staff must consult with the LGBTQ Coordinator when an LGBTQ child or youth is demonstrating signs of stress or anxiety and must be referred to a mental health professional experienced in serving LGBTQ youth.

k) Child Welfare Do's and Don'ts

Do:

- 1) The LGBTQ Coordinator should be notified when a DCFS child/youth is identified as LGBTQ. When there are acknowledged or suggested concerns regarding the sexual orientation, gender identity and/or gender expression with a child or youth for whom the department is responsible the LGBTQ Coordinator must be contacted immediately.** For example, a child or youth may confide to staff that his foster parent or other children/youth in the home tease him because he “acts like a girl” or “acts gay.” The Coordinator can provide information, training, and resources as well as participate in staffings and assessments. DCFS staff and POS staff should notify the LGBTQ Coordinator whenever questions or concerns surrounding a child or youth's sexual orientation or gender identity arises, even if the child does not identify as LGBTQ. The LGBTQ Coordinator can be contacted in the Clinical Division's Specialty Services office at 855-814-8421 and also through the DCFS outlook email system completing the Clinical Referral Form CFS-399 and sending to *ClinicalRef* utilizing DCFS Outlook.

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- 2) **Implement recommendations made by the LGBTQ Coordinator within five working days of the contact. If there are barriers to meet this deadline, contact the DCFS LGBTQ Coordinator to request additional assistance or to see if an extension can be granted.**

- 3) **Inform children and youth about their legal rights.** All LGBTQ individuals are protected by the Illinois Human Rights Act <http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID+2266>. Children and youth have many legal rights while in care, including the right to be free from verbal, emotional and physical harassment in their placements, schools, and communities. The adults involved in their care have a legal and ethical obligation to ensure that they are safe and protected. These children and youth also have the right to be treated equally, to express their gender identity, and to have the choice to be open or private about their sexual orientation.

- 4) **Ensure that LGBTQ children and youth are placed in LGBTQ affirming environments that respect the children's and youth's right to self-determination.** The LGBTQ Coordinator can assist by providing training and resources to the caregiver or provider prior to placement or anytime gender or sexual orientation matters are identified. When there is risk of impending emotional or physical harm in the child/youth's placement due to the bias of others about his or her acknowledged or perceived sexual orientation, gender identity or gender expression, the caseworker must contact the LGBTQ Coordinator and consider the prompt removal of the child/youth from that placement when the risk cannot be mitigated.

- 5) **Always be respectful of the children's and youth's gender expression and self-determination.** Child welfare staff must be sensitive to the nature and timing of the children's and youth's coming out process. The children's and youth's choice of clothes, hairstyles, make-up, friends, and age appropriate activities should be respected along with regard for the children's/youth's chosen name and preferred gender pronoun. If there are places in the child/youths place of residence where their name is listed-for example on an in/out board, use the child/youth's preferred name unless they say not to do so.

In terms of transgender children and youth who are placed in a male-only or female-only facility that does not conform to the child or youth's gender identity (based primarily on the youth's perception of where they should be placed and would feel safest), should be allowed to dress consistent with their gender identity, notwithstanding any dress code.

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- 6) **Protect the children’s and youth’s right to privacy about their sexual orientation and gender identity.** Child welfare staff must obtain the child/youth’s explicit oral or written permission (CFS 600-3 form) for disclosure of this information to persons other than the LGBTQ Coordinator. The information may be disclosed to persons other than the LGBTQ Coordinator *without* permission only if there is reason to believe that the child/youth is in immediate danger to their self or is at risk of being harmed by others because of their LGBTQ identity.
- 7) **Documentation and disclosure of LGBTQ matters shall be guided by the child/youth’s right to privacy, the scope of document distribution, and the child/youth’s informed consent** (CFS 600-3 form). Unless a child or youth permits otherwise, DCFS and POS staff should not include information disclosed in confidence about their sexual orientation or gender identity. Permission to include explicit LGBTQ references in assessments must be obtained from the child/youth. If the child/youth does not or cannot consent, general references regarding “identity” and “relationships” may be substituted. Document recommendations in the child/youth’s service plan only as they relate to specific daily living, emotional or behavioral concerns. This may include recommendations for counseling or support groups “to address identity and relationship matters” but there should be no explicit references to LGBTQ services without the child/youth’s permission.
- 8) **Provide supportive and affirming care regardless of one’s personal attitudes, beliefs, preconceptions and/or judgments, if any, surrounding matters of sexual orientation, gender identity, and gender expression.** LGBTQ youth in care are entitled to receive care and services from individuals who treat them with respect and without bias. Individuals who have difficulty meeting this standard for personal reasons should seek assistance from supervisors and the LGBTQ Coordinator in order to address those issues. DCFS will not tolerate exposing LGBTQ children and youth to staff/service providers who are not supportive of children and youths’ right to self-determination of sexual/gender identity.
- 9) **Create an environment in your office and in meetings that signals to all clients that you are a safe and supportive person for them to talk with about LGBTQ matters and concerns.** “Safe space” stickers, DCFS LGBTQ printed material or informational pamphlets from local LGBTQ child/youth support and drop-in groups must be displayed in the office reception area.

Do Not:

- 1) **Include specific information about a child/youth’s sexual orientation, gender identity or expression *without* the permission of the child/youth *except* when the child/youth presents a danger to self or is at risk of being harmed by others because of their LGBTQ status.** General references regarding “identity” and “relationships” may be included in written records.

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- 2) **Address a child/youth as deviant, pathological, immoral or in need of changing because of their sexual orientation, gender identity, gender expression or questioning status or allow a child/youth to receive services from such providers.**
- 3) **Contract or seek treatment services for the purpose of changing a child/youth's sexual orientation, gender identity, or gender expression.** Such treatment would be ineffective and extremely damaging to the children's/youth's sense of self and well-being. Reparative/conversion therapy is illegal [815ILCS 505/2Z]
- 4) **Assume that only LGBTQ adults can be effective in working with LGBTQ child/youth.**
- 5) **Ask children or youth about their sexual orientation, gender expression/gender identity in a public space.** A private space will help keep the conversation confidential and increase the likelihood of children and youth feeling safe in disclosing their identity and/or sexual orientation.
- 6) **Discuss sexual orientation, gender expression/gender identity in front of family without consent of the child/youth.** They may not be ready to come out to family members, and if the family does know, they may not yet be supportive of the child/youth's gender identity/sexual orientation.
- 7) **Assume that all sites/service providers/agencies that serve LGBTQ children and youth are transgender inclusive.** The needs of transgender/gender expansive child/youth are different than that of lesbian, gay and bisexual child/youth and not all places are able to work effectively with transgender/gender expansive child/youth. For example, transgender/gender expansive children and youth may need private bedrooms, access to private bathrooms and showers, for individual shower time. DCFS requires that all agencies, providers and sites are culturally competent, affirming and equipped to care for LGBTQ children and youth. Human Rights Campaign www.hrc.org has guidelines and certifications for agencies to become LGBTQ culturally competent.
- 9) **Assume the sexual orientation of transgender/gender expansive individuals. Gender and sexual orientation are separate and distinct matters.**
- 10) **Shame a child/youth for fluctuating gender presentation.** Switching names/pronouns/physical presentation is often a developmental step for LGBTQ child/youth.
- 11) **For many LGTQ children and youth their gender pronouns are fluid and flexible.** Do not assume that you know the child/youth's preferred gender pronoun, always ask.

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Resources

Chicago LGBTQ services:
<http://chicagolgbtservices.org/>

Child Welfare Information Gateway:
www.childwelfare.gov/

Lambda Legal – Making the Case for Equality – lambdalegal.org fighting for LGBTQ
right
www.lambdalegal.org/

American Civil Liberties Union:
WWW.ACLU-IL.ORG

Illinois Safe Schools Alliance
www.illinoissafeschools.org

Human Rights Campaign
www.hrc.org

LGBTQ resources are available on the Statewide Provider Database at
<https://illinoisspdinfo.wordpress.com/lgbtq/>

The LGBTQ Coordinator can provide additional resources including community services,
publications, videos and websites.

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Glossary: These are some additional terminologies/terms that are used or are outdated in the LGBTQ community and they are important do understand when working with LGBTQ children and youth.

Closeted: Keeping one's sexual orientation or gender identity secret.

Gender fluid/expansive/creative: Conveys a wider, more flexible range of gender expression, with a range of interests and behaviors. Expanding beyond traditional gender stereotypes. It reinforces the notion that gender is not-binary, but a continuum; and that many children and adults express their gender in multiple ways.

Gender Non-binary: Those with non-binary genders can feel that they: Have an androgynous (both masculine and feminine) gender identity, such as androgynous. Have an identity between male and female, such as intergender. Have a neutral or nonexistent gender identity, such as agender or neutrois.

Heteronormativity: A belief system that assumes heterosexuality is normal and that everyone is heterosexual.

Heterosexism: A belief system that assumes that heterosexuality is inherently preferable and superior to other forms of sexual orientation.

Heterosexual: A person whose emotional, romantic, and sexual attractions are primarily for individuals of a different sex. Sometimes this is referred to as straight.

Homophobia: Fear, hatred of, aversion to, or discrimination against homosexuality, LGBTQ individuals or those perceived as LGBTQ, and anyone associated with LGBTQ persons.

Homosexual: This is an outdated term used to refer to a person based on their same-sex sexual orientation, identity or behavior. Many LGBTQ individuals prefer not to use this term, especially as a noun, because of its historically negative use.

Pansexuality: Is sexual attraction, sexual desire, romantic love, or emotional attraction toward people of any sex or gender identity. Individuals who are pansexual refer to themselves as gender-blind, asserting that gender and sex are insignificant or irrelevant in determining whether they will be attracted to others.

Transphobia: Discriminatory acts or behaviors directed toward those who are gender expansive or transgender.

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APPENDIX L

SERVICES FOR DEAF AND HARD OF HEARING CLIENTS

Procedures 302, Appendix L establishes requirements for DCFS and POS child protection and child welfare workers to ensure that children and adults who are deaf or hard of hearing have equal access to services provided by the Department and that the services or interventions are beneficial to them.

I. ACCESSIBILITY OF SERVICES TO ALL PERSONS

Titles VI and VII of the Civil Rights Act of 1973 (29 U.S.C. 793 and 794); the U.S. Constitution; the 1970 Illinois Constitution; and applicable state and federal laws, regulations or court orders which prohibit discrimination in the delivery of services based on race, color, national origin, sex, religion, ancestry, inability to speak or comprehend the English language, handicaps or age. There is no distinction in eligibility for or in the availability or manner of providing services.

All persons and organizations having occasion either to refer persons for services or to recommend DCFS services are advised to do so without regard to the person's race, color, national origin, sex, religion, ancestry, inability to speak or comprehend the English language, disability or age. It is the policy of the Department to provide services to all persons without regard to race, color, national origin, sex, religion, ancestry, inability to speak or comprehend the English language, handicaps or age. Such services shall be provided in compliance with Titles VI and VII of the Civil Rights Act of 1973 (29 U.S.C. 793 and 794); the U.S. Constitution; the 1970 Illinois Constitution; and applicable state and federal laws, regulations or court orders which prohibit discrimination in the delivery of services. There is no distinction in eligibility for or in the availability or manner of providing services. Additionally, children or their families shall not be denied services under this part solely on the basis that a parent is admitted to an Illinois mental health facility, detained in an Illinois jail, or committed to the Illinois Department of Corrections.

II. DEFINITIONS

American Sign Language (ASL) means a language in and of itself, different from the English language: It has its own word order and syntax.

Auxiliary Aids include but are not limited to amplifiers or amplified phones, decoders or flashing lights which can indicate a phone or doorbell ringing or the presence of smoke or fire; Baby Crying (a monitor which picks up the sound of a baby's cry), closed caption devices for televisions, hearing aids and flash cards.

Deaf means the absence of the ability to hear and understand speech or monitor one's own speech production with or without a hearing aid.

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Department Statewide 504 Coordinator means the employee in the Office of Affirmative Action responsible for coordinating Department compliance with Section 504 of the Rehabilitation Act.

Hard of Hearing is a description for a person who has sufficient hearing, with or without hearing aids, to understand the speech of others and monitor his own speech, even though he has a hearing loss.

Illinois Relay Center (IRC), also known as "Dual Party Relay," is a 24-hour-a-day, seven-day-a-week service which provides a communications link between those who use a Telecommunications Device for the Deaf (TDD) and those who use a standard voice telephone. IRC provides relay service through a program by the Illinois Telecommunications Access Corp. (ITAC), the local phone company, and AT&T.

Interpreter means a person who facilitates communication through sign language or other visual means for persons who are deaf or persons who have a partial or severe hearing loss. A person who translates sign language or other means of visual communication into spoken English for persons who are deaf or hard of hearing.

Lip reading (or speech reading) means watching a person's mouth and face to read what words are being said. Research indicates that only about 3 out of every 10 words can be speech read easily.

Manually coded English (or "signed English") means signs that represent English words in English word order.

Prelingual Deafness means deafness which occurs before the acquisition of language (usually before 3 years of age). Such a person will have no language frame of reference for English when learning to speak, write, or speech read.

Primary language means the language which the client normally uses in day-to-day activities.

Postlingual Deafness means deafness which occurs after the acquisition of language (usually after 3 years of age). In most cases, persons who have lost their hearing after this age have a relatively strong language base.

Registry of Interpreters for the Deaf (RID) means a national organization that has established an evaluation and certification mechanism for sign language and oral interpreters. A certificate signifies that an interpreter has attained a minimum skill level. A registry of certified Interpreters is published annually by the RID, and is recommended as a way of verifying current certification status.

Telecommunication Device for Deaf (TDD) means a special typewriter-style device that enables the telephone conversation to be typed rather than spoken. A deaf person can communicate directly with anyone who has a similar device.

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III. BACKGROUND

On September 20, 1991, the Department entered into a Voluntary Compliance Agreement with the U.S. Department of Health and Human Services, Office of Civil Rights, which addressed how the Department would provide services to persons with hearing impairments and limited/non-English speaking persons. As the Agreement applies to persons with hearing impairments, the Department is required to do the following:

- a) Develop policies and procedures to assure effective communications between Department staff and all hearing-impaired persons coming into contact with the Department;
- b) Develop and implement a procedure for assessing special language needs at the point of intake and ensuring that the language needs are noted throughout case files and communicated between appropriate staff;
- c) Notify deaf or hard of hearing persons that the Department has entered into written agreements with sign language interpreter services or will otherwise provide appropriate interpreter services at the Department's cost;
- d) To NOT use family members or friends of adult deaf or hard of hearing persons as interpreters involving alleged abuse, neglect, dependency, or in hearings and appeals, and never use family members or friends of a deaf or hard of hearing child as interpreters for any purpose;
- e) Provide TDDs (The term TDD is generic and replaces the earlier term TTY which refers specifically to teletypewriter machines.) at each office, with appropriately trained staff, and publicize the TDD numbers to community agencies dealing with deaf or hard of hearing persons;
- f) Train all staff with direct client contact and their supervisors on all of the policies and procedures relevant to the Agreement;
- g) Implement and maintain a record-keeping system; and
- h) Review compliance by Department service providers.

As a result, the Department revised many of its procedures to address the issues described in the agreement. In addition, training was conducted in all Department Regions explaining the Department's policies on services to deaf or hard of hearing persons.

Compliance Issues

On October 7, 1997, the Office of Civil Rights initiated an investigation pursuant to a complaint alleging that a person with a hearing impairment was discriminated against on the basis of her hearing impairment, because the Department failed to make adequate

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arrangements for the provision of sign language interpreters. The issues subject to investigation included whether the person filing the complaint was denied sign language interpreters and whether the Department, through its methods of administration, fails to ensure that qualified disabled individuals are not subject to discrimination on the basis of disability.

New Agreement

The Office of Civil Rights suspended further administrative action on the complaint pending verification that the Department completed the actions outlined in a new agreement. The provisions of the new agreement are described in Section IV below.

IV. REQUIREMENTS FOR THE DEPARTMENT

- a) The Department must develop or reiterate policy and procedures clearly stating the obligations of purchase of service providers to offer and provide sign language interpreters or other auxiliary aids which enable deaf or hard of hearing persons to participate and benefit from their services. The procedure must provide instructions on how to arrange for an interpreter (directly or through the Department) and whether the Department or the POS provider is responsible for the cost of the interpreter.
- b) The Department must disseminate the policy and procedure to all current POS providers and provide training for these providers on its implementation.
- c) The Department has developed a plan that ensures that all current POS providers, prior to executing a service contract, are made aware of their obligation to provide interpreter services and agree to adhere to the policy.
- d) Through its State Deaf Services Coordinator, the Department conducts training on the Department's policy and procedure regarding interpretive services and the Department's obligation to assure the compliance of its POS providers.
- e) Through its State Deaf Services Coordinator, the Department provides all regional and field offices within Cook County and statewide a composite list of resources for sign language interpreter services, updated at least annually, and ensures that staff is informed of these resources via memoranda or other communication.
- f) The Department will appoint a person who will be responsible for evaluating each field office's and provider's procedure and/or plan of action to assure that each has demonstrated the ability to comply with the requirements, and for taking necessary corrective action whenever compliance problems are discovered.

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V. WORKING WITH DEAF OR HARD OF HEARING CHILDREN OR FAMILIES

In the time that has passed since the 1997 agreement with the Office of Civil Rights, the Department has continued its efforts to improve services to deaf and hard of hearing individuals. Educating the child welfare community about the needs of individuals who are deaf or hard of hearing, revising policies and procedures and providing ongoing guidance and support to employees of the Department and those in the private sector have been a critical part of this process.

Understanding the Disability

The primary disability of deaf or hard of hearing persons is a greatly reduced ability to communicate with most hearing persons. Staff should exercise sensitivity when interacting with persons with hearing impairments. The invisibility of deafness/hearing impairment often makes it difficult for others to understand and a deaf or hard of hearing person's actions can be misinterpreted. Furthermore, there is a misconception that deaf people can overcome the communication barrier through lip reading and use of hearing aids. The person's degree of hearing loss and the method they use to overcome it will dictate the method used.

Deafness is an invisible. One cannot tell whether or not a person is deaf or hard of hearing by looking at them. It is not until they demonstrate their inability to communicate verbally or in some other manner that their deafness becomes known. Unfortunately, there is a long history of deaf persons being misdiagnosed as having numerous physical and/or mental limitations and placed in hospitals-or programs that did not address their deafness. Communication barriers are prevalent and make it impossible for a deaf person to communicate their condition or illness to a doctor or other professional that does not know sign language.

At one time, the term deaf and dumb was used to describe persons who could not hear and could not speak. Deafness and its association with ignorance is a stigma that to this day is prevalent in some areas of society. In some areas, the deaf are placed in classrooms with the mentally retarded because of their inability to communicate or because school systems do not have the resources to provide the auxiliary aids they need.

When a deaf person tries to speak, they often do so in a monotone voice. Others can only make shrill noises as they try to form and speak words. To the person not familiar with deafness, it would be possible to assume the person has a speech impediment rather than deafness. They cannot hear themselves speak, making it impossible for them to control the tone, pitch or volume of their voices. A deaf person who tries to speak may do so in a loud voice which can be mistaken for anger if the person being spoken to is not aware that the person is deaf. Deaf culture dictates that their members not use their voices. Deaf persons rely upon their visual skills to observe and express themselves in society. Depending on what is being discussed, two deaf persons involved in a conversation (signing) may use extreme hand, arm, and facial expression to communicate their position. To the unfamiliar observer, it may appear that those involved in the

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conversation are angry and on the verge of violence. However, it is possible that they are just communicating to each other what they saw on television last night. Being deaf does not equate to being an angry person.

Like most minority populations in our society, a deaf have developed a culture that reflects the uniqueness of lives. They communicate with each other in their own language (American Sign Language or ASL) which is recognized as the third largest method of communication behind English and Spanish. Deaf culture consists of many customs and traditions practiced only by them. They have a number of role models who are deaf or come from the deaf culture including a number of deaf authors, actors, comedians, and entrepreneurs.

VI. SPECIALIZED INTERVENTIONS AND SERVICES FOR DEAF AND HARD OF HEARING CLIENTS

a) Requirements for DCFS and POS Workers

The following requirements are for DCFS and POS Workers alike. Monitoring of POS Workers' compliance with the following requirements takes place through IDCFS POS Monitoring Office.

1) Initial Contact

Department and POS staff who are responsible for initial contact with the client shall ensure that persons with hearing impairments are identified and the mode of communication which they use is documented. In many instances, at the initial contact, the worker will have been alerted by the referring party, agency, family member, client, etc., that the client is deaf or hard of hearing and requires the use of an interpreter to facilitate communication. DCFS and POS staff shall then obtain the services of a certified sign language interpreter whenever possible for the initial contact with the client or at the earliest time an interpreter can be secured. If the staff person does not know how to obtain an interpreter or translator for communication with deaf or hard of hearing persons, he or she must immediately contact the Deaf or Hard of Hearing office (see **Attachment I** of these procedures for additional information). Interpreter services are provided at no cost to the client. POS agencies have funds allocated within their contract for these services.

A written notice shall be given to the deaf or hard of hearing client at the initial contact, informing the client of the right to an interpreter or other auxiliary aids at no cost to the client. The notice describes the circumstances under which an interpreter must be provided, a description of auxiliary aids options, the right to a psychological assessment performed by a qualified professional, services available to meet the needs of deaf or hard of hearing individuals and contact information for the Deaf

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Services Coordinator and the Office Deaf Services Coordinator if there is a question or complaint regarding compliance with the auxiliary aids policy. Video tape notices using American Sign Language may be provided to deaf parents with limited or no English language literacy. The notice also informs deaf or hard of hearing individuals of their right to contact the Office for Civil Rights if there are questions regarding compliance.

The DCFS or POS worker shall document on the **SACWIS Case Note** the individual's preferred method of communication and shall identify the client as deaf or hard of hearing in the initial **SACWIS Client Service Plan, under "Language/Mode of Communication."** Additionally, workers must document as described above, any needed specialized communication services required, including but not limited to sign language interpreter services, to successfully service the corresponding case.

2) Use of Sign Language Interpreters and Translators

The Department provides interpreters, translators and other auxiliary aids in order to enable deaf and hard of hearing clients access to the service it provides at no cost to the client. POS agencies have funds allocated within their contract for these services. A certified interpreter is also provided when clients must be present in court related to Department matters (if the court does not have such services available) when clients attend a hearing or appeal, when clients must be present at an Administrative Case Review and all other appearances required to conduct business with the Department related to their case.

A certified **interpreter for the deaf** must show proof of a certificate issued by the Registry of Interpreters for the Deaf (RID); a satisfactory evaluation by the National Association of the Deaf; a satisfactory Interpreter Skills Assessment Screening (ISAS) evaluation; or licensure or certification or a satisfactory evaluation or screening in another state.

According to the Illinois Deaf Hard of Hearing Commission (IDHHC) the following requirements are true for State Licensure Levels for Sign Language Interpreters working for DCFS.

- Red Licensure SLI – Provisional Skills (Unable to provide any sign language services to DCFS.)
- Yellow Licensure SLI – Intermediate Skills (Qualified to provide general meeting and communication sign language services to DCFS and POS when youth or caregivers are not present.)

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- Green Licensure SLI – Advanced Skills (Qualified to provide services to all DCFS programs except legal services.)
- Silver Licensure SLI – Masters Level (Qualified for all DCFS services.)

All Sign Language Interpreters are licensed by IDHHC and will provide proof of, at least, green licensure when working for DCFS youth in care, care givers, POS, Intact Families, IA, etc and proof of Silver Licensing for Juvenile Court and other legal venues.

A **sign language translator** is a person who is qualified to translate due to their education and experience.

A registered interpreter shall be present for all of the following:

- All visits between a hearing child and deaf adult;
- All Investigations;
- Court appearances;
- Home Visits;
- Office visits;
- Visits with children attended by Recipient's staff;
- Case Plan Meetings;
- Evaluations;
- Social histories;
- Psychological evaluations;
- Psychiatric evaluations;
- Substance abuse treatment evaluations; and
- Other interactions as deemed necessary by IDCFS or POS provider or the client.

Family members or friends of the adult or minor deaf or hard of hearing person **may not** be used as interpreters in cases involving alleged abuse, neglect, dependency, and hearings and appeals. The use of family or friends to interpret may compromise the Department's investigation of child abuse or neglect if, for example, a parent is reluctant to disclose child abuse or domestic violence if the spouse is present and interpreting or a deaf child does not disclose child abuse if the parent is interpreting for child. Minor children are never to be used as interpreters as doing so places the child in an unacceptable child-parent role, increases the likelihood of inaccurate information being conveyed, and allows the child access to the parent's confidential information including such matters as mental health or substance abuse treatment history. These restrictions are to ensure confidentiality of information and accurate communication.

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In other situations, after being informed in writing that the Department will provide an interpreter at no cost to the client, adult deaf or hard of hearing clients may request that a family member or friend be used as an interpreter for themselves. Such a request shall be documented in the case file. However, parents may not provide such consents for their children. Sign language interpreters are to serve only as facilitators of communication and are not otherwise involved in the client's business. Interpreters should never be expected to act as social workers, psychologists or counselors. All certified interpreters are bound by the Registry for Interpreters for the Deaf Code of Ethics and all applicable state laws to keep all information strictly confidential.

DCFS workers and those employed by private child welfare agencies shall document on the **SACWIS Case Note** each instance that an interpreter was provided, including the date and purpose and explain any circumstances under which an interpreter was not provided.

No determination or final decision regarding service delivery shall be made until an interpreter has been involved.

3) **Auxiliary Aids**

In addition to qualified interpreters, auxiliary aids and services for deaf and hard of hearing clients and wards shall, if needed by a child or adult, be provided at no cost to the client. Auxiliary aids and services may include qualified sign language or oral interpreters, computer-assisted real time transcription service (CARTS), written materials, telephone handset amplifiers, assistive listening devices and systems, telephones compatible with hearing aids, TDDs and service animals. There are also devices available to the deaf person that will assist in making his or her environment safer for themselves and their families. They include:

- Monitors that flash when the child cries or makes noise in the nursery;
- Devices that allow a lamp and a phone line to be plugged into them. The light flashes when the phone rings;
- Devices that are wired into the door bell and flash when the door bell rings;
- Smoke detectors that have high powered strobe lights that flash when set off;

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- Devices that are available for deaf motorists to alert them when an ambulance or other emergency vehicle is with a siren is approaching; and
- Most communities have a pager available to deaf persons that I set off when severe weather warnings are sent out.

Each DCFS Regional Office shall maintain a list of resources and provide DCFS and POS workers with instructions regarding how to access them. The Statewide Coordinator for Deaf Services will assist the Regional Offices in acquiring resources. Catalogues are available from the Deaf Services Coordinator and a list of suppliers is maintained for reference.

b) Assessments

A mental health or psychological assessment of a deaf client requires effective communication between the deaf or hard of hearing client and a therapist or psychologist that is skilled in signed language communication or familiar with using qualified sign language interpreters. The therapist, psychologist or other clinician conducting the assessment shall have extensive knowledge of deafness and the cultural implications. This knowledge is particularly critical in the evaluation of the deaf individual's interests, abilities, life experiences, and aspirations.

c) Misdiagnosis and Biases

There are a number of tools available to qualified professional clinicians that will prevent misdiagnosis of their deaf clients. Most deaf clients will not be able to read at higher grade levels or comprehend many of the terms used in diagnostic tools that are not designed specifically to meet their needs. Some diagnostic tools are inherently biased toward the deaf due to the language used in the tool.

It is extremely important for the selected professional to be familiar with these tools and their use. There have been cases in which psychometric tools unsuited for use with individuals who are deaf or hard of hearing were used, resulting in the individual being misdiagnosed as mentally retarded. Misdiagnosis and biases are obstacles to achieving the preferred outcome for children and families, preventing or delaying their reunification. The caseworker may be able to determine whether the therapist/psychologist is familiar with the deaf and their culture by how they respond to questions about deaf persons and how they communicate to deaf persons themselves or through qualified interpreters.

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Common Indicators of Misdiagnosis and Bias

There are several indicators in the assessment of deaf clients that may indicate the presence of misdiagnoses or bias: The following are some examples:

- The findings of the assessment indicate the deaf client is mentally retarded;
- A psychiatric examination was conducted by a person who is not fluent in sign language or without a qualified interpreter present;
- The assessment was not individualized to meet the needs of a deaf client;
- An evaluation tool was used which relies heavily upon English language competence and the client is diagnosed as mentally retarded;
- The clinician conducting the assessment has no training in the psychosocial aspects of deafness, no exposure to deaf culture and no experience evaluating deaf clients; or
- Failure by the psychologist to conduct both cognitive and adaptive functioning.

If one or more of these indicators is present, a copy of the assessment report shall be forwarded to the Statewide Deaf Services Coordinator and the Clinical Services Coordinator in the child's region and a clinical review shall be conducted.

d) Services

1) Communication Requirements

A prerequisite to the provision of services to Department clients is that the services be made available in a manner which can be understood by clients with special communication needs such as those who have limited or no English speaking ability or who have hearing loss. The Department's facilitates communication with such clients through the early identification of communication needs, the assignment of staff who can communicate with the clients, the translation of forms, notices and letters into a language the client can understand and through the use of interpreters and other auxiliary aids. DCFS and POS caseworkers and supervisors are responsible for locating and accessing services that are provided in the client's preferred mode of communication.

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2) **Specialized Parenting Services**

A person's inability to hear does not render them unfit as parents. Evaluation of a deaf or hard of hearing parent's ability to care for children must be individualized. The DCFS or POS worker shall explore the technology and auxiliary aids that may assist such parents in caring for their children. Auxiliary devices such as door bell and a flashing device, closed captioning which enables hearing children of deaf parents to hear and read, specialized webcams, baby monitors and alerts, computer programs to teach sign language, and other devices can improve the ability of deaf parents to take care of their children. Parent coaching on the use of auxiliary devices should be provided.

e) **Placement Considerations for Deaf or Hard of Hearing Children**

DCFS and POS workers must adhere to **Procedures 301.60, Placement Selection Criteria** when selecting a placement for children. All placements are to be made consistent with the best interests and special needs of the children. The Department will make diligent efforts to place children who have special communication/language needs in a home that can meet those needs. This includes children with limited English speaking ability and children who are deaf or deaf or hard of hearing. The Department uses specialized caseworkers, sign language interpreters or translators, and other auxiliary aids to meet the communication needs of children and adults who are deaf and hard of hearing.

Communication must be a critical consideration when placing deaf or hard of hearing children or hearing children of deaf adults (CODA). In order to preserve the child's deaf culture and maintain his or her ties to the deaf community, when a deaf or hard of hearing children must be removed from the home, DCFS and POS caseworker shall document all efforts to place the child in a home that is communication accessible.

1) **Placement of a Deaf or Hard of Hearing Child (HOH)**

In prioritized order, a deaf or hard of hearing child shall be placed in a foster home in which:

- At least one individual that is deaf or HOH, has sign language abilities, and is willing to undergo the necessary training to become specialized foster parents for the deaf.
- Individuals that are familiar with sign language and the deaf culture but cannot sign and may or may not be deaf or HOH. Examples would be adult children of deaf adults (CODA'S), audiologists, or others working in fields who may work with the deaf and HOH on a regular basis.

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- Any other foster home that is willing to undergo the necessary training to become communication accessible for individuals who are deaf or hard of hearing.

If a home meeting these criteria is not available, the DCFS or POS worker shall initiate targeted recruitment for a home that can support the child's communication needs. Locating an emergency foster home or adoptive home that is communication accessible must be a priority for the DCFS or POS worker and the supervisor.

In the absence of an interpreter, it may be necessary to communicate by writing or if the child is unable to read or write, books, computer software, or video tapes/DVD's showing and teaching signs are available. Auxiliary aids to assist in communication must be provided and may include video equipment (television sets, VCR's, DVD players, etc.) that display the closed captions on the video programs, a TDD if the child is old enough to use a telephone and special alarms for smoke/carbon monoxide detectors, fire alarms, doorbells, and telephones. Videophones are available free of charge to deaf or hard of hearing individuals provided they have high speed internet in the home.

The child's worker is responsible for developing a Plan of Accommodation when a deaf or hard of hearing (HOH) child is placed in a home with hearing foster parents who have no sign language skills.

2) Placement of a Hearing Child of Deaf Adults (CODA)

Children of deaf adults (CODA) who are not deaf or HOH shall be placed in communication accessible homes where they will be able to maintain or develop their signing skills, be exposed to the deaf culture, and maintain their involvement in deaf organizations and activities. If an accessible home is not available, targeted recruitment efforts shall be conducted. The child's case plan shall include sign language classes and exposure to deaf culture.

VII. MONITORING SERVICES TO DEAF OR HARD OF HEARING CLIENTS

The Office of Information Technology provides the Statewide Deaf Services Coordinator with identifying information on children, youth, caregivers and family members who are deaf or hard of hearing each month. The Coordinator monitors to ensure that appropriate resources and supports are provided. The Statewide Deaf Services Coordinator notifies the Clinical Services Coordinator if the services and interventions that are being provided to a deaf or hard of hearing child or adult do not provide access to appropriate services. The Clinical Services Coordinator is responsible for oversight of the case until effective services and intervention are put into place.

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VIII. CASE ASSIGNMENT

For deaf and hard of hearing clients, DCFS and POS supervisors shall make case assignments the following prioritized basis:

- Staff that specialize in services to deaf or hard of hearing individuals and who are able to effectively communicate using American Sign Language(ASL); or
- Experienced staff person having no fewer than 5 years of experience with IDCFS or a private agency who has completed all of the training pertaining to deaf clients and deaf needs; or
- If there are no staff available meeting these criteria, the most senior staff will be assigned to the case and, if not already trained, will contact the Statewide Coordinator of Deaf Services for immediate training.

IX. TRAINING

Ideally, parent training for deaf HOH clients should be conducted by a parent trainer and professionals that are either deaf or come from a deaf family (CODA) and can sign to the parents. If such a trainer is not available, a certified interpreter shall be present at the training sessions and translate the information to the parent(s). Training sessions can be one on one or in groups. Group sessions encourage sharing concerns that all deaf parents have in common about their children such as discipline, health and general child rearing. A portion of the training should also cover the cultural issues unique to the deaf.

Parent training for hearing parents who have deaf children also requires a trainer specialized in deaf culture and familiar with all of the auxiliary aids that are available to the parents to assist them in raising their deaf child.

Training of potential foster parents in areas specific to the deaf and hard of hearing will be arranged through the Statewide Deaf and Hard of Hearing coordinator provided resources. A communication plan for ongoing training of foster parents wanting to be a communication accessible household will be developed and followed.

Training of IDCFS staff and POS Agency Staff across the entire state: An online training course has been completed and participation in this training has been made mandatory for all staff. This online training course will help all direct service child welfare professionals apply the DCFS Deaf and Hard of Hearing Policy to your job, as either a child protection investigative specialist, a child welfare caseworker to either intact family or placement cases, or a casework supervisor. After completing Working with Deaf and Hard of Hearing Families online training, staff will be able to:

- Explain the services the Department is mandated to provide to individuals who are Deaf and Hard of Hearing.

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- Locate resources for Deaf and Hard of Hearing persons.
- Engage Deaf and Hard of Hearing persons.
- Assess the need for service provision of Deaf and Hard of Hearing persons.
- Provide service intervention to Deaf and Hard of Hearing persons in the following areas:
 - DCP investigations;
 - Intact services; and
 - Permanency/foster care services.
- Reference rules, procedures, and regulations related to communicating effectively with the Deaf and Hard of Hearing.

X. RESOURCES

Each region shall compile a list of providers who provide services to persons who are deaf or hard of hearing and make the list available to DCFS and POS direct service staff. These services include but are not limited to interpreter services, counseling, advocacy, foster care and adoption, homemaker, case management, residential and psychological services. Additionally, updated lists of resources by region are available online by visiting the State of Illinois Deaf and Hard of Hearing Commission's (IDHHC)_website at <http://www.idhhc.state.il.us/interpreter/interpreter.htm>, or the IDHHC's Homepage at <http://www.idhhc.state.il.us/>. The Department will develop and provide needed services not available in the community from public and private agencies.

Technical assistance can be obtained from the Department's Statewide 504 Coordinator in the Office of Affirmative Action, the Illinois Department of Rehabilitation Services or local Centers for Independent Living.

Note: Please refer to Procedures 359.5(k), Payment for Interpreter Services and Auxiliary Aids, for payment information.

Targeted Resource Development

In its ongoing efforts to meet the needs of children and families it serves, DCFS has developed a resource development plan for its deaf and hard of hearing clients which focuses on:

- Contracting with specialized counseling, treatment, evaluation and case management services for the deaf and hard of hearing child and adult.
- Recruitment of communication accessible foster and adoptive homes for deaf children to prevent placement of deaf children with foster parents unable to communicate with the children in their language.

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The Department has established the following priorities in recruiting homes that allow for equal foster home access for deaf or hard-of-hearing children:

- Homes with at least one individual that is deaf or hard of hearing has sign language abilities, and is willing to undergo the necessary training to become specialized foster parents for the deaf.
- Individuals that are familiar with sign language and the deaf culture but cannot sign and may or may not be deaf or hard of hearing. Examples would be children of deaf adults (CODA'S), audiologists, or others working in fields who may work with the deaf or hard of hearing on a regular basis.
- Any other foster home that would be willing to undergo the necessary training to become communication accessible for the deaf or hard of hearing.

To lessen the trauma children experience, first as the result of the abuse/neglect they have suffered and subsequently by separation from their parents, recruitment of accessible foster homes willing to serve children on an emergency basis is a critical part of this initiative. Targeted recruitment will be conducted when an accessible home is not available for a child who is deaf or hard of hearing.

XI. DISCRIMINATION COMPLAINTS

If any individual seeking or receiving Department services has reason to believe that they have been discriminated against because of race, color, national origin, sex, religion, ancestry, inability to speak or comprehend the English language, disabilities or age, they shall be directed to file a complaint with the Department's Office of Affirmative Action:

Department of Children and Family Services
Office of Affirmative Action
1911 South Indiana Avenue, 4th Fl.
Chicago, IL 60616
(312) 328-2495

A complaint can be initiated verbally or in writing, but must be filed within 180 days of the alleged discriminatory act. The individual will be asked to complete the complaint form, **CFS 766, Discrimination Complaint Form**, or the **CFS 766-1 Discrimination Complaint Form for non-employees**, which are to be sent to one of the above addresses. Staff will assist individuals in obtaining and/or completing the form, if assistance is needed.

The Office of Affirmative Action will conduct an internal investigation and make a recommendation within 30 working days to appropriate management personnel regarding whether there is substantial evidence to support the charge. If there is substantial evidence finding, conciliation will be recommended. If there is a lack of substantial evidence finding, conciliation will not be recommended. The complainant will be notified of the results of the investigation.

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If the complainant is not satisfied with the results of the investigation, the complaint can also be filed with any of the following agencies:

Illinois Department of Human Rights
State of Illinois Center
100 West Randolph, Suite 10-100
Chicago, Illinois 60601
(312) 814-6200

Illinois Department of Human Rights
222 S. College – Room 101A
Springfield, Illinois 62702
(217) 785-5100
(217) 785-5125 (TTY)

Office for Civil Rights
233 N. Michigan Ave – Suite 240
Chicago, IL 60601
(312) 886-2359

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ATTACHMENT I

NOTICE TO DEAF AND HARD OF HEARING CLIENTS

FOR OUR DEAF OR HARD OF HEARING CLIENTS KNOW YOUR RIGHTS!

The Illinois Department of Children and Family Services (DCFS) has policies and procedures in place to protect you and your family during in any interaction you may have with DCFS or the private agencies (POS) that provide services to you on its behalf.

DCFS is required to provide to you all of the following at no charge to you:

• **A certified interpreter for:**

All investigations	Court appearances
Home visits	Office visits
Case plan meetings	Evaluations
Social histories	Psychological evaluations
Psychiatric evaluations	Substance abuse treatment evaluations
Visits with children	
Other interactions as deemed necessary by IDCFS or POS provider	

• **Auxiliary Aids, if needed, such as:**

Child Monitor	Smoke Detectors
Written materials	Telephone handset amplifiers
TDDs Service animals	
Assistive listening devices and systems	
Telephones compatible with hearing aids	
Computer-assisted real time transcription service (CART)	

- Specialized Services such as parenting classes, advocacy, counseling provided by a professional who is knowledgeable about deaf culture and the needs of deaf or hard of hearing adults or children.

If you have any questions about obtaining these services or require more information, contact:

Marsha Northrup M.S.W - DCFS Statewide Coordinator of Deaf Services

100 Randolph, 6th Floor, Chicago, IL 60601

TTY (312) 814-4117 - Fax (312) 814-5986

(866) 327-8877(for hearing callers)

IP 163.191.22.4 - VP (312)814-4117

Email: Marsha.Northrup@illinois.gov

IF YOU FEEL YOUR NEEDS HAVE NOT BEEN MET BY DCFS, CONTACT:

Office of Civil Rights
233 N. Michigan Ave – Suite 240
Chicago, IL 60601
(312) 886-2359

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ATTACHMENT II

INTERPRETER STANDARDS

Sign language interpreters are considered “facilitators” for the deaf or hard of hearing client, family and the hearing. However, sign language interpreters will be the main communication link between the deaf and often hearing IDCFS staff person or POS staff. It is important that staff persons dealing with the deaf understand the terminology used in classification of sign language interpreters.

According to Illinois Law (225 ILCS 443/1) “Interpreters for the Deaf” licensure Act of 2007; “On or after January 1, 2009, no person shall practice as an interpreter for the deaf, hold himself or herself out as a licensed interpreter for the deaf, or use the title “Licensed Interpreter for the Deaf,” “Licensed Transliterator for the Deaf,” or any other title or abbreviation to indicate that the person is a licensed interpreter, unless he or she is licensed in accordance with the provisions of this Act.”

A person practicing as an interpreter for the deaf under this new law must be licensed with the State of Illinois Deaf and Hard of Hearing Commission. DCFS will recommend that only licensed interpreters be used. See above, Section VI (a) (2) of these procedures for additional licensure requirements for interpreters working with DCFS.

Certified Deaf Interpreters (CDI) are increasingly being used in the interpreting process. The CDI is a person who is deaf or hard of hearing. In addition to proficient communication skills and general interpreter training, the CDI has specialized training and/or experience in the use of gesture, mime, props drawings and other tools to enhance communication. The CDI has knowledge and understanding of deafness, the Deaf community, and Deaf culture. The CDI also possesses native or near-native fluency in American Sign Language.

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ATTACHMENT III

CODE OF ETHICS OF THE REGISTRY OF INTERPRETERS FOR THE DEAF

The Registry of Interpreters for the Deaf, Inc., has set forth the following principles of ethical behavior to protect and guide interpreters and transliterators and hearing and deaf consumers. Underlying these principles is the desire to insure for all the right to communicate.

This Code of Ethics applies to all members of the Registry of Interpreters for the Deaf, Inc., and to all certified non-members.

- 1) Interpreters/translitterators shall keep all assignment-related information strictly confidential.
- 2) Interpreters/translitterators shall render the message faithfully, always conveying the content and spirit of the speaker using language most readily understood by the person(s) whom they serve.
- 3) Interpreters/translitterators shall not counsel, advise or interject personal opinions.
- 4) Interpreters/translitterators shall accept assignments using discretion with regard to skill, setting, and consumers involved.
- 5) Interpreters/translitterators shall request compensation for services in a professional and judicious manner.
- 6) Interpreters/translitterators shall function in a manner appropriate to the situation.
- 7) Interpreters/translitterators shall strive to further knowledge and skills through participation in workshops, professional meetings, interactions with professional colleagues, and reading of current literature in the field.
- 8) Interpreters/translitterators, by virtue of membership or certification by the RID, Inc., shall strive to maintain high professional standards in compliance with the Code of Ethics.

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302 APPENDIX M – Transition Planning for Adolescents

a) Purpose

The purpose of this Appendix is to provide guidance to staff regarding effective planning for adolescent youth that will be transitioning from the child welfare system to self-sufficiency.

b) Population Served

The Department or purchase of service (POS) provider agencies shall provide appropriate transition planning and services to adolescents 14 years of age or older for whom the Department is legally responsible.

c) Transition to Independence

Transition planning must be an ongoing process for adolescents for whom family reunification, subsidized guardianship or adoption is not an option. It begins with an assessment of the adolescent's needs and allows for input from the youth, caregiver, caseworker and other appropriate individuals who have strong concern for the adolescent's welfare (e.g., youth's family, teachers and counselors). This must be done through the development of a **CFS 2032-1, Youth Driven Transition Plan (YDTP)** at age 17. The YDTP must also ensure accountability on the part of the youth, the Department, other service providers and include periodic reassessment of services to ensure successful transition to independence. Regardless of permanency goal, it is the Department's position that all youth in placement will be provided developmental activities and support services designed to assess and enhance their independent living skills development. The **CFS 2032-1, Youth Driven Transition Plan (YDTP)** developed at age 17 must also contain information about the importance of designating another individual to make health care treatment decisions on behalf of the youth, if the youth becomes unable to participate in such decisions, and he or she does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions. The youth must be provided the option to execute a health care power of attorney, health care proxy or other similar document recognized under State law.

It is the Department's expectation that older youth in care (age 17+) will be engaged in a post secondary educational or vocational program, employed at least part time (80 hours/month), or participating in a program or activity designed to promote or remove barriers to employment. This engagement is critical to ensure the youth is learning skills necessary to successfully sustain themselves upon emancipation from care.

For Federal IV-E claiming purposes, documentation of one of the above activities must be noted in the Service Plan for youth in care age 18 through 20 years old. If the youth is incapable of doing any of the activities described above due to a medical condition, this must also be noted with supporting documentation maintained in the case file (see below for definition of "medical condition").

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Note: The following definition is to be used to determine if a youth has a “medical condition” that prevents him/her from attending school, working, or participating in a job training related activity.

A disability, as defined in the Americans with Disabilities Act of 1990 (ADA), means either:

- *a physical or mental impairment that substantially limits one or more of an individual's major life activities;*
- *a record of such an impairment; or*
- *being regarded as possessing such an impairment.*

“Major Life Activities” are those basic activities that the average person can perform with little or no difficulty. This includes, but is not limited to, walking, seeing, hearing, speaking, breathing, learning and working.

Any youth 18 through 20 years of age, placed in a residential treatment center or group home setting is presumed to have a medical condition, due to mental illness and/or developmental disability, which prevents him/her from attending school, working or participating in a job training activity.

Caseworker Responsibilities

Additionally, as part of the **CFS 2032-1, Youth Driven Transition Plan (YDTP)** completed at age 17, caseworkers must also complete the following steps to comply with the informed health care decision requirements:

- Provide education regarding Power of Attorney for Healthcare to all youth in care who are 17 years of age, regardless of living arrangement, and inform the youth regarding their option to execute the Power of Attorney for Health Care on or after their 18th birthday by reviewing **CFS 2032-2, Your Future, Your Health;** with Statutory Short Form Power of Attorney for Health Care with the youth;
- Obtain the transitioning youth’s signature on the **CFS 2032-3, Receipt of Information & Education Regarding Health Care Options;**
- Sign and date the Receipt of Information & Education Regarding Health Care Options and retain copies for the youth’s permanent record as appropriate; and
- When applicable, provide the Administrative Care Reviewer with copies of all signed documents, i.e., the **CFS 2032-1, CFS 2032, and CFS 2033.**

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1) Life Skills Assessment

The objective of the life skills assessment is to establish a base line for the life skills needs of the adolescent. The Department has chosen the Casey Life Skills Assessment (CLSA) to establish the baseline life skills needed of youth served by the Department. The CLSA is a self-reporting instrument that allows youth and their caseworker to assess their strengths and challenges for each of the eight life skill domains: Daily Living; Self Care; Relationships and Communication; Housing and Money Management; Work and Study; Career and Education Planning; Looking Forward and Permanency.

The CLSA is appropriate for all youth ages 14 to 21 regardless of living circumstances. There are also assessments available for children ages 8 to 13. Workers are required to administer the assessment to adolescent youth on their caseload no later than 30 days after the youth's 14th and 16th birthdays, and six months prior to the youth's planned discharge from guardianship. Those youth entering the child welfare system after their 14th birthday will be administered the life skills assessment no later than 60 days after their entry into substitute care.

Administering the CLSA at the specified intervals provides an ongoing guide for Department or purchase of service providers in developing appropriate service plans for adolescent youth ages 14 to 21 to acquire independent living skills at varying intervals. Permanency workers shall provide the administrative case reviewer with a copy of the assessment results in addition to documentation of programs or services in which the youth is participating. This may include chores and/or training and direction that the youth is receiving in their foster home or living arrangement. When appropriate, new life skill objectives, tasks and timeframes to address identified unmet needs should be established. Permanency workers shall do the following prior to an adolescent's administrative case review:

- Schedule a meeting with the youth's Child and Family Team to evaluate the youth's progress in completing service plan life skills objectives;
- Administer a new CLSA to the youth utilizing only those questions that will assess the service plan life skills objective or objectives. Provide the administrative case reviewer with a copy of the assessment results in support of programs or services that will enable the youth to live independently; and
- When appropriate, establish new life skills objectives, tasks and timeframes to address identified unmet needs.

For those youth that are either Spanish-speaking or who express a preference to complete the assessment in the Spanish language, the assessment shall be completed in Spanish and all written documentation accompanying services must be in the Spanish language in accordance with the Burgos Consent Decree. Social work practice dictates that caseworkers must assess the linguistic needs of all

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clients and help them obtain services and educational opportunities in their native language. The CLSA can be administered in English, Spanish or French.

Permanency workers can obtain copies of the Casey Life Skills Assessment instruments, a sample template for the service plan and a resource guide from the organization's website, www.caseylifeskills.org. This website can also be accessed through the resource link on the D-net. To administer the life skills assessment, caseworkers need to establish an account on the Casey website. If assistance is needed, click on the "Help and Training" link on the Casey Life Skills homepage. "How to" guides, as well as, video tutorials are also available on the website.

The Casey Life Skills Assessment may not be appropriate for adolescents with special needs due to developmental disabilities. Assessments for these youth must be specifically designed to determine the youth's functioning, cognitive and social, as well as his or her ability to live independently. Permanency workers should consult staff of the Department's Clinical Division to determine assessment needs for youth with developmental disabilities.

Pregnant/parenting youth should complete the CLSA supplement for pregnant/parenting youth in addition to the primary assessment, and receive parenting education and/or training to address identified deficits and reinforce identified strengths.

2) Life Skills Training

Critical to the achievement of economic and social self-sufficiency is the acquisition of daily living skills. As part of the CLSA process, the permanency worker will develop a transition plan for the youth. The plan will contain individualized objectives, tasks, and resources that are developed in consultation with the youth, caregiver and involved providers using the youth's assessment as a guide. Workers shall use the **Service Plan** to document transition planning objectives and tasks.

A significant segment of the youth's practical independent living training will take place in his or her placement environment and workers must provide caregivers with life skills instructional activities and suggestions. Workers should utilize the "Resources to Inspire Guide" as a reference for caregivers. The Guide lists goals, learning objectives and a sample of youth appropriate resources that may be useful additions to a youth's service plan.

There are also community-based life skills development programs available for those youth who demonstrate a need for training beyond what can be provided by his or her caregiver and worker. These programs utilize curriculums to deliver services and practical experiences to reinforce learned theory of money management, consumer awareness, food management, personal appearance,

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health, housekeeping, transportation, educational planning, job-seeking skills, emergency and safety skills, knowledge of community resources, interpersonal skills, and housing. Classes are structured to meet the identified needs of the participants and meet for approximately 12 sessions at various locations and times. Workers must refer youth to community-based life skills training programs when appropriate.

Youth may only be enrolled in a life skills class with a referral from their permanency worker. Permanency workers are required to submit the Referral Packet in duplicate to the OETS Transition Manager in the worker's region. The Transition Manager will respond to the referral within ten business days.

A) Referral Packet

- **CFS 912, Transition Referral form;**
- The youth's scored CLSA report;
- The youth's current **Service Plan;**
- Updated social history or integrated assessment for the youth; and
- **CFS 600-3, Consent for Release of Information form.** Children 12 years of age or older are required to sign the consent in addition to their parent or guardian when their mental health information and information regarding birth control services, pregnancy, treatment for sexual diseases or drug or alcohol abuse treatment will be released. If a Department youth is age 18 or over and has not been declared incompetent by a court of law, only the youth may consent to release of his or her personal information.

B) Transition Managers

Cook Region Transition Manager
100 W. Randolph, 6th Floor
Chicago, Illinois 60601
312/814-5959

Northern Region Transition Manager
8 E. Galena Blvd., Suite 300
Aurora, Illinois 60506
630/801-3446

Central and Southern Region Transition Manager
2309 West Main Street, Suite 108
Marion, IL 62959
618/993-7100

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3) Vocational and Career Planning

The purpose of vocational and career planning is to ensure that Department youth are prepared for post-secondary school employment or continuing education. By the adolescent's high school freshman year, formalized planning, high school credits, and relevant experiences should be considered annually and included in the youth's educational and transition plans. For youth eligible for special education or receiving special education services, planning post-secondary education or employment must start at age 14½ and be a part of a transition plan that is later noted in the **CFS 2032-1, Youth Driven Transition Plan (YDTP)** developed at age 17. The transition plan at this age drives the education plan process (**Procedures 314.50, Educational Plan**).

Adolescents planning for post-secondary education should obtain information and assistance from their school counselor concerning colleges or trade schools, campus visitation, American College Test (ACT) or Scholastic Aptitude Test (SAT) registration and preparation, financial aid and scholarships. The youth's caseworker should provide the youth with information regarding payment of educational expenses and the Department scholarship. See **Procedures 359, Section 359.60 (Payments for Independent Living Arrangements)** and **Section 359.75 (Educational Expenses)** for detailed information.

Department staff can obtain technical assistance for education issues from the following regional OETS/DCFS Education Advisors. Purchase of service staff should utilize their agency Education Liaison.

DCFS EDUCATION ADVISORS

Cook North (Chicago)

Department of Children and Family Services
1911 South Indiana, 10th Floor
Chicago, IL 60616
312.328.2607 or 312.328.2634
Fax: 312.328.2819

Cook North (Suburbs)

Department of Children and Family Services
8100 South McCormick Boulevard
Skokie, IL 60076
708-338-6637 or 312-328-2634
Fax: 708-338-6653

Cook Central (Suburbs)

Department of Children and Family Services
1701 S. 1st Avenue, 10th Floor
Maywood, IL 60153
708-338-6637
Fax: 708-338-6653

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Cook Central – Chicago and Suburbs

Department of Children and Family Services
1026 S. Damen
Chicago, IL 60612
312-793-3217
Fax: 312-793-4973

Cook South – Chicago and Suburbs

Department of Children and Family Services
6201 S. Emerald
Chicago, IL 60621
708-338-6750
Fax: 708-338-6726

Northern Region – Rockford and Aurora Sub-regions

Department of Children and Family Services
200 S. Wyman, Ste. 201
Rockford, IL 61101
815-967-3750
Fax: 815-987-7275

Central Region - Champaign Sub-Region

Department of Children and Family Services
2900 North Oakland Ave.
Decatur, IL 62526
217-875-6568
Fax: 217-875-6565

Central Region - Peoria and Springfield Sub-Regions

Department of Children and Family Services
2001 NE Jefferson
Peoria, IL 61603
309-671-7952
Fax: 309-671-7946

Or

Department of Children and Family Services
521 South 11th Street
Springfield, IL 62703
217-557-3985
Fax: 217-557-0093

Southern Region – East St. Louis and Marion Sub-Regions

Department of Children and Family Services
10 Collinsville Avenue
East St. Louis, IL 62201
618-583-2125
Fax: 618-583-2141

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4) Health Care

Medical services are available through the Department of Healthcare and Family Services Medical Assistance Program via the Medicaid card for Department wards. The Department will provide continued medical coverage for youth determined Medicaid ineligible when the Department is legally responsible for the youth (**Procedures 359, Authorized Child Care Payments; Section 359.90, Payments for Medical Care**).

Medical services available to all children for whom the Department is legally responsible include:

- Assignment of a primary care physician;
- Ongoing medical care (i.e., physical, dental, hearing and vision exams, and immunizations);
- Specialty care;
- Medical case management services through the Department of Human Services for pregnant wards and children of wards (0-5 years of age).

Youth age 18 and under are eligible for a 12-month extension of medical assistance after the case is closed. In order to ensure continued coverage for youth while in transition to reunification or independence, it is important that this information be provided as part of transition planning. When closing a case the worker shall inform the family or the youth, in the case of youth in independent living situations, that the youth is eligible for the 12 month extension and of the importance of keeping the Technical Support Unit informed of any address changes. In addition, the Technical Support Unit will send this notice to youth who qualify for the extension. (**Procedures 302.360, Health Care Services**)

5) Clinical Services-Counseling

Counseling may be provided to assist the adolescent with problem resolution or to identify and obtain other community services. This service can be accessed directly by Department staff or POS referral or through purchase (**Procedures 302.320, Services Delivered by the Department; 359.52, Authorized Child Care Payments**).

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d) Housing

Housing services provided by the Department include arrangements for safe and adequate housing, education regarding housing choices, financial management, community resources, and tenants' rights and responsibilities.

1) Youth Housing Assistance – Transition (YHAT)

A) Housing Advocacy

Youth may receive housing advocacy services when it is determined that those services are necessary to ensure that a youth's housing situation becomes or remains stable after he or she is emancipated.

i) Eligibility Criteria

Youth applying for housing advocacy services shall:

- Be the legal responsibility of the Department or a public child welfare agency in another state;
- Be at least 17 1/2 years of age;
- Be within six months of becoming emancipated;
- Be less than 21 years old;
- Need housing advocacy services to ensure that his or her housing situation becomes or remains stable after case closure; and
- Have an earned income or disability benefits income that is sufficient to meet rent and utility costs or be in a program that will help them obtain an income before housing is obtained (e.g., employment and training programs).

Note: Youth who formerly had a legal relationship with the Department may be eligible to apply for housing advocacy services until his or her 21st birthday. Subsection (d)(2)(A) of this appendix addresses housing advocacy procedures for youth who formerly had a legal relationship with the Department.

ii) Referral Process

Referrals for housing advocacy services may be made by the youth's caseworker by submitting a completed **CFS 370-5, Request for Cash Assistance and/or Housing Advocacy** to the casework supervisor for approval. POS case referrals are to be made to the POS Monitor or Youth Housing Assistance

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Coordinator for approval. Referrals for youth that have an open case in another state must be forwarded directly to the Youth Housing Assistance Coordinator for approval. Attach a printout of the youth's CM-07 screen to his or her approved referral before forwarding it to the appropriate community based housing advocate provider for implementation of services. The CM-07 will be used to verify that the youth meets the age and open case requirements for the program. Housing advocacy services may include the following:

- Assistance in securing affordable housing;
- Consumer education;
- Budget counseling;
- Linkages to community based resources for assistance with utilities, food and clothing; and
- Follow-up services for a minimum of three months after the youth secures appropriate housing.

B) Housing Start-Up Grant

i) Eligibility Criteria

Youth applying for a housing start-up grant shall:

- Have an open case with the Department or a public child welfare agency in another state and be ready for emancipation;
- Be at least 18 years of age;
- Be less than 21 years of age;
- Be homeless or in a situation that will result in the youth becoming homeless if cash assistance is not provided; and
- Have an earned income or disability benefits income that is sufficient to meet rent and utility costs after the housing start-up grant is provided.

Note: The housing start-up grant cannot be paid on or after the youth's 21st birthday.

ii) Referral Process

Referrals for housing start-up grants may be made by the youth's caseworker by submitting a completed **CFS 370-5, Request for Cash Assistance and/or Housing Advocacy**, and **370-5C, Monthly Budget** form, to the casework supervisor for approval. Department supervisors with access to the CM-48 screen may approve cash assistance requests up to \$800 for authorized

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expenditures if the youth provides evidence that he or she will be capable of paying his or her future budgeted monthly living expenses without assistance from the Department. POS and out-of-state case referrals are to be made to the Youth Housing Assistance Coordinator for approval. Referrals should be made no later than one week prior the ward's emancipation date to allow time for any required corrections.

The maximum housing start-up grant that a youth may receive is \$800. The Youth Housing Assistance Coordinator or designee may approve grants up to \$1200 if the youth is pregnant, parenting or disabled.

iii) Authorized Expenditures

Cash assistance may be authorized for the following reasons:

- Housing security deposit;
- Rent, if the youth is able to make future rent payments;
- Beds for the youth and his or her children;
- Utility deposits or bills, if the youth is able to make future utility payments;
- Appliances; and
- Other items necessary to ensure that the youth's housing situation becomes or remains stable after case closure.

2) Youth Housing Assistance – Crisis (YHAC)

The Department may provide housing advocacy services and/or cash assistance to stabilize the housing situation of a youth who formerly had a legal relationship with the Department to ensure that the youth does not become homeless.

A) Housing Advocacy Services

Youth may receive housing advocacy services when it is determined that those services are necessary to ensure that the youth's housing situation becomes or remains stable. Housing advocacy services may include:

- Assistance in securing affordable housing;
- Consumer education;
- Linkages to community based resources for assistance in obtaining utilities, clothing and/or food; and
- Follow-up services for a minimum of three months after the youth secures appropriate housing.

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i) Eligibility Criteria

Youth applying for housing advocacy services shall:

- Have had his or her Department case or case with a public child welfare agency in another state closed on or after his or her 18th birthday or in accordance with the Emancipation of Mature Minors Act; or
- Have been adopted or entered subsidized guardianship between the ages of 14 and 18; and
- Be under 21 years of age; and
- Need these services to ensure that his or her housing situation becomes or remains stable; and
- Have an earned income or disability benefits income that is sufficient to meet rent and utility costs in the future of show commitment to obtaining an income (e.g., youth is in a job placement program).

ii) Referral Process

Youth in crisis can make a self-referral by contacting the Youth Housing Assistance Coordinator directly or through any Department Field Office, POS agency or housing advocacy provider. The youth must complete a **CFS 370-5**.

B) Cash Assistance

The total YHAC cash assistance, which includes a YHAT start-up grant but not a partial housing subsidy, may not exceed \$2,000 per 12-month period. The lifetime limit for combined YHAC and YHAT cash assistance may not exceed \$4,000.

Cash assistance may be authorized for the following:

- Housing security deposit;
- Current or back due rent when the youth cannot make the payment but will be able to make future payments;
- Beds for the youth and the youth's children;
- Utility deposits or bills, if the youth is able to make future utility payments;
- Appliances; and
- Miscellaneous other expenses necessary to avoid or manage a crisis.

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i) Eligibility Criteria

Youth applying for cash assistance shall:

- Have had his or her Department case or case with a public child welfare agency in another state closed on or after his or her 18th birthday or in accordance with the Emancipation of Mature Minors Act;
- Be under 21 years of age;
- Be homeless or in real and significant danger of becoming homeless; and
- Have an earned income or disability benefits income that is sufficient to meet future rent and utility costs.

Note: Youth that do not have an earned income or disability benefits income may be referred for housing advocacy services and receive a onetime cash assistance grant up to \$600 if the youth is able to show that he or she is committed to obtaining an income (e.g., the youth is in a job training or placement program).

ii) Referral Process

Youth in crisis can make a self-referral by contacting the Youth Housing Assistance Coordinator directly or through any Department Field Office, POS agency or housing advocacy provider. The youth must complete a **CFS 370-5** and **CFS 370-5C** and provide verification that he or she is in a crisis situation (e.g., a written statement from a community service provider, eviction notice or utility disconnect notice). The Youth Housing Assistance Coordinator or designee may only approve those requests where the youth can provide verification that a crisis situation exists.

C) Partial Housing Subsidy

Youth may receive a maximum partial housing subsidy of \$250 per month for a period that may not exceed 12 months or the youth's 21st birthday, whichever comes first. Youth are required to contribute 30% of their income towards the cost of their housing during the first six months of the subsidy and 50% during the final six months. If necessary, the maximum partial housing subsidy will be reduced by these percentages to ensure that the youth is contributing the appropriate amount of his or her income towards housing.

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i) Eligibility Criteria

Youth applying for a partial housing subsidy shall:

- Have a closed case with the Department or a public child welfare agency in another state;
- Have had his or her case closed on their 18th birthday or in accordance with the Emancipation of Mature Minors Act;
- Be less than 21 years of age;
- Have housing costs that exceed 30% of the youth's income; and
- Have completed a budget statement, **CFS 370-5C**, which demonstrates that the subsidy when combined with the youth's income will enable the youth to cover all remaining living expenses (i.e. housing, utilities, clothing and food).

ii) Referral Process

Referrals for partial housing subsidy may be made by the youth's caseworker or housing advocate by submitting a completed **CFS 370-5, CFS 370-5C and CFS 370-5B** to the Youth Housing Assistance Coordinator for approval. The Youth Housing Assistance Coordinator may approve the entire subsidy at the time eligibility is determined. A youth that is ready for emancipation may be referred for a partial housing subsidy, but the Youth Housing Assistance Coordinator cannot authorize release of payments prior to receipt of documentation that the youth's case has been closed (i.e., CM-07 screen printout or copy of the court order).

e) Youth in Transition Programs

The following Department, State and Federal programs are available to assist youth in becoming successful members of their community, work and school.

1) Youth in College / Vocational Training Program (YIC/VT)

The YIC/VT Program is a Department placement available to youth for whom the Department is legally responsible and who are enrolled in an accredited, full-time post-secondary educational or vocational training program. Youth in this program have four years of eligibility and will receive a medical card up to the age of 21 (**Procedures 314.175 c), Youth in College Program/Vocation Training Program; Procedures 359.60, Payments for Independent Living Arrangements**).

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2) Community College Payment Program (CCPP)

Youth enrolling in an Illinois Community College are eligible to have four semesters of their *in-district tuition*, fees and books paid by the Department if they cannot be paid through Federal Pell Grant, Federal Supplemental Educational Opportunity Grant or Monetary Award Grant. The CCPP will pay the community college the *in-district tuition*, fees, and book costs from funds provided by the Department for youth whose requests are approved.

Youth must be under legal guardianship of the Department to be eligible. Youth that have secured sufficient financial aid to cover their tuition, fees and books are ineligible for the CCPP. Requests for out-of-district tuition and prior fiscal years' expenses will not be approved (**Procedures 314.175 a), Community College Payment Program**).

3) Education and Training Voucher Program (ETV)

The ETV program assists youth with eligible post-secondary education related expenses not covered by financial aid grants. Youth for whom the Department is legally responsible, those who age out of care at 18 or older, and those who go to adoption or guardianship at age 16 or older are eligible for the program. Youth must be attending a US Department of Education accredited post-secondary program. Youth who access the ETV program prior to age 21 and continue to make satisfactory progress towards completion of their post-secondary program are eligible to have their ETV benefits extended up to age 23.

4) Independent Living Placement Services (ILO)

The Supervised Independent Living Program provides supportive services and living maintenance to youth for whom the Department is legally responsible. The purpose of the SILP is to assist youth who have demonstrated the minimum requirements for living independently to progress toward their goal of independence (**Procedures 302 Appendix H; Procedures 359.60, Payments for Independent Living Arrangements**).

5) Department Scholarship Program

The Department Scholarship Program provides a maximum of 48 scholarships each year, four of which are awarded to children of veterans. The Department Scholarship Committee awards scholarships to students for whom the Department has legal responsibility, who aged out of the Department's care at age 18 or older, or who the Department had legal responsibility for immediately prior to the adoption or private guardianship being finalized. Scholarship recipients receive up to four consecutive years of tuition and academic fee waiver to be used at participating Illinois state universities and community colleges, a monthly grant and a medical card until age 23 (**Rules 312, Department of Children and Family Services Scholarship Program; Procedures 359.60, Payments for Independent Living Arrangements**).

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6) **Pregnant and/or Parenting Program**

The Pregnant and/or Parenting Program provides supportive services and living maintenance to pregnant and/or parenting children and youth for whom the Department is legally responsible. Services are provided to female and male parenting youth. Non-custodial male youth shall receive support services that promote and enhance the youth's awareness and positive fatherly engagement with his child or children. The Department recognizes that these youth and their children are a family, and this program is designed to ensure that the youth's role and responsibility as a parent are respected and supported through a comprehensive array of services (**Procedures 302 Appendix J, Pregnant and/or Parenting Program**).

7) **Employment Incentive Program (EIP)**

The Employment Incentive Program (**Procedures 302 Appendix F**) provides supplemental services and cash stipend to youth who are 17 but not yet 21 years of age for whom the Department has court-ordered legal guardianship. The youth must be employed and working a minimum of 20 hours per week, have a high school diploma or a General Education Development (GED) certificate, and have completed independent life skills training. The EIP is designed to provide financial and supplemental services to help youth gain marketable skills through on-the-job training experience or through job training programs.

8) **Lincoln's Challenge Program**

The Illinois National Guard's Lincoln's Challenge Program is a voluntary, federally funded youth program for 16 to 18 years old at-risk youth. This program is designed to offer its students a variety of educational and vocational opportunities as well as the necessary life skills to be a successful member of their community, work and school. This is a 17-month, two-phased military modeled training program. Information and applications for the program can be obtained by calling 1-800-851-2166 or at www.lincolnschallengeacademy.org. Applications must be received 30 days prior to the class start date.

9) **Job Corps**

The Job Corps is a voluntary, residential education and training program for disadvantaged youth between the ages of 16 and 24. There are 110 Job Corps centers throughout the United States, the District of Columbia and Puerto Rico. The program offers students the opportunity to enroll in basic education and GED classes while they receive vocational training. Program information for the can be obtained by calling (312) 596-5470 or at www.jobcorps.gov.

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f) Youth in Care Website

The Department maintains a website to provide youth, caregivers, and caseworkers with a tool to access information on Department programs and services for older youth. The website can be accessed at www.state.illinois.us/dcfs.

g) Youth Advisory Boards

The Regional and Statewide Youth Advisory Boards are comprised of youth, ages 14 to 21, who have received or are currently receiving services from the Department. Youth on these Boards advise the Director about program issues that relate to youth in care. Information concerning Youth Advisory Boards may be obtained by calling the DCFS Youth Hotline at 866-459-6884 (866-IL YOUTH) or at the DCFS Website, www.state.il.us/dcfs.

h) National Youth in Transition Database (NYTD)

1) Description

In 1999, Congress passed Public Law 106-169, establishing the John H. Chafee Foster Care Independence Program (CFCIP), amending section 477 of the Social Security Act. This law expanded state funding to carry out programs to help youth transition from foster care to self-sufficiency. The law also requires the federal Administration for Children and Families (ACF) to develop a data collection system to track independent living services that states provide to youth and develop outcomes to measure states' success in preparing youth for independence. The law requires ACF to impose a penalty of between 1 and 5 percent of states' annual Chafee allotment for any state that does not comply with reporting requirements.

To meet the mandate, ACF published a rule in the Federal Register on February 26, 2008. The rule establishes the National Youth in Transition Database (NYTD) requiring states to conduct client-specific data collection activities on an ongoing basis.

The purpose of NYTD is to measure the effectiveness of providing independent living services to youth by measuring outcomes for youth who have aged out of care.

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2) NYTD Requirements

The NYTD regulation identifies three populations that are separate, but not mutually exclusive. Together, these three populations comprise the reporting population.

NYTD requires that states report to ACF all youth who receive at least one independent living skills service paid for, or provided by, the Chafee funded agency (DCFS). This is the **served population**. NYTD requires that the following 14 independent living skills services be reported:

- ***Independent Living Needs Assessment*** – An independent living needs assessment is a systematic procedure to identify a youth's basic skills, emotional, and social capabilities, strengths, and needs to match the youth with appropriate independent living services. An independent living needs assessment may address knowledge of basic living skills, goal setting, task completion, and transitional living needs. These procedures require youth to complete the Casey Life Skills Assessment (CLSA) at age 14, 16, and 6 months prior to discharge. The caseworker shall indicate the names of any youth who were given a CLSA during the report month and the date the Assessment was given.
- ***Academic Support*** – Academic supports are services designed to help a youth complete high school or obtain a General Educational Development (GED) credential. Such services include the following: academic counseling; preparation for a GED, including assistance in applying for or studying for a GED exam; tutoring; help with homework; study skills training; literacy training; and help accessing educational resources. Academic support does not include a youth's general attendance in high school. The caseworker shall indicate the names of any youth who received academic supports as defined here during the report month and the dates of those services.
- ***Post-secondary educational support*** – Post-secondary educational support are services designed to help youth enter or complete a post-secondary education and include the following: Classes for test preparation, such as the Scholastic Aptitude Test (SAT); counseling about college; information about financial aid and scholarships; help completing college or loan applications; or tutoring while in college. The caseworker shall indicate the names of youth who received post-secondary educational support during the report month and the dates of those services.
- ***Career Preparation*** – Career preparation services focus on developing a youth's ability to find, apply for, and retain appropriate employment. Career preparation includes the following types of instruction and support services: vocational and career assessment, including career exploration and planning, guidance in setting and assessing vocational and career interests and skills,

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and help in matching interests and abilities with vocational goals; job seeking and job placement support, including identifying potential employers, writing resumes, completing job applications, developing interview skills, job shadowing, receiving job referrals, using career resource libraries, understanding employee benefits coverage, and securing work permits; retention support, including job coaching; learning how to work with employers and other employees; understanding workplace values such as timeliness and appearance; and understanding authority and customer relationships. The caseworker shall indicate the names of youth who received career preparation services during the report month and the dates of those services.

- ***Employment Programs or Vocational Training*** – Employment programs and vocational training are designed to build a youth's skills for a specific trade, vocation, or career through classes or on-site training. Employment programs include a youth's participation in an apprenticeship, internship, or summer employment program and do not include summer or after-school jobs secured by the youth alone. Vocational training includes a youth's participation in vocational or trade programs and the receipt of training in occupational classes for such skills as cosmetology, auto mechanics, building trades, nursing, computer science, and other current or emerging employment sectors. The caseworker shall indicate the names of youth who attended an employment program or received vocational training during the report month and the dates of those services.
- ***Budget and Financial Management*** – Budget and financial management assistance includes the following types of training and practice: Living within a budget; opening and using a checking and savings account; balancing a checkbook; developing consumer awareness and smart shopping skills; accessing information about credit, loans and taxes; and filling out tax forms. The caseworker shall indicate the names of youth who received budget and financial management assistance during the report month and the dates of those services.
- ***Housing Education and Home Management Training*** – Housing education includes assistance or training in locating and maintaining housing, including filling out a rental application and acquiring a lease, handling security deposits and utilities, understanding practices for keeping a healthy and safe home, understanding tenants rights and responsibilities, and handling landlord complaints. Home management includes instruction in food preparation, laundry, housekeeping, living cooperatively, meal planning, grocery shopping and basic maintenance and repairs. The caseworker shall indicate the names of youth who received housing education or home management training during the report month and the dates of those services.

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- ***Health Education and Risk Prevention*** – Health education and risk prevention includes providing information about: Hygiene, nutrition, fitness and exercise, and first aid; medical and dental care benefits, health care resources and insurance, prenatal care and maintaining personal medical records; sex education, abstinence education, and HIV prevention, including education and information about sexual development and sexuality, pregnancy prevention and family planning, and sexually transmitted diseases and AIDS; substance abuse prevention and intervention, including education information about the effects and consequences of substance use (alcohol, drugs, tobacco) and substance avoidance and intervention. Health education and risk prevention does not include the youth's actual receipt of direct medical care or substance abuse treatment. The caseworker shall indicate the names of youth who received these services during the report month and the dates of the services.
- ***Family Support and Healthy Marriage Education*** – Such services include education and information about safe and stable families, healthy marriages, spousal communication, parenting, responsible fatherhood, childcare skills, teen parenting, and domestic and family violence prevention. The caseworker shall indicate the names of youth who received these types of services during the report month and the dates of the services.
- ***Mentoring*** – Mentoring means that the youth has been matched with a screened and training adult for a one-on-one relationship that involves the two meeting on a regular basis. Mentoring can be short-term, but it may also support the development of a long-term relationship. While youth often are connected to adult role models through school, work, or family, this service category only includes a mentor relationship that has been facilitated, paid for or provided by the State or private agency, and its staff. The caseworker shall indicate the names of youth who received mentoring services (as defined above) during the report month and the dates of those services.
- ***Supervised Independent Living*** – Supervised independent living means that the youth is living independently under a supervised arrangement that is paid for or provided by the Department. A youth in supervised independent living is not supervised 24 hours a day by an adult and often is provided with increased responsibilities, such as paying bills, assuming leases, and working with a landlord, while under the supervision of an adult. The caseworker shall indicate the names of youth who were living in a supervised independent living setting during the report month and the dates of service.
- ***Room and Board Financial Assistance*** – Room and board financial assistance is a payment for room and board, including rent deposits, utilities, and other household start-up expenses. The caseworker shall indicate the names of youth who received financial assistance for room and board during the report month, the amount of funds provided, and the dates of service.

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- **Education Financial Assistance** – Education financial assistance is a payment for education or training, including allowances to purchase textbooks, uniforms, computers, and other educational supplies; tuition assistance; scholarships; payment for educational preparation and support services (i.e., tutoring), and payment for GED and other educational tests. This financial assistance also includes vouchers for tuition or vocational education or tuition waiver programs paid for or provided by the Department. The caseworker shall indicate the names of youth who received education financial assistance during the report month and the dates of service.
- **Other Financial Assistance** – Other financial assistance includes any other payments made or provided to help the youth live independently. The caseworker shall indicate the names of youth who received other financial assistance during the report month and the dates of services. The caseworker shall either choose what type of assistance was provided from the selections provided or choose “other” and describe the assistance provided, including the monetary value.

Once every three years the Department must collect outcome information on all youth who are in care on or within 45 days of their 17th birthday. These youth must complete a **CFS 2030-1, NYTD Baseline Survey**. From this “**Baseline Population**,” a follow-up sample of youth will be drawn by the Department.

The Department must locate the “**Follow-Up Population**” within the reporting period of their 19th and 21st birthdays to collect outcome information. The goal is for these youth to again complete an outcome survey.

The surveys for both the baseline and follow-up populations seek information about the following outcomes:

- Financial self-sufficiency
- Experience with homelessness
- Educational attainment
- Positive adult connections
- High risk behavior
- Access to health insurance.

States have implemented these standards and have collected data since October 1, 2010.

3) Case Worker Responsibilities

A) Reporting of Services for the Served Population

Caseworkers must report any independent living service that he/she delivers to a youth or that is arranged for the youth and delivered by another person/entity. The service is to be entered in SACWIS within 30 days of service delivery date.

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B) Completing Outcome Survey for Baseline Population

Every third year any youth who become 17 years old, while under legal guardianship of the Department must complete a **CFS 2030-1, NYTD Baseline Survey**, within 45 days of his or her 17th birthday. The case worker is responsible for ensuring this mandate is met. The **CFS 2030-1** may be administered via email or in person at the caseworker's office or the youth's residence. The survey will also be available online, so youth can complete the survey over the Internet. The **CFS 2030-1** is available on the Templates Drive and the Department's website.

C) Completing Outcome Survey for Follow-Up Population

Youth who are part of the Baseline Population are required to complete the **CFS 2030-2, NYTD Follow-up Survey for 19-21 Year Old Youth**, at ages 19 and 21. These youth comprise the Follow-up Population. For those youth still under legal guardianship of the Department, the case worker is responsible for ensuring this requirement is met. The Outcome Survey may be administered via email or in person at the case worker's office or the youth's residence. The **CFS 2030-2** is available on the Templates Drive and the Department's website.

4) Questions / Additional Assistance

Additional information regarding NYTD, including FAQs, can be found on the NYTD link on the DCFS D-Net home page. In addition, questions or concerns can be emailed to NYTD@illinois.gov.

i) Release of Guardianship

The permanency goal of independence is achieved when a) the youth is age 18 (or older) or b) is an emancipated minor under the Emancipation of Mature Minors Act and, in the worker and supervisor's judgment, the youth is functioning successfully on his or her own. In most instances, the youth will be employed, be enrolled in a job training or educational program, and will have financial support or income from an outside source, and custody or guardianship has been terminated and case closure is planned (**Procedures 306, Service Termination**).

At a minimum, the caseworker must review the **CFS 2032-1, Youth Driven Transition Plan (YDTP)**, or for youth in TLP or ILO, the Transition Plan required of those programs, with the youth 90-days prior to discharge and updated/revised as necessary or directed by the youth. This review should include discussions concerning the youth's employment and/or educational opportunities, job resume, housing, health care, counseling, health and life insurance, information on use of community resources, reference letters and a list of emergency contact persons.

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The youth should also be assisted in obtaining or compiling documents necessary to function as an independent adult. Those documents should include:

- Identification card;
- Social Security card;
- Driver's license and/or State ID;
- Medical records and documentation to include, but not be limited to:
 - Health Passport;
 - Dental Reports;
 - Immunization Records;
 - Name and contact information for Primary Care Physician, and any Specialists working with the youth;
 - Name and contact information for OB/GYN, when applicable;
 - Education on Healthcare Power of Attorney, including signed certification on having received information and education regarding health care options;
- Certified copy of birth certificate;
- Documents and information on the youth's religious background;
- U.S. documentation of immigration, citizenship or naturalization;
- Death certificate(s) of parent(s), if parent(s) is deceased;
- Medicaid card or other health eligibility documentation;

Note: *The youth should be enrolled for medical benefits, or have applied for benefits one month prior to emancipation or case closure. DFHS will not accept an application for DCFS youth in care prior to 30 days before the youth's emancipation or case closure.*

- Life book or compilation of personal history and photographs;
- List of known relatives, with relationships, addresses and telephone numbers, with the permission of the involved parties;
- Copy of Court Order for Case Closure;
- Resume;
- List of schools attended, previous placements, clinics used;
- Educational records, such as high school diploma or general equivalency diploma; and
- List of community resources with self-referral information, including The Midwest Adoption Center, Phone: 1-847-298-9096 or info@macadopt.org.

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SUBPART C: DEPARTMENT CHILD WELFARE SERVICES

APPENDIX N -Transition Planning For Wards With Developmental Disabilities

Procedures 302. Appendix M - Transition Planning for Adolescent Wards, describes components of planning for adolescents who are transitioning from the child welfare system into the self-sufficiency of adulthood. This Appendix outlines additional procedures applicable to those youths for whom the Department is legally responsible who have special needs due to a developmental disability.

A. DEFINITIONS

“Developmental disability” means a disability which is attributable to (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any condition which results in impairment similar to that caused by mental retardation and which requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

“Developmental disability services” means an array of community-based supports and residential services designed to enable individuals with developmental disabilities to reside in their own homes whenever possible, and to achieve their maximum potential for independence and self-sufficiency.

“Disabled person” means a person 18 years or older who (a) because of mental deterioration or physical incapacity is not fully able to manage his person or estate, or (b) is a person with mental illness or a person with a developmental disability and who because of his mental illness or developmental disability is not fully able to manage his person or estate.

“Independent Service Coordination Agency (ISC)” means a community agency under contract with the Department of Human Services to provide information, referral and coordination of services to person(s) with developmental disabilities and their families.

The following disability codes in the DCFS CYCIS system relate to developmental disabilities:

- D= Autism
- E= Traumatic Brain Injury
- G= Mild Mental Retardation

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H=	Moderate Mental Retardation
I=	Severe Mental Retardation
J=	Profound Mental Retardation
K=	Cerebral Palsy
L=	Epilepsy
N=	Mental Retardation/Physical Disability
V=	Developmentally Disabled/Child In Need of Mental Health Services
W=	Developmentally Disabled/Substance Abuse
X=	Medically Complex/Developmentally Disabled

It is essential that child welfare staff correctly enter disability codes on the CFS 1410, Registration/Case Opening form so that children/youth with disabilities are identified and included in service planning.

B. TRANSITION PLANNING

Effective transition planning begins early and starts with appropriate assessment of the youth's skills and needs. Assessment tools for other children and youth may not be appropriate for youths with developmental disabilities. The child welfare worker should consult with staff of the Department's Clinical Division to determine assessment needs. At minimum, assessment tools must be specifically designed to assess the functioning of the adolescent with developmental disabilities and determine cognitive function, social adaptive function, and capacity for independent living.

When the child welfare worker determines, or has reason to believe, that a youth for whom the Department is legally responsible may be unable to fully manage on his or her own or manage his or her estate without ongoing supports, the child welfare worker must ensure that adult developmental services and/or adult guardianship are in place prior to the youth's discharge from care.

Not all persons with developmental disabilities require or need specialized services such as adult guardianship. Many are able to function independently. Others are able to function in the community with such natural supports as family, friends or neighbors. These resources should be explored before considering whether the youth may need specialized adult services.

Child welfare workers shall develop service plans for children for whom the Department is legally responsible that lead to reduced need for services and increased capacity for independent functioning, economic self-sufficiency, and community integration. Skill areas include but are not limited to: personal care, simple food preparation, safety precaution, use of public transportation, basic money management, and vocational training and placement.

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The Department of Children and Family Services (DCFS), the Department of Human Services (DHS) and the Guardianship and Advocacy Commission (GAC) have entered into an interagency agreement which defines the responsibilities of the three agencies for planning and carrying out the transition of youth from the child welfare system to adult developmental services.

C. ACCESSING ADULT DD SERVICES

1) DHS Developmental Disability(DD) Network

Adult developmental services are provided by the Department of Human Services (DHS) through its statewide network. When the youth reaches 17 1/2 years old, the child welfare worker should contact the DHS DD Network representative for the area (See Attachment A for list) to indicate that he/she believes a youth for whom DCFS is legally responsible may be in need of adult developmental disability services.

At minimum, the information required for a referral will include social history, current service plan, copies of psychological or psychiatric assessments, and Individual Education Plan (IEP).

The DHS DD Network representative will review the referral for appropriateness. Included in this review process is the youth's disability code. If the disability code is missing or does not indicate a developmental disability, processing of the referral could be delayed while additional information is sought to verify that the youth has a developmental disability.

If in reviewing the referral, the DHS DD network staff determine that it is inappropriate for an Independent Service Coordination agency (ISC) to begin working with a youth, they will notify the child welfare worker in writing of the reason(s) for this determination.

If the referral is deemed appropriate, the DHS DD Network representative will authorize the case for assignment to a local Independent Service Coordination agency.

2) Independent Service Coordination Agencies

Access to DHS services for persons with developmental disabilities is determined by an assessment completed by a statewide network of Independent Service Coordination agencies (ISCs).

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The assessment done by the ISC focuses on the following areas:

- X **Self Care** - Ability to perform daily activities to meet basic life needs including feeding, bathing, toileting, dressing, hygiene and grooming;
- X **Language** - Communication involving verbalization or an alternative communication system which enables an individual to convey ideas and information to others;
- X **Learning** - General cognitive competence; the ability to acquire new behaviors, perceptions, and information; and the ability to apply experiences to new situations; and
- X **Mobility** - Ability to perform gross and fine motor-skills. The capability of locomotion, either by independent ambulation or with mobility assistance such as adaptive equipment/ mechanical aids.

See Attachment B for a listing of ISCs and the areas they serve.

The child welfare worker is expected to provide all information requested by the ISC to make their assessment on a timely basis. The worker shall also ensure that the youth is available for appointments, if requested.

Consent of the guardian and authorizations for release of information shall be requested as required by Department policy.

In assessing a youth's needs, the ISC will provide the child welfare worker information regarding available services which are appropriate to meet the youth's needs. If placement is required in an adult facility other than the youth's current foster home, the ISC will suggest placement options. The ISC will also provide a recommendation regarding whether the youth needs an adult guardian.

The child welfare worker, in conjunction with his or her supervisor, retains responsibility for providing any necessary referral information to the adult service provider(s) proposed by the ISC, and for final selection of the service provider. The decision-making process should include the youth with developmental disabilities and take into consideration his or her preferences. The ISC cannot recommend one particular service provider over another.

D. ADULT GUARDIANSHIP

When the ISC assessment concludes that a youth may need an adult guardian, the child welfare worker is responsible for taking the necessary steps to ensure the appropriate

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appointment of a guardian. In addition to complying with Sections B and C of this Appendix to ensure appropriate adult placement, services and funding, the child welfare worker must obtain supporting documentation from a physician and identify an appropriate guardian before a petition for guardianship can be filed. As part of this process, the child welfare worker should explore less restrictive alternatives such as appointment of a limited guardian or protective payee for youths who have some ability to manage their own affairs.

Guardianship of an adult with a disability requires filing a petition in the Probate Court of the county in which the youth resides. The DCFS Regional Counsel, in conjunction with the Office of State Guardian (OSG) if applicable (see Section F below), will file the petition in the appropriate county, when the appropriate steps have been completed. Generally, the petition should be filed no later than the date the youth reaches the age of twenty years and six months to allow time for the court proceeding before the youth reaches age twenty-one. The following information and documents should be gathered by the child welfare worker and presented to the DCFS Regional Counsel, so that they can file the petition for appointment of an adult guardian.

1) **Physician's Report**

A petition for the appointment of a guardian through the Probate Court must be accompanied by the report of a licensed physician who has examined the individual with a disability within the past three months. The physician's report attests to the mental and physical condition of the individual as well as the physician's assessment of the individual's ability to make decisions and function independently. Since the physician's report filed in the court proceeding must be based on an examination which occurred less than three months prior to the filing of the guardianship petition, the child welfare worker shall coordinate securing the examination with the Regional Counsel and the Guardianship and Advocacy Commission, if applicable.

The physician's report should be completed by a physician who has some familiarity with the youth with a disability since the report calls for an opinion as to the youth's ability to function independently. Accordingly, if the youth's condition arises from a V Code disability such as a mental illness diagnosis, the report is most appropriately completed by the youth's treating psychiatrist. If, however, the youth's condition is organically based, a report from the youth's primary physician should be obtained.

NOTE: A psychological evaluation or a statement by a mental health professional is **NOT** sufficient to support a petition for adult guardianship. The physician's report must be completed by a licensed physician.

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2) Identifying a Suitable Guardian

The identified guardian for a youth may be a private citizen such as a family member, friend, current or former foster parent(s). A private organization may be appointed such as a designee at a residential facility or social service agency. As a last resort, the Office of the State Guardian under the Guardianship and Advocacy Commission may be appointed.

It is the responsibility of the child welfare worker to determine the suitability of the person he or she wishes to recommend be named as guardian of a person with developmental disabilities. The assessment of the individual's suitability shall include, at minimum, the following:

- (a) Whether the person meets the statutory definition of who may act as guardian under The Probate Act of 1975 (755 ILCS 5/11a-5) which states:

A person who has attained the age of 18 years; is a resident of the United States, is not of unsound mind, is not an adjudged disabled person as defined in this Act, and has not been convicted of a felony, and who the court finds is capable of providing an active and suitable program of guardianship for the disabled person is qualified to act as guardian of the person and, if he is a resident of this State, guardian of the estate of a disabled person.

Background Check Required

The person selected to serve as adult guardian is required to authorize CANTS and LEADS checks with the understanding that without these checks the Department will be unable to determine their suitability. The individual is required to sign a CFS 718G, Authorization For Background Check. The CFS 718G includes an acknowledgment that the information resulting from the CANTS and LEADS investigations will be shared with DHS, the GAC and the court as necessary in processing the adult guardianship.

Once the individual has authorized the CANTS and LEADS checks by signing CFS 718G, the child welfare worker, with proper identification, may telefax the form to the State Central Register at 217/524-0359 to request the background check. The results of the background check and the confirmation number provided by SCR shall be recorded on the CFS 718G for later use in filing a guardianship petition.

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NOTE: Under provisions of the Child Care Act of 1969, persons convicted of some felonies may be licensed after meeting certain criteria. The Probate Act requires that the individual appointed guardian of a person be **free of felony convictions**. Therefore, a LEADS check is required regardless of whether the individual is currently licensed as a foster parent.

The suitability of a person with a record of indicated child abuse or neglect on CANTS may be evaluated in accordance with the criteria set forth in Part 385, Background Checks, Section 385.50.

- (b) Whether the person is an indicated perpetrator of child abuse or neglect or has a criminal record;
- (c) In addition to statutory requirements and safety, other factors to assess in determining the suitability of a person to serve as guardian include, but are not limited to:

- X The wishes of the person with the developmental disability;
- X The length of time the individual has known the person with the developmental disability and the nature of the relationship;
- X Whether the individual is likely to exert undue influence or pressure on the person with a developmental disability rather than permit him or her to exercise independence and judgment to the maximum extent to which the person with a developmental disability is capable;

Whether the person demonstrates an understanding of any special needs that the youth might have as a result of his or her developmental disability;

- X Whether the person can communicate with the youth in the youth's preferred mode of communication and/or language;
- X Whether the person has an observable or diagnosed illness, disability or other impairment (including substance/alcohol dependency or abuse) which might interfere with their ability to meet the needs of the youth with a disability;

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- X Whether the person demonstrates a willingness to work with the youth, siblings or other family members and/or community agencies to meet any special needs the youth might have;
- X Whether there are members of the individual's household who might pose a threat to the person with a disability; and
- X Whether the proposed residence can physically accommodate the needs of the youth; if necessary, it is wheelchair accessible or can be made accessible by a ramp, lift, etc.

It may be necessary to assess several potential guardians before making a recommendation. A written record shall be maintained of all persons considered and the reason(s) they were determined unsuitable. In the event of a referral to the Office of the State Guardian, it may also be necessary to explain why these individuals were ruled out.

E. OFFICE OF THE PUBLIC GUARDIAN

The Office of the Public Guardian should be explored as the potential adult guardian when the youth has an estate of more than \$25,000. The Office of the Public Guardian then manages the estate and is responsible for providing the appropriate accountings to the Probate Court each year. If the youth has such an estate, the child welfare worker should contact the DCFS Office of the Guardian to obtain information about the exact nature and extent of the estate, and then refer the youth to the Office of the Public Guardian.

F. OFFICE OF THE STATE GUARDIAN

The Office of the State Guardian (OSG), a division of the Guardianship and Advocacy Commission, is charged with the responsibility of serving as guardian of the person or guardian of the estate of an individual, or both, when so appointed by a court under the Probate Act of 1975. The Office of State Guardian may assume full or partial guardianship of a person depending upon the individual's ability to manage his or her own affairs. By statute, the Office of State Guardian is the "guardian of last resort" and can assume its guardianship role only when no private individual or agency is available to function as guardian. The Office of State Guardian may also recommend alternatives to guardianship (such as protective payee or power of attorney) when it is felt that guardianship is not needed.

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1) Referral to OSG

Prior to making a referral to the Office of the State Guardian, the child welfare worker shall identify and assess other potential guardians from among the youth's family members, friends, former and current foster parents, and other interested parties and organizations.

Also, prior to making a referral to the OSG, details such as who the adult service provider will be and how services will be funded need to be worked out in conjunction with the ISC's and DHS Network staff.

A referral to the Office of the State Guardian is made through the regional office of the Guardianship and Advocacy Commission serving the area where the individual lives. See Attachment C for a directory of GAC offices.

To make a referral to OSG, the child welfare worker must telephone or visit the nearest GAC office and request the referral form, GAC309-0781, Guardianship Referral/ Client Status Form. In Cook County, the child welfare worker can call 708/338-7500 and ask to speak with an intake worker who can complete the referral form over the phone.

The Referral/Client Status Form requires complete information, including:

- a) Availability of potential guardians (other than DCFS);
- b) Funding sources;
- c) Nature of the disability necessitating guardianship; and
- d) Type of guardianship required (full or partial).

The OSG will review the referral and notify the child welfare worker of its guardianship decision, in writing, usually within thirty days. In urgent cases (such as a child/youth placement disruption), OSG will complete its review within fourteen days.

If OSG determines that adult guardianship is appropriate, DCFS Regional Counsel will petition the Probate Court to have OSG appointed guardian of the youth. The OSG guardianship will serve as the basis for requesting termination of DCFS guardianship in the Juvenile Court.

If the OSG determines that adult guardianship is not appropriate or necessary, or that OSG is not best suited to serve as guardian for the youth, the OSG will

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notify the child welfare worker of the reasons for that conclusion. OSG may also offer alternatives to state guardianship to effect the youth's transition to adulthood.

Should the child welfare worker and supervisor disagree with the conclusion of the OSG, the supervisor should request a staffing with the OSG to resolve point(s) of disagreement. The assistance of Regional Counsel should be sought to clarify technical issues and present additional information which might assist in resolving the situation.

2) Other Required Documentation

The child welfare worker must also provide certain background information to the DCFS Regional Counsel before a petition for adult guardianship can be prepared and filed. At a minimum, the child welfare worker must submit a thorough social investigation, a current Service Plan (or equivalent treatment plan if the youth resides in a residential facility), and a list of all known relatives of the youth with mailing addresses, if available. The list of relatives is used to satisfy notice requirements of the Probate Act of 1975. The child welfare worker should also be prepared to provide any additional information which may be requested by the Regional Counsel, such as a psychological evaluation, education information or vocational information.

G. ENSURING CONTINUITY OF FUNDING

Unlike child welfare services, adult disability services are not an entitlement. It is not sufficient to identify a vacancy in an adult program which is appropriate to the youth's needs. It is also necessary to ensure that a source of funding the adult services is secured.

On a quarterly basis, DCFS provides DHS reports of youth for whom DCFS is legally responsible who have developmental disabilities who are 17 1/2 years old or older. DHS begins planning at that point for these youth who will be aging out of the child welfare system. Youth-specific planning becomes more concrete when the child welfare worker begins working with the ISC on behalf of a particular youth.

DHS will notify the ISC when funding is available for a particular youth, and the ISC will communicate this information to the child welfare worker.

In addition to funds which may be available through DHS for services, the child welfare worker shall ensure that an application has been submitted to the local office of DHS for medical assistance to provide for the youth's medical needs.

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During transition planning and prior to referring a situation to the Guardianship and Advocacy Commission, the child welfare worker should contact the DCFS Children's Accounts Unit at 217/785-2671 to determine whether the youth is receiving Supplemental Security Income (SSI) benefits. SSI provides monthly cash assistance for persons who are over 65 or disabled and lack income or resources. (See Procedures 351, Federal Benefits and Other Federal Funds, Section V for SSI eligibility requirements and benefits.)

If the youth is not receiving SSI benefits, the child welfare worker should contact the Children's SSI Project, which is managed by two DCFS contractors. For youth served by the three Cook Regions, contact Maximus at 312/782-5300. For youth served by the Downstate Regions, contact the Center for Law and Human Services at 800/841-2812.

Staff of Maximus or the Center for Law and Human Services, as appropriate, will review the youth's case record, obtain supporting evidence, prepare the necessary application package and pursue any administrative appeals when the contractor determines that the SSI case has merit. In developing the case for SSI, the contractor will talk with the youth's caregiver and child welfare worker. The child welfare worker may be required to provide the Contractor information regarding youth's level of functioning, services that are being provided. Additionally, the child welfare worker may need to assist with obtaining a current psychological assessment and assist the current caregiver with arrangements to make sure the youth attends a consultative examination and/or administrative hearing scheduled by the Social Security Administration.

Expedited Transitions

Generally, DHS will attempt to schedule a youth's transition to an adult setting following the completion of the school year in which the youth turns 21. However, if the child welfare placement of a youth 18 years of age or older is being disrupted and his or her service plan calls for transition to adult services, the child welfare worker shall notify the Regional Clinical Services Manager, and shall seek expedited transition to adult services. If appropriate adult services are available, DCFS will retain payment responsibility until the youth reaches 21 years of age. (In the event that DHS does not receive an appropriation for transition services in the year in which the youth reaches 22, DCFS will assume payment responsibility for that year as well.) Payment for adult residential services for youth over age 18 requires the development of new contract(s) through the Regional Business Office. DHS will provide a recommended rate to the DCFS Regional Business Office upon request. Payment arrangements for 22 year olds will be handled by the DCFS Central Office of Financial Management.

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H. TERMINATION OF DCFS GUARDIANSHIP AND CASE CLOSING

If a youth requires an adult guardian, a petition to terminate DCFS guardianship must be filed in the Juvenile Court having jurisdiction once adult guardianship has been awarded to either a private individual or the Office of the State Guardian. The basis for termination of (juvenile) guardianship is the appointment of an adult guardian. The child welfare worker must contact the DCFS Regional Counsel for instructions regarding the court procedures for termination of guardianship.

The DCFS case should remain open on CYCIS until the child welfare worker can document that funding responsibility has been transferred to a source other than DCFS and that guardianship has been transferred to a private individual, the OSG or the Office of the Public Guardian as appropriate.

Questions regarding these procedures should be directed to the Regional Clinical Services Manager.

DHS Comprehensive community Service Networks for Developmental Disabilities	
NETWORK	Network Facilitators for Developmental Services
Northwest	Liz (Holland) Bernahl 419 William Stratton Building Springfield, Illinois 62765 217/524-2515
Northcentral	Linda Shroyer 419 William Stratton Building Springfield, Illinois 62765 217/524-2515
Central	Cynthia Brown 419 William Stratton Building Springfield, Illinois 62765 217/524-2515
Southern Metro East Southern Illinois	Sheila Edstrom Choate Mental Health and Development Center 1000 North Main Street Anna, Illinois 62906 618/822-5161, ext 2640

DHS Comprehensive community Service Networks for Developmental Disabilities	
NETWORK	Network Facilitators for Developmental Services
Chicago Metropolitan	<p><i>North:</i> Dave Voytanic 100 West Randolph Street Chicago, Illinois 60601 312/814-4282</p> <p><i>South:</i> Andrew Ryal 100 West Randolph Street Chicago, Illinois 60601 312/814-2786</p> <p><i>North Suburban:</i> Bob Scanlan 100 West Randolph Street Chicago, Illinois 60601 312/814-2758</p> <p><i>South Suburban:</i> Gerard Beagles 100 West Randolph Street Chicago, Illinois 60601 312/814-6113</p>

INDEPENDENT SERVICE COORDINATION AGENCIES	
AGENCY	COUNTIES/AREA SERVED
Access Services of Northern Illinois 1009 Main Street Mendota, IL 61342 815/539-3813 800/447-8869 FAX-815/539-3816	Carroll, Lee, ogle, Whiteside, Bureau, Marshall, Putnam, LaSalle, Jo Daviess, Stephenson
Access Services of Northern Illinois 7399 Forest Hill Road Loves Park, IL 61111 815/282-8824 FAX-815/282-8835	Winnebago, Boone, DeKalb
CSO of Rock Island & Mercer Counties 5447 3 rd Avenue Moline, Il 61265 309/736-1260 FAX-309/738-1263	Rock Island, Mercer
Western IL Service Coordination 1117 East Jackson Street Macomb, IL 61455 309/833-1621 FAX-309/837-1730	Fulton, McDonough, Knox, Warren, Henry, Henderson, Stark
Central Illinois Service Access, Inc. 1491 Valle Vista Pekin, IL 61554 309/347-7202 FAX-309/347-7297	Tazewell, Woodford, Peoria, McLean, Sangamon, Menard, Logan, Mason, Christian
Central Illinois Service Access, Inc. 301 North 6 th Street, Ste 170 Springfield, IL 61701 217/527-3390 FAX-217/527-8002	Taxewell, Woodford, Peoria, McLean, Sangamon, Menard, Logan, Mason, Christian

INDEPENDENT SERVICE COORDINATION AGENCIES	
AGENCY	COUNTIES/AREA SERVED
Option and Advocacy 31 East Crystal Lake Avenue Crystal Lake, IL 60014 815/477-4720 FAX-815/477-4700	McHenry
Kane-Kendall Case Coordination 335 N. River St., Ste. 201 Batavia, IL 60510 630/879-2277 FAX-630-879-9098	Kane and Kendall; Fax Valley and Hanover Township
South Suburban Access 923 West 175 th Street, 3 rd Floor Homewood, IL 60430 708/799-9190 FAX-708/799-9198	West Suburban Cook County: Lemont, Orland, Bloom, Rich, Thornton, Worth, Palos, Calumet, and Breman Townships South Suburban Cook County: Berwyn, Cicero, Downers Grove, Leyden, Lyons, Oak Park, Proviso, River Forest, Riverside, Stickney
Community Alternatives Unlimited 8700 West Bryn Mawr Avenue Suite 550, South Chicago, IL 60631 773/714-9400 FAX-773/714-8262	Lake County, North/NW Cook County, City of Chicago (North)
West Central Service Coordination 955 West Washington Pittsfield, IL 62363 217/285-5227 FAX-285-6903	Adams, Brown, Cass, Pike, Schuyler
Prairieland Service Coordination 250 1 st America Center Box 315 Decatur, IL 62525 217/424-0766 FAX-217/424-2366	Macon, DeWitt, Moultrie, Piatt, Shelby, Coles, Cumberland, Douglas, Edgar, Effingham, Clark, Vermilion

INDEPENDENT SERVICE COORDINATION AGENCIES	
AGENCY	COUNTIES/AREA SERVED
Champaign County RPC 1776 E. Washington Avenue P.O. Box 339 Urbana, IL 61801-0339 217-328-3313 FAX-217/3258-2426	Champaign, Ford, Iroquois
Macoupin/Montgomery 116 West Ryder P.O. Box 267 Litchfield, IL 62056 217/314-6600 FAX-217/324-6605	Macoupin, Montgomery
Great Rivers Service Coordination UPS Lincoln Square Shopping Center P.O. Box 638 Jacksonville, IL 62651 217/243-2330 FAX-217/243-3971	Morgan, Scott, Greene, Jersey, Calhoun
Livingston County 708 210 East Torrance P.O. Box 504 Pontiac, IL 61764 815/844-7708 FAX-815/844-7712	Livingston
DD Services 929 South 59 th Street Belleville, IL 62223 618/236-7957 FAX-618/236-7925	Madison, St. Clair
Southern Illinois Case Coordination 519 South Locust P.O. Box 588 Centralia, IL 62801 618/532-4300; 800/828-7422 FAX-618/532-9416	Monroe, Randolph, Clinton, Facette, Marion, Jasper, Clay, Wayne, Edwards, Richland, Crawford, Lawrence, Wabash, Jefferson, Hamilton, White, Gallatin, Bond, Saline, Washington, Perry, Jackson, Union, Johnson, Pope, Hardin, Alexander, Pulaski, Massaic, Franklin, Williamson

INDEPENDENT SERVICE COORDINATION AGENCIES	
AGENCY	COUNTIES/AREA SERVED
Community Service Options, Inc. 8704 South Constance Chicago, IL 60617 773/768-4492 FAX-773/768-4892	City of Chicago (South)
PACT, Inc. 555 E. Butterfield Road Suite 201 Lombard, IL 60148 630/960-9700 FAX-630/960-9823	DuPage
Service, Inc. 211 W. Jefferson, Room 242 Joliet, IL 60435 815/741-0800 FAX-815/741-1678	Will, Grundy, Kankakee

ILLINOIS GUARDIANSHIP AND ADVOCACY COMMISSION
REGIONAL OFFICES

East Central Regional Office
2310 East Mound Road, Unit D
Decatur, Illinois 62526-9359
Telephone: 217/875-6185
FAX: 217/875-6187

Rockford Regional Office
4301 North Main Street
Rockford, Illinois 61103-5202
Telephone: 815/987-7657
FAX: 815/987-7227

Egyptian Regional Office
#7 Cottage Drive
Anna, Illinois 62906-1669
Telephone: 618/833-4897
FAX: 618/833-5219

West Suburban Regional Office
Madden Mental Health Center
Pavilion 9
P.O. Box 7009
Hines, Illinois 60141-7009
Telephone: 708/338-7500
FAX: 708/338-7505

Metro East Regional Office
Pine Cottage
4500 College Avenue
Alton, Illinois 62002-5009
Telephone: 618/462-4561
FAX: 618/462-4554

North Suburban Regional Office
9511 Harrison Avenue, FA 101
Des Plaines, Illinois 60026-1565
Telephone: 847/294-4264
FAX: 847/294-4263

Peoria Regional Office
5407 North University, Suite 7
Peoria, Illinois 61614-4785
Telephone: 309-693-5001
FAX: 309/693-5050

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SECTION 302.APPENDIX O REFERRAL FOR NURSING CONSULTATION SERVICES

a) Diagnoses and Medical Conditions that Are Appropriate for Referral

Referrals for nursing consultation services may be made to the Chief of Nursing Services by the Division of Specialized Care, HealthWorks, Department and purchase of service agency staff for children who have or who are suspected of having special health care needs. Children who have special health care needs are those who have chronic or acute health conditions that require medical supervision or intervention beyond that which is required by children in general. Such conditions include, but are not limited to:

- * Any rare genetic health disorder (e.g., familial dysautonomia, Tay-Sachs)
- * Asthma, moderate persistent or severe persistent
- * Asthma, despite the severity of the condition, with poor control and any of the following circumstances: two emergency room visits within a 12 month period; one hospital admission in a 12 month period; intubation (insertion of a breathing tube); prior admission to an Intensive Care Unit for the treatment of asthma; frequent and consistent absences from school due to asthma attacks; hospitalization or emergency room visit within the past month; any severity of asthma and a cardiopulmonary medical condition
- * Apnea episodes, monitored/current
- * Behavioral/psychological problem and a medical condition (e.g., autism, asthma)
- * Blind or severe vision impairments, such as retinal conditions
- * Bronchopulmonary dysplasia
- * Cerebral palsy
- * Children with multiple psychiatric hospitalizations and/or multiple psychotropic medications
- * Compromised Immune System
- * Deaf or severely hearing impaired
- * Diabetes Type I or II
- * Diseases of any organ (e.g., kidney disease, liver disease, heart disease with the exception of functional heart murmur)
- * Durable medical equipment (e.g., child uses or requires the use a wheelchair, leg brace, apnea monitor)
- * Eating disorders, severe
- * Facial paralysis
- * Failure to thrive
- * Head or facial deformities (e.g., cleft lip, cleft palate, severe burn scars)
- * Hemophilia
- * Hormone deficiencies (e.g., lack of growth hormone)
- * Hydrocephalus with shunts and/or seizures
- * Indwelling catheters or ostomies (e.g., gastrostomy tube, jejunostomy tube, tracheostomy, colostomy)
- * Life threatening condition (e.g., brain tumor, cancer, leukemia)
- * Major birth defects leading to physical/developmental impairments
- * Mental retardation/developmental delay or disability and a medical condition (e.g., moderate mental retardation and asthma)

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- * Cystic fibrosis
- * Neurofibromatosis
- * Neurological conditions (e.g., nerve, brain, spinal cord)
- * Organ transplant, including pre-transplant
- * Orthopedic conditions, moderate to severe (e.g., bone, muscle, joints)
- * Osteogenesis imperfecta
- * Psychiatric problems that are moderate to severe (e.g., multiple psychiatric hospitalizations and/or psychotropic medications)
- * Quadraplegic, paraplegic, hemiplegic
- * Respiratory problems, moderate to severe that require nebulization and/or suctioning
- * Metabolic disorders, congenital (e.g., phenylketonuria-PKU, galactosemia)
- * Muscular dystrophy
- * Multiple sclerosis
- * Second and third degree burns over 10% of the child's body
- * Seizure disorder
- * Shaken baby syndrome/abusive head trauma
- * Sickle cell anemia, not sickle cell trait
- * Spina Bifida, if it causes moderate to severe impairment
- * Substance exposed infants
- * Technologically dependent, (e.g., ventilator, dialysis, oxygen dependent)
- * Traumatic brain injury-TBI/accidental head trauma
- * Urinary system impairments (e.g., kidney, ureter, bladder, except treatable enuresis)

b) Referral Process

The Chief of Nursing Services has the sole authority to evaluate referrals and authorize nursing services.

Note: The University of Illinois at Chicago, Division of Specialized Care for Children is the Illinois Title V agency that provides care coordination for families and children with special health care needs. The program content and guidelines are located at <http://dsc.uic.edu>.

When an alleged child victim of abuse/neglect is identified by the Child Protection Specialist as having special health care needs, the Child Protection Specialist shall refer the child victim for nursing consultation services no later than 48 hours after case assignment. Additional children residing in the home or who temporarily stay in the home of the alleged perpetrator who have special health care needs and are **not** subjects of the pending investigation, should be added to the investigation as an alleged victim of Allegation 79 Medical Neglect or Allegation 60 Environment Injurious to Health and Welfare, if appropriate.

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The Permanency Worker and Intact Family Worker must ensure that a child with special health care needs is referred for nursing consultation services during the 45-day assessment period (if a nursing referral has not been submitted by the Child Protection Specialist).

1) Referral Forms

DCFS/POS staff may request consultation from a DCFS Regional Nurse by completing the **CFS 531, DCFS Regional Nurse Referral Form**, and e-mail the completed form with any supporting documentation via Outlook to “**nurseref**” or fax the form to the attention of Child Welfare Associate Specialist at 866-531-1459. Emergency referrals may be made during normal business hours by completing the **CFS 531** and checking “Emergency” in the Reasons for Referral section.

Reasons for emergency referrals include protective custody situations involving children with special health care needs.

Emergency nursing consultations may be requested after hours and on weekends by contacting the Chief of Nursing (312-718-6657).

HealthWorks and private agency staff with access to DCFS Outlook may submit the **CFS 531** with any supporting documentation to “**nurseref**”. Requestors without access to DCFS Outlook must fax the **CFS 531** with any supporting documentation to the Child Welfare Associate Specialists at 866-531-1459. They may not submit the **CFS 531** using the Internet or the agency’s website.

2) Notification Authorizing or Denying Nursing Consultation Services

- a) For all emergency referrals, notification of acceptance or denial of consultation services from the DCFS Regional Nurse will be provided to the referring worker within 12 hours after receipt of the referral by the Chief of Nursing Services.
- b) For all non-emergency referrals, notification of acceptance or denial of consultation services from the DCFS Regional Nurse will be provided to the referring worker within five days after receipt of the referral by the Chief of Nursing Services.

The Chief of Nursing Services may expedite a request for nursing consultation services to accommodate an investigation deadline. However, Child Protection Specialists must ensure that required referrals are made within identified timeframes.

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c) Nursing Consultation Services to Support Investigation and Casework Activities

With appropriate consent, DCFS Regional Nurses may provide the following consultation/assistance services, after a referral for services is approved by the Chief of Nursing Services:

- 1) Assessment of presenting medical conditions to determine if a child has special health care needs;
- 2) Identification of a child's specific health care needs that must be fulfilled by his or her caregiver/parent;
- 3) Liaison with health care professionals to obtain required medical information;
- 4) Interpretation of a child's treatments and medications, and the effects on the child's condition when medications, medical appointments, or treatments are altered without medical consent;
- 5) Identification of safety issues linked to the child's condition that should be explored with health professionals in order to make a knowledgeable safety assessment;

Note: When nursing consultation services are being provided to a child with special health care needs, the Child Protection Specialist is required to consult with the assigned DCFS Regional Nurse prior to making an unfounded recommendation. The DCFS Regional Nurse may make recommendations concerning the need to review the child's health information, the need to interview additional health related sources or the need to initiate a staffing. The DCFS Regional Nurse's recommendations must be followed prior to discontinuing the investigation.

Note: When an intact family case that involves a child with special health care needs is receiving nursing consultation services, the Intact Family Worker must consult with the DCFS Regional Nurse prior to reducing the frequency of worker/child face-to-face contacts as part of the service termination plan.

- 6) Concurrent visitation with the Child Protection Specialist in the home of the child to assess the caregiver's/parent's knowledge and/or ability to provide for the child's special health care needs. The Chief of Nursing Services will consult with the Child Protection Specialist, the Child Protection Specialist Supervisor and DCFS Regional Nurse to determine the value of a home nursing visit. The DCFS Regional Nurse must receive consent from the Chief of Nursing Services prior to visiting the caregiver's/parent's home with the Child Protection Specialist;
- 7) Assessment of the child's home to determine if it is safely equipped and configured to meet the specific health needs of the child

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- 8) Consultation regarding pharmacokinetics/pharmacodynamics and medication compliance issues;
- 9) Liaison with the child's medical providers; and
- 10) Identification of the need for medical consultation services.

d) Protective Custody of Children with Special Health Care Needs

When there is an urgent and immediate necessity to take a child with special health care needs into temporary protective custody, do not delay the course of action until a DCFS Regional Nurse can become involved. However, whenever possible the Child Protection Specialist should consult the DCFS Regional Nurse to plan for the child's safety prior to taking the child into custody. A **CFS 531** must be completed as soon as possible after the child is taken into custody so that the plan for living arrangement/placement takes into consideration all of the relevant and necessary health issues.

1) Transportation of Technology Dependent Children

Children with a tracheostomy or who are ventilator dependent must be transported by an advanced life support ambulance to the nearest acute care facility for evaluation and treatment. If a DCFS Regional Nurse is providing nursing consultation services to the case, the DCFS Regional Nurse will call 911 to arrange for the child's specialized transportation. The child's health care plan must accompany the child to the facility.

2) Transportation of Children Who Are Not Technology Dependent

If a DCFS Regional Nurse is providing nursing consultation services to the case, the Child Protection Specialist and the DCFS Regional Nurse must jointly arrange for transportation that is appropriate for the specific health care needs of the child. The child's health care plan must accompany the child to his or her placement, and the child must receive an initial health screen.

e) Services that Are Not Provided by DCFS Regional Nurses

- 1) DCFS Regional Nurses do not provide a second medical opinion or direct nursing care.
- 2) DCFS Regional Nurses do not provide case management or safety assessment decisions.

f) Authorization to Document in the case file

The Chief of Nursing Services is authorized to grant DCFS Regional Nurses the approval necessary to document consultations and follow-up visits in the case file.

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302.Appendix P Food Allergies and Anaphylaxis

This Appendix addresses food allergies in children and the potentially life threatening allergic reactions (“anaphylactic reaction” or “anaphylaxis”) that may result from contact with or ingestion of certain foods. However, it is important to note that substances other than food can also cause anaphylactic reactions. At the end of this Appendix is a list of websites that address food allergies, anaphylaxis, and other substances that cause potentially life threatening allergic reactions. This list is not intended to be exhaustive, but is a good starting place for caseworkers and caregivers to obtain additional information about allergies to food and other substances.

a) Frequently Asked Questions and Answers

1) Do many children have food allergies?

Food allergies affect 8% of children under age three, 6%-8% of school age children and 2.5% of adults. Nationwide, three million children suffer from food allergies. A child with an undiagnosed food allergy may experience his/her first food allergy reaction at school.

According to published studies, allergy prevalence has increased significantly in the last five years. Forty to fifty percent of those persons with a diagnosed food allergy are judged to be at high risk of having an anaphylactic reaction (a life threatening allergic reaction).

2) How do I know if a child has a food allergy?

A food allergy happens when the body reacts against harmless proteins found in foods. The reaction usually happens shortly after a food is eaten. Food allergy reactions can vary from mild to severe. Because there are many things that can be confused with food allergies, it is important to know the difference.

3) What foods tend to cause food allergies?

Food allergies are more common among children than adults. Ninety percent of all food allergy reactions are caused by 8 foods: milk, soy, eggs, wheat, peanuts, tree nuts, fish and shellfish.

Severe, life threatening reactions are more common with allergies to peanuts, tree nuts, shellfish, fish and eggs. These life-threatening reactions are more common in people who also have asthma.

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4) **How serious are food allergies?**

Allergic reactions to foods vary and can range from mild to severe life threatening “anaphylactic reactions.” Some children who are very sensitive may react to just touching or inhaling the food or substance. The severity of a reaction is not predictable. A life threatening reaction can occur immediately, within minutes or even hours after exposure to the food or substance.

A child may suffer a cumulative effect from past exposures to a particular food or substance, and his/her reaction may worsen with each subsequent exposure.

5) **Do other allergens (besides food) cause anaphylactic reactions?**

Medications, insect stings, foods and latex most often cause anaphylaxis and anaphylactic reactions.

- **Medications are the leading cause.** Anaphylactic deaths from taking medications are well documented. Common culprits are penicillin and other antibiotics, aspirin and aspirin-related products, muscle relaxants, seizure medications and dyes used during certain procedures such as nuclear imaging. People with allergies or asthma are more likely to have an anaphylactic reaction to shots.
- **Stings from insects** such as bees, wasps, yellow jackets, hornets and fire ants can cause anaphylaxis. Bites from the "kissing bug" and deer fly also cause the reaction. Experts estimate that at least 40 deaths per year are caused by anaphylaxis to insect stings.
- **Intense exercise**, particularly in hot weather, can bring on anaphylaxis. Sometimes this only occurs with exercise after eating celery, shellfish, wheat, peaches or other specific foods to which the person is allergic.

6) **What is an “anaphylactic reaction”?**

An anaphylactic reaction (also called anaphylaxis) is a potentially life threatening medical condition that can occur after exposure to a particular food or substance. The most dangerous symptoms of an anaphylactic reaction include difficulty breathing and a drop in blood pressure or shock. Other symptoms can include flushed skin, rash, swelling of tissues such as lips or joints, stuffy nose, sweating, paleness, panting, nausea, abdominal cramps, rapid pulse, faintness, confusion, wheezing, convulsions and passing out, itching of the mouth and throat, frequent ear infections, hoarseness, cramping of the uterus, and feeling the need to urinate.

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An anaphylactic reaction can occur immediately, within minutes or even hours after exposure to the food or substance. For children with known allergies, the onset of any of the symptoms noted above can precede an anaphylactic reaction, and immediate action is required. When these symptoms occur in children who do not have known allergies, the caregiver should be urged to watch the child closely for any further signs of distress.

7) **How is an anaphylactic reaction treated?**

An anaphylactic reaction is usually treated initially with epinephrine, which is a prescription medication. Epinephrine is given to the child by injection using an EpiPen (registered trademark for an autoinjector of epinephrine - a.k.a. adrenaline - used in medicine to treat anaphylactic shock) or similar prescribed device. After injecting epinephrine, the caregiver or responsible adult should call 911 and the child should be transported by ambulance to the nearest hospital emergency room even if the symptoms have begun to disappear.

Since a child can die if epinephrine is withheld during an anaphylactic reaction, caregivers should be told to always give epinephrine to a child having an anaphylactic reaction and to seek immediate medical help.

If a child with a life threatening allergy doesn't have an EpiPen or Ana-kit, the worker should consult with the child's physician immediately.

8) **How can a child's food or other potentially life threatening allergies be addressed while at school?**

At the beginning of each school year (or immediately after the diagnosis of a food or other potentially life threatening allergy), the caseworker shall ensure that the caregiver meets with the school nurse to discuss the child's allergies. The caseworker shall ensure that the child's primary care physician or allergist and the school nurse develop an Individual Health Care Plan that details the preventative steps the school will take to help protect a child with potentially life threatening allergies, and an Emergency Action Plan that details how the school officials will respond when the child faces a potentially life threatening emergency. The caseworker shall also ensure that a **504 Plan (Section 504 of the Rehabilitation Act of 1973)** is developed, if appropriate, with input from the child's primary care physician or allergist that identifies the child's needs while in the school environment and the actions required of school officials to meet those needs. The 504 plan will describe:

- the child's disabling condition;
- the major life function affected by the condition in the school setting;

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- how the major life activity within the school setting is limited; and
- the services to be provided by the school district to meet the needs identified.

The 504 Plan should specify that service provided by the school district will include a medication administration and monitoring program.

The caseworker shall ensure that the 504 Plan is on file with the child's school.

Additional Information on 504 Plans is available at the following website: http://www.foodallergyinitiative.org/section_home.cfm?section_id=8&sub_section_id=3)

b) Guidelines for Children with Potentially Life Threatening Food Allergies

The long-term goal for children with potentially life threatening food allergies is to be independent in the prevention, care, and management of their food allergies and reactions based on their developmental level.

A child should be taught:

- not to trade or share foods.
- to wash hands or use hand wipes before and after eating.
- to recognize symptoms of an allergic reaction and notify an adult immediately if a reaction is suspected.
- to promptly tell an adult as soon as accidental exposure occurs or symptoms appear.
- to develop a relationship with the school nurse and at least one other trusted adult in the school to help in identifying issues related to the management of the allergy in school.
- not eat anything with unknown ingredients or ingredients known to contain an allergen.
- to develop a habit of always reading ingredients before eating food.
- never board the school bus if experiencing any symptoms of an allergic reaction.

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- if medically necessary and developmentally appropriate, to be responsible for carrying and taking his/her medications appropriately. If a medical ID bracelet or necklace is provided, the child is responsible for wearing the ID at all times.

c) Guidelines for Caregivers

Caseworkers should ensure that caregivers are informed of the child's food allergies. Caregivers must assist in the prevention, care, and management of the child's food allergies and reactions. Additionally, caregivers should be encouraged to foster independence on the part of the child, based on her/his developmental level. To achieve this goal, caregivers should be asked to follow these guidelines.

- Ensure that an Individual Health Care Plan, Emergency Action Plan and a 504 Plan (if appropriate) are on file with the school, informing school officials of the child's allergies prior to the opening of school (or immediately after a diagnosis). In addition, provide:
 - medication orders from the physician;
 - EpiPen (or similar prescribed device) and other necessary medications;
 - annual updates on the child's allergy status;
 - a current picture of the child, for the Individual Health Care Plan at school; and
 - if the child carries medications, periodically check for expiration dates and replace medications as needed.
- Contact the caseworker for assistance in obtaining a medical ID bracelet or necklace for a child with a potentially life threatening allergy. When required, the child's medical ID bracelet or necklace can be purchased using payment Code 1116 (medical supplies and equipment). Vouchers for these payments are processed through the DCFS Regional Office.
- Introduce the child to the bus driver and head cook to explain the child's allergy.
- While the school will not exclude an allergic student from a field trip, a caregiver may choose to do so. Be willing to go on the child's field trips if requested.
- If needed, help decide upon an "allergy-free" eating area in the cafeteria.
- Provide safe classroom snacks for the child.
- Talk with the child about the school lunch menu as often as necessary based on the child's knowledge and maturity. If eating a lunch provided by the school is not appropriate, have the child take a lunch to school. Call the school nurse or head cook to discuss any concerns about ingredients in the school lunch menu.

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It is important that children take increased responsibility for their allergies as they grow older and as they become developmentally ready. The caregiver should consider teaching the child to:

- Understand the seriousness and recognize the first symptoms of an allergic or anaphylactic reaction and notify an adult immediately.
- Carry and use an EpiPen (or similar prescribed device that contains self-injectable epinephrine), when this is an age appropriate task, or know where it is kept.
- Recognize safe and unsafe foods and do not touch or share snacks, lunches, or drinks.
- Encourage the habit of reading ingredient labels before eating food.
- Understand the importance of hand washing before and after eating.
- Inform others of his/her allergy and specific needs.

d) **Additional Information**

Here are several web sites that offer additional information about allergies to foods and other substances:

- New Jersey's "Ask Before You Eat" campaign home page: <http://www.foodallergy.rutgers.edu/index.htm>
- Mayo Clinic: <http://www.mayoclinic.com/health/food-allergies/AA00057>
- National Institutes of Health (NIH), U.S. Department of Health and Human Services: <http://health.nih.gov/result.asp/265/29>
- Nutrition.gov, National Agriculture Library, U.S. Department of Agriculture: http://www.nutrition.gov/nal_display/index.php?info_center=11&tax_level=2&tax_subject=392&topic_id=1752&placement_default=0
- The Food Allergy and Anaphylaxis Network: <http://www.foodallergy.org/>
- National Institute of Allergy and Infectious Diseases, National Institutes of Health: <http://www3.niaid.nih.gov/topics/foodAllergy/default.htm>

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- Asthma and Allergy Foundation of America: <http://www.aafa.org/>
 - General food and drug allergy information:
<http://www.aafa.org/display.cfm?id=9&sub=20>
 - Information on how the Americans with Disabilities Act protects the rights of those with allergies and asthma:
<http://www.aafa.org/display.cfm?id=9&sub=20&cont=280>

- New Jersey Department of Agriculture Links to Food and Nutrition Websites:
<http://www.state.nj.us/seafood/consumerlinks.htm>

- American Academy of Pediatrics, Children's Health Topics - Asthma and Allergies: <http://www.aap.org/healthtopics/asthma.cfm>

- *Recommended Guidelines for Medication Administration in Schools*, Illinois Department of Human Services and Illinois State Board of Education (2000):
http://www.isbe.state.il.us/spec-ed/pdfs/medication_administration.pdf

- Food Allergy Initiative. This link provides links to many other food allergy websites: http://www.foodallergyinitiative.org/section_home.cfm?section_id=9

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302.Appendix Q Case Management Guidelines for Children's Asthma Management

a) Frequently Asked Questions and Answers

1) What is asthma?

Asthma is a chronic disorder of the airways that involves a complex interaction of airflow obstruction, bronchial hyper-responsiveness and an underlying inflammation. Asthma can be a life threatening condition. The cause of asthma is unknown.

According to the Centers for Disease Control and Prevention, more than 22 million people in the United States have asthma, including 6.5 million children under age 18. Asthma is the most common chronic illness in children and is the leading cause of school absenteeism due to chronic disease. Allergy induced asthma is the most common type of asthma in the United States. Sixty to seventy-five percent of the people who have asthma have associated allergies.

Asthma cannot be cured, but it can be controlled with proper environmental and medical management. For children with asthma, it is essential to provide the proper management of asthma that includes four main components: assessment and monitoring of asthma, patient education, control of factors contributing to asthma severity, and treatment with medications.

2) How severe is asthma?

Asthma severity in children is classified based upon the most severe category in which any feature occurs. The classifications of asthma severity are: intermittent, mild persistent, moderate persistent and severe persistent.

- **Intermittent:** Asthma is considered intermittent when daytime asthma symptoms occur less than or equal to twice per week, nighttime symptoms occur less than twice per month, and the child has fewer than two episodes per year. Peak flow measurements remain between 80-100% of predicted normal values.
- **Mild persistent:** Asthma is considered mild persistent when daytime symptoms occur more than twice per week but less than daily and nighttime symptoms occur more than two times per month. Peak flow measurements remain between 80-100% of predicted normal values.
- **Moderate persistent:** Asthma is considered moderate persistent when daytime symptoms occur daily and nighttime symptoms occur more than one time a week. Peak flow measurement falls between 60 – 80 % of the predicted normal values.

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- **Severe persistent:** Asthma is classified as severe persistent when daytime symptoms occur continually and nighttime symptoms occur frequently. Peak flow measurements fall below 60% of the predicted normal values.

Note: Peak flow is measured by a peak flow meter, which is a portable hand held device used to measure how air flows from the lungs. The peak flow meter helps a child with asthma see how well his/her lungs are working by measuring child's ability to push air out of the lungs at any given time. Changes in normal peak flow values can provide early warning of an asthma attack.

3) **What triggers an asthma attack?**

Asthma can be triggered by inhaled allergens, such as dust, dust mites, mold, pollen, various grasses, animal dander, saliva from any pets, paint, perfume, strong odors, fumes, cockroaches and their droppings, wood smoke, cigarette smoke, cold air, abrupt changes in the weather, strong emotions, exercise, and having the common cold, influenza, other respiratory illnesses, etc.

4) **How is asthma managed?**

The symptoms of asthma can be managed with appropriate medical treatments, environmental adjustments and life-style changes.

Asthma Action Plan. An Asthma Action Plan helps the child with asthma and the family understand how best to keep asthma under control, what the health care provider says to do if the asthma becomes out of control and when to seek help.

Medications. Medications for asthma are categorized into two general classes: long-term control medications and quick-relief medications. Long-term control medications are used daily to achieve and maintain control of persistent asthma. The most effective long-term medications are those that address the underlying inflammation characteristic of asthma. Quick-relief medications are used to treat acute symptoms and exacerbations. The type, amount and scheduling of medications is determined by the level of asthma severity or asthma control.

Medical equipment. Medical equipment for a child with asthma may include items such as an inhaler, spacer, nebulizer, humidifier, peak flow meter or oxygen. An inhaler holds medicine that is breathed into the lungs. A spacer is placed on the end of the inhaler and helps more of the medication reach the lungs. A nebulizer also helps the medication reach the lungs.

Environmental adjustments. The child's caregiver is required to eliminate allergens, pollutants or irritants from the home environment that may cause an asthma attack and compromise the child's life and well-being. Examples include: tobacco or wood smoke in or outside of the home, pet dander, cleaning products, dust, perfumes or strong odors.

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Life-style changes. Managing a child's asthma may require changes in the child or caregiver's day to day activities, including changes in such things as food preparation procedures and eating habits, and stress reduction. The caregiver and child should work with the child's health care provider to identify known or suspected allergens, irritants, pollutants, triggers and stimuli, and reduce or eliminate the child's exposure to these items.

5) How is asthma addressed while the child is at school?

Children with asthma are permitted to carry asthma medication with them and use this medication at school, at school-sponsored activities, while away from school under the supervision of school personnel, and at before- or after-school activities on school property.

To meet the requirements of the School Code for the self-administration of medication, the caseworker must:

- provide written authorization for the child's self-administration of medication; and
- provide a written statement from the child's health care provider containing the name and purpose of the medication, the prescribed dosage, and the times that, or the special circumstances under which, the medication is to be administered.

The caseworker shall ensure that the child's health care provider and the school nurse develop an Individual Health Care Plan that details the preventative steps the school will take to help protect a child with asthma, and an Emergency Action Plan that details how the school officials will respond when the child faces a potentially life threatening emergency.

The caseworker shall also ensure that a **504 Plan (Section 504 of the Rehabilitation Act of 1973)** is developed, if appropriate, with input from the child's health care provider that identifies the child's needs while in the school environment and the actions required of school officials to meet those needs. The caseworker shall ensure that the 504 Plan is on file with the child's school.

The 504 plan will describe:

- the child's disabling condition;
- the major life function affected by the condition in the school setting;
- how the major life activity within the school setting is limited; and

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- the services to be provided by the school district to meet the needs identified. A 504 Plan may, for example, require the school to provide alternate activities when a child has asthma symptoms and cannot participate in gym, or require the school to eliminate triggers from the school environment such as animals with fur or strong odors.

The 504 Plan should specify that service provided by the school district will include a medication administration and monitoring program (when appropriate).

Additional Information on 504 Plans is available at the following website: http://www.foodallergyinitiative.org/section_home.cfm?section_id=8&sub_section_id=3)

If the child's asthma contributes to learning difficulties, then an Individualized Education Plan/Program (IEP) may also be required.

b) Guidelines for workers

1) Initial Health Screening

When a child is known to have asthma, the investigation specialist shall inform IHS staff of that fact and review the IHS Encounter form **before** leaving the site to ensure that the examining physician documented an asthma diagnosis, asthma severity classification and medications. The investigation specialist shall obtain a temporary Asthma Action Plan at the IHS and ensure that the physician prescribes a rescue medication in case the child's asthma flares up.

The investigation specialist shall prepare and fax a **CFS 691, Identification of a Child Diagnosed with Asthma** to the Division of Service Intervention - Health Services as directed on the form, and place a copy in the child's record.

2) Referral to Regional Nurse

Any child brought into the system with known **moderate persistent to severe persistent asthma, uncontrolled asthma or with severe exacerbations** shall be referred to the DCFS Regional Nurse. Included with the referral should be as much history and medical documentation as can be obtained.

Any child newly diagnosed with **moderate persistent to severe persistent asthma, uncontrolled asthma or with severe exacerbations** shall be referred to the DCFS Regional Nurse for assessment recommendations, and potential follow-up with a health care provider or specialist regarding the caregiver's knowledge and comfort in handling the child's asthma.

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Any child currently diagnosed with **moderate persistent to severe persistent asthma, uncontrolled asthma or with severe exacerbations** who is to be moved to a new foster or relative care setting shall be referred to the DCFS Regional Nurse to assess the home environment and caregiver's knowledge, and assist the new caregiver as necessary regarding the medical needs of the child.

As a general rule, any child who suffers **two emergency room visits or one hospital admission during a year** due to the child's asthma problems will require a referral of the case to the DCFS Regional Nurse. As a part of the referral, the caseworker shall provide copies of the child's Asthma Action Plan, Unusual Incident Reports related to asthma exacerbations, HealthWorks medical records and/or other health documentation and the updated Health Passport information.

Any concerns about the control management of asthma for any child, despite the severity of the condition, shall be referred to a DCFS Regional Nurse. **The following are examples of asthma that is poorly controlled** that require a DCFS nursing consultation and/or referral.

- two emergency room visits for asthma in a year's time;
- one hospitalization for asthma in a year's time;
- intubation (insertion of a breathing tube) for asthma;
- prior asthma admission to a hospital Intensive Care Unit;
- frequent and consistent absences from school due to asthma attacks;
- hospitalization or emergency room visit for asthma within the past month;
- any severity of asthma and a cardiopulmonary medical condition;
- a health care provider's statement that the child's asthma is not controlled;
or
- frequent use of rescue albuterol inhaler.

Note: DCFS Regional Nurse Referral instructions are set out in Procedures 302-Appendix O.

3) **Placement requirements for children with asthma**

When selecting placement for a child with asthma, the caseworker shall rely on the environmental and treatment recommendations of the child's physician for eliminating allergens, pollutants, or irritants (such as smoke, animals, or others)

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from the child's environment that the child may react to and that may compromise the child's life and well-being. These recommendations shall be documented in the SACWIS health information section and the child's case record and followed with the urgency indicated by the child's physician.

The child shall not be placed with, or be allowed to remain in a placement with, a caregiver who is unable or unwilling to adhere to the Asthma Action Plan and the health care provider's environmental or treatment recommendations. If a caregiver is unable or unwilling to follow these recommendations, the investigator or caseworker must immediately seek another placement. When time is not of the essence, the caregiver should be given an opportunity to make necessary changes or obtain training that would allow for the child's health needs to be met.

If a child must be moved to a different placement, the caseworker must ensure that medications, medical equipment, the Asthma Action Plan, and other environmental aids for the child's asthma are moved with the child. The caseworker shall also provide the new caregiver with the child's list of known or suspected allergens, irritants, pollutants, triggers, and stimuli.

4) Follow-up worker's responsibilities

- A) If the child is diagnosed with asthma at the IHS, the investigation specialist or caseworker (if no protective custody was taken) shall ensure that the Division of Service Intervention-Health Services is notified by faxing a **CFS 691, Identification of a Child Diagnosed with Asthma**. The investigation specialist shall also document the diagnosis in SACWIS.
- B) If a child currently diagnosed with asthma does not have an Asthma Action Plan, the caseworker shall ensure that the caregiver takes the child to a health care provider to have an Asthma Action Plan developed. The caseworker will share with the caregiver the list of known or suspected allergens, pollutants, irritants, triggers, and stimuli.

The caseworker shall ensure that the health care provider has prescribed appropriate maintenance medication and a rescue medication, and that the rescue medication is available in case the child's asthma flares up.

The caseworker shall place a copy of the Asthma Action Plan in the child's case record, and ensure that the caregiver distributes the Asthma Action Plan to the child's school, day care or preschool. If the child is school age and is involved in extracurricular activities, the caregiver shall ensure that the Asthma Action Plan is given to the adult supervising that activity.

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- C) The caseworker shall regularly reinforce the necessity of the caregiver taking the Asthma Action Plan to every health care provider visit so it can be reviewed and revised as needed and also informing the health care provider of all medicines taken by the child (prescribed and over the counter), all diagnoses, and all equipment used.
- D) The caseworker shall ensure that the caregiver has been advised by the health care provider of the impairment, risk, and category of severity of the child's asthma (intermittent, mild persistent, moderate persistent or severe persistent). The health care provider should be consulted about whether the child may receive or benefit from the annual flu vaccination.
- E) The caseworker shall also ensure that that the caregiver has been advised on recognizing the early signs, symptoms, and peak flow expiratory flow measures, if a peak flow meter has been prescribed, that indicate worsening asthma.
- F) The caseworker shall ensure that the caregiver requests a peak flow meter from the health care provider, especially if the child has moderate or severe persistent asthma or has a history of severe exacerbations, or takes daily asthma medication. If the health care provider has prescribed a peak flow meter, the caseworker shall reinforce the need for the caregiver to review the readings with the health care provider.
- G) In addition to seeing their health care provider, children who have had difficulties with maintaining control of asthma, or recurrent exacerbations and children with moderate persistent and severe persistent asthma should be referred to a specialist, such as an allergist, immunologist or pulmonologist for evaluation and/or co-management of the disease.
- H) The caseworker shall ensure that the caregiver takes measures that reduce or eliminate the child's exposure to allergens. For example, the caregiver may need to encase the child's mattress and/or pillow with an allergy barrier cover, or many need to reduce or eliminate the child's exposure to tobacco or wood smoke in or outside of the home or to irritants like perfume, cleaning products, dust, or vapors.
- I) The caseworker shall ensure that placement and service guidelines related to management of the child's asthma are placed in child section of SACWIS Service Plan.

5) **Reunification**

Before finalizing reunification of children with asthma with their parents, the caseworker must document that the parents have demonstrated to the child's health care provider a level of proficiency in their knowledge about their child's

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asthma and asthma care. All of the child's medications, medical equipment, the Asthma Action Plan, other environmental aids for the child's asthma, and copies of the child's health information shall go with the child upon reunification.

c) **Role of the DCFS Regional Nurse**

Upon receiving a referral, the DCFS Regional Nurse shall contact the caregiver, caseworker and/or health care provider to determine what actions are needed. When a child with severe persistent asthma is referred, the DCFS Regional Nurse shall schedule a site visit. The child's caseworker shall accompany the Regional Nurse during the site visit.

The DCFS Regional Nurse shall assess and reinforce knowledge the child and caregiver have received from the health care provider, treating physician and/or hospital discharge instructions regarding:

- medications (proper dosage, times, side effects);
- proper use of an inhaler, spacer, and nebulizer. If these items were not prescribed, the DCFS Regional Nurse shall contact the physician or specialist to obtain a prescription for the needed equipment (if appropriate); and
- use and care of the peak flow meter. The Regional Nurse shall encourage the caregiver to request the doctor to prescribe a peak flow meter for each child with moderate persistent or severe persistent asthma.

If the DCFS Regional Nurse determines that the caregiver needs additional training to care for the child, the Regional Nurse shall recommend that the caregiver contact the child's health care provider to arrange for the needed training.

The DCFS Regional Nurse shall assess the environment to identify environmental triggers that could precipitate an attack (e.g., pollutants, allergens, insects, etc.) and make recommendations as needed based on the assessment.

The Regional Nurse shall ensure that all children with moderate persistent or severe persistent asthma are referred to an allergist, immunologist or pulmonologist.

d) **Guidelines for children**

- 1) A child with asthma shall follow the recommendations of his/her health care provider. This may include following the Asthma Action Plan, using a preventative inhaler on a daily basis, using nasal medication, receiving ongoing allergy shots, etc.

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- 2) A child with asthma should learn to identify the early signs and symptoms that indicated that his/her asthma is becoming worse, and be able to identify the steps that he/she should take when these signs and symptoms occur. The child should keep his/her rescue inhaler handy and accessible at all times, and know what to do if his/her asthma reaches a crisis level (e.g., call 911).
- 3) The child should be able to identify the list of known or suspected allergens, irritants, pollutants, and stimuli that triggers his/her asthma and avoid exposure to these items.

e) **Guidelines for caregivers**

- 1) If a child is suspected of having asthma because of breathing problems, the caregiver should contact the child's health care provider as soon as possible for an appointment, or, in the event of an emergency, take the child to the emergency room for immediate medical care.
- 2) The caregiver shall obtain information from the health care provider about the impairment, risk, and category of severity of the child's asthma (intermittent, mild persistent, moderate persistent or severe persistent). The health care provider should be consulted about whether the child may receive or benefit from the annual flu vaccination.
- 3) If a child currently diagnosed with asthma does not have an Asthma Action Plan, the caregiver shall ask the child's health care provider to develop one.
- 4) The caregiver shall provide a copy of the Asthma Action Plan to the child's day care provider, preschool or school nurse. Each time the Asthma Action Plan is revised, the caregiver shall give a copy of the revised plan to the day care provider, preschool or school nurse. The caregiver shall give the day care provider, preschool or school nurse a sufficient supply of the child's prescribed rescue medication, and shall refill the medication when requested.
- 5) The caregiver shall be able to recognize the early signs, symptoms, and peak flow expiratory flow measures (if a peak flow meter has been prescribed) that indicate worsening asthma. The caregiver shall ensure that the child's maintenance medication is up-to-date and being taken as prescribed, and that the child's rescue medication is always immediately accessible in case the child's asthma flares up.
- 6) The caregiver shall request a peak flow meter from the health care provider, especially if the child has moderate or severe persistent asthma or has a history of severe exacerbations, or takes maintenance medication. If the health care provider has prescribed a peak flow meter, the caregiver shall review the readings with the health care provider at each visit.

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- 7) The caregiver shall remove potential allergens, pollutants, irritants, triggers, and stimuli from the home, and shall take measures that reduce or eliminate the child's exposure to them. For example, the caregiver may need to encase the child's mattress and/or pillow with an allergy barrier cover, or many need to reduce or eliminate the child's exposure to tobacco or wood smoke in or outside of the home or to irritants like perfume, cleaning products, dust, or vapors.
- 8) The caregiver shall take the Asthma Action Plan to every health care provider visit so it can be reviewed and revised as needed, and shall also inform the health care provider of all medicines taken by the child (prescribed and over the counter), all diagnoses, and all equipment used.
- 9) The caregiver shall cooperate with requests made by the DCFS Regional Nurse with regard to the child. If the DCFS Regional Nurse determines that the caregiver needs additional training to care for the child, the caregiver shall contact the child's primary care or treating physician for assistance in obtaining the needed training.
- 10) The caregiver shall comply with the Asthma Action Plan and the health care provider's recommendations. **If a caregiver is unable or unwilling to adhere to a health care provider's environmental or treatment recommendations or Asthma Action Plan, the investigation specialist or caseworker must immediately seek another placement.** When time is not of the essence, the caregiver should be given an opportunity to make necessary changes or obtain training that would allow for the child's health needs to be met.
- 11) The caregiver shall complete all caregiver activities identified in the child's service plan.

f) **Additional information**

- American Academy of Pediatrics, Children's Health Topics - Asthma and Allergies: <http://www.aap.org/healthtopics/asthma.cfm>
- Asthma and Allergy Foundation of America: <http://www.aafa.org/>
 - General food and drug allergy information:
<http://www.aafa.org/display.cfm?id=9&sub=20>
 - Information on how the Americans with Disabilities Act protects the rights of those with allergies and asthma:
<http://www.aafa.org/display.cfm?id=9&sub=20&cont=280>
- National Institutes of Health (NIH), U.S. Department of Health and Human Services: <http://health.nih.gov/result.asp/265/29> and <http://kids.niehs.nih.gov/asthma.htm>

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- Mayo Clinic: <http://www.mayoclinic.com/health/asthma/AS99999>
- http://www.asthmaactionamerica.org/media/asthma_control_made_simple.pdf
- The American Lung Association:
<http://www.lungusa.org/site/c.dvLUK9O0E/b.33276/>
- National Heart Lung and Blood Institute:
http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhatIs.html
- U.S. National Library of Medicine:
<http://www.nlm.nih.gov/medlineplus/asthma.html>
- Centers for Disease Control and Prevention: <http://www.cdc.gov/asthma/>

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APPENDIX R: CASE OPENING PROTOCOL

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a) Definitions

“Hand-Off staffing/Supervisory Conference” is the meeting that takes place between the investigation specialist and/or the investigation supervisor and the placement worker or intact specialist and/or supervisor. Assessment of safety factors shall be comprehensive and ongoing with the primary assigned investigator having responsibility for safety during the entire investigation process. Once the case has been fully transferred to a placement worker or intact specialist, the safety assessment will be a collaborative assessment between the investigator specialist and the assigned placement worker or intact specialist until the completion of the child abuse/neglect report. Referral documents provided by the investigation specialist shall include:

- SACWIS Intake Report;
- Referral Form for Formal Intact Family Services;
- CFS 1000-1, Hispanic Client Language Determination Form (if applicable);
- SACWIS case notes and service referral information;
- Child Endangerment Risk Assessment, approved by the child protection supervisor;
- SACWIS Risk Assessment Summary;
- CFS 440-5, Adult Substance Abuse Screen;
- SACWIS/CANTS 17A-DV, Domestic Violence Screen;
- Paramour Checklist (if applicable);
- Law Enforcement Agency Data System (LEADS) information; and
- Any available applicable records (e.g., medical, school, etc.).

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“Transitional visit (TV).” The placement worker or intact specialist assigned to provide services to the family is introduced during the transitional visit. The following issues shall be addressed during the transitional visit:

- Identified safety and risk concerns;
- Service needs;
- How the Department will be involved with the family (schools, doctors, family meetings, etc.); and
- Worker’s contact information, initial consents for information, etc.

b) Identifying Families Appropriate For Services

In consultation with the investigation specialist, the investigation supervisor makes the critical decision that a family can benefit from Department services. Additionally, certain situations mandate opening a family and/or child case in order to document a legal relationship such as protective custody. In each instance, the supervisor must ensure that all required steps for case opening are completed to facilitate the delivery of services to the child and family.

c) Intact Family Cases

- 1) When the investigation supervisor and investigation specialist determine an intact family case needs to be opened, the supervisor shall ensure that the following steps are completed:
 - A) The investigation specialist and/or supervisor shall submit a fully and comprehensively completed **CFS 2040**, Intact Family Services Case Referral and Assignment Form to the Investigation Manager, who has the authority to make final decisions regarding case openings for services pertaining to investigations. If the Investigation Manager supports the recommendation for case opening, the Manager will ensure that the assigned investigation specialist has fully and comprehensively discussed the case opening plan with the family and has documented the case opening plan. The investigation specialist shall advise the family regarding their rights, inform them that the intact specialist will hold a more comprehensive discussion with the family regarding their rights, and discuss available dates for the Transitional Visit.
 - B) If the Investigation Manager supports opening the family case, the **CFS 2040** is sent to the Intact Manager for assignment to an intact team. The investigation supervisor will ensure that the documents for case opening required in Procedures 302.388 are submitted immediately to the identified intact team supervisor.

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- C) **All internal DCFS Intact Case Assignments:** Within 48 hours (excluding holidays and weekends) of selection of an intact family team, the investigation supervisor must conduct a supervisory conference/**handoff meeting** with the intact team supervisor. Prior to or at the handoff meeting, the assigned intact specialist will be identified. The sending and receiving workers must also be present at the meeting, unless a worker's presence has been waived by his/her supervisor. These supervisory conference/handoff meetings should never be waived. **At the conclusion of the meeting, the case will be immediately (same day) opened in SACWIS for service in the name of the intact specialist.** Required documents for Case Assignment Payment Unit (CAPU) are to be completed, checked by the supervisor for completeness and accuracy and forwarded to CAPU **by the fastest and safest means of delivery.**

All POS Intact Case Assignments: Within 48 hours (excluding holidays and weekends) of selection of a POS agency referral, the investigation supervisor must conduct a supervisory conference/handoff meeting with the receiving POS agency staff. If the receiving worker has been identified, he/she is expected to be present at the handoff meeting along with the investigator unless waived by his/her supervisor. Due to the varying complexities of referrals to POS agencies, the SACWIS intact case will be opened on the day of the Transitional Visit. All delays beyond the timeframes cited below should be approved by the Investigation Manager.

- D) The Transitional Visit (TV) shall be scheduled at the supervisory conference/handoff meeting and that visit must occur within **48 hours** (excluding holidays and weekends) of the handoff meeting. The investigation specialist shall contact the family during or immediately following the supervisory/handoff meeting to provide the date and time for the TV and shall request that all involved family members attend (including a paramour, when applicable). Scheduling an appointment is more likely to ensure that the family (including extended family stakeholders) is available and will be present at the TV. Unscheduled contacts are discouraged. If the worker learns at the time of the supervisory conference/handoff meeting that the family's head of household is unavailable to participate in the TV because he/she is resistant to accepting service, or is missing or is "unavailable" for the foreseeable future, the supervisory conference/handoff meeting participants must fully discuss the barriers to case opening for services. The investigation supervisor will alert the Investigation Manager and both Intact and Investigation Managers will discuss the pros and cons of opening a case or obtaining a protective order from the Juvenile Court (if applicable) within 24 hours. If there is disagreement, the Assistant Regional Administrator or Regional Administrator will make a final determination. If a determination is made to open a case, it shall be

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opened within 24 hours. If a decision is made to close the case, the Investigation Manager will document the decision in a SACWIS Contact note from the service case.

- E) When meeting with the family, the investigation and intact specialists shall:
- **Explain the family's right of self determination** as defined in the DCFS Code of Ethics and Handbook pertaining to services, and **ensure that the family's head of household understand the family's rights.** Both workers must fully document this conversation in a Case Contact Note.
 - **Provide full disclosure of the services to be offered and ensure that the adult family members have given informed consent for those services** according to the DCFS Code of Ethics and Handbook. Both workers must fully document these disclosures in a Case Contact Note.
 - **If the family's head of household refuses to accept services after full disclosure and an explanation of the family's rights, the investigation specialist and supervisor shall notify the Investigation Manager within 24 hours.** If the Investigation Manager determines that the Department should request the State's Attorney to file petition in Juvenile Court seeking court-ordered services for the family, the investigation specialist will contact the State's Attorney's Office within 24 hours of the decision. If the court orders the family to accept services, a family case will be opened immediately, if not already opened, in accordance with the court order and in compliance with Department policy.
 - The investigation specialist shall review and complete the applicable sections of the **CFS 496, Client Rights and Responsibilities** with the family's head of household. The Investigation specialist shall circle each of the applicable bullet points reviewed with the head of household, and ask him/her to check the applicable boxes and sign the form. This form documents that the head of household understands his/her rights and confirms his/her interest in receiving intact family services.
- F) If the TV did not occur, the investigation and intact specialists shall schedule another visit to the home immediately. The visit shall occur within 24 to 48 hours of the failed visit.
- G) If attempts to conduct a TV are unsuccessful, the investigation supervisor shall consult with the Investigation Manager who, after consultation with the Intact Manager, will decide whether the workers should attempt

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additional visits, or whether to request the State's Attorney's office to file a petition in Juvenile Court. The Investigation Manager shall enter a Contact Note in the SACWIS service case, documenting the final decision.

- 2) **Intact Case Opening Requirements** (case opening requirements from investigations to intact family services).

The investigation supervisor shall ensure that the following steps are completed:

- Create the case in SACWIS. (**Note: A case must be opened in SACWIS before it can be opened in CYCIS.**)
- From the SACWIS "Create Case" window, select "Create a Family Case."
- Update family relationship and address information, making sure to end date ALL duplicate and obsolete addresses.
- Verify all current CYCIS household members by selecting **Yes** or **No**.
- Forward the **SACWIS CFS 1410, Registration/Case Opening** and the **CFS 1425, Change of Status** as attachments to the CAPU Distribution Group (Cook County) or the Downstate CAPU Distribution Group (Downstate) in order to complete the opening process.
- Both the sending and receiving sides of the **CFS 1425** must be thoroughly completed.
- In the subject line of the e-mail, identify if the case is **Norman** or **Intact**.
- The assigned intact specialist and the manager must be copied in the e-mail.

CAPU is responsible for completing the following steps:

- **Norman cases** – open the family case in CYCIS to the investigation specialist within 24 hours.
- **Intact cases** – open the family case in CYCIS and transfer to the identified intact specialist within 24 hours.

d) **Placement Cases**

All traditional placement case assignments are based upon a child's school catchment area. For each child attending school, the worker must include the child's school name and address when contacting CAPU for case assignment/opening.

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Protective Custody in Open Intact Cases

When an investigation involves children from an open intact family case, the investigation specialist or supervisor shall immediately notify the intact specialist and/or supervisor. Both workers and their supervisors should have a brief staffing to discuss the family and nature of the current investigation before the initial contact is made. Ideally, the workers should make a joint visit to initiate the investigation; however, the investigation specialist must not delay initiating the investigation if the intact specialist is unavailable.

If the investigation specialist determines that the children must be taken into protective custody to ensure their safety, the intact specialist is responsible for physically placing the children. The investigation specialist is responsible for completing the court screening packet. While the investigation specialist is expected to take the lead during screening with the State's Attorney's Office, both workers are expected to be present and participate in the screening. The current after-hours process will continue in both Cook County and Downstate Regions.

For a child taken into protective custody that presents with special needs, the investigation specialist shall complete the **CFS 418-J, Checklist for Children at Initial Placement** and shall fax the **CFS 418-J** with supporting documentation identifying the special needs of the child to the Specialized Foster Care Unit at 312-814-1905. The investigation specialist should do this as early into the investigation as possible so the child can be properly assessed, eliminating the chance the case gets assigned to an inappropriate agency that cannot meet the child's needs. If a specialized foster care home is needed, the Specialized Foster Care Unit will work with the Investigation specialist to match the child with a specialized foster care agency for placement.

If the Department is granted temporary custody of the child by the Juvenile court, the Investigation specialist shall complete the **CFS 1425-L, Legal History Maintenance Form**. The **CFS 1425-L** must be sent via e-mail or fax to CAPU. Fax numbers for CAPU are 312-808-4315 (Cook County) and 312-808-4335 (Downstate).

If temporary custody is not granted, the investigation specialist shall close all child cases, but shall leave the family case open for intact services if the family agrees to comply with these services or if services are court ordered.

Intact cases remain the responsibility of the intact specialist until the court grants the Department temporary custody of the child.

Case Opening Requirements for Protective Custody in Open Intact Cases:

- 1) The investigation supervisor shall ensure that the following steps are completed:
 - If traditional foster care is required, the investigation specialist shall contact CAPU at 312-808-5160 (select option 2) for an agency assignment or page 312-250-5625 (Cook County) or 888-609-0052 (Downstate).

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- Create the child case in SACWIS from the open investigation, or from the open family case. The child case can only be created from the investigation when the investigation is properly linked to the case with the same family group numbers. When a case is assigned to a POS agency, it shall be opened by the investigation supervisor. In non-POS situations, the case can be created by the CWS worker and/or supervisor.
 - From the SACWIS “Create Case” window from the open/pending investigation, select “Create Child Case.”
 - Check the CYCIS Family Member indicator “yes” for **each child case** to be opened in CYCIS.
 - Update family relationship and address information.
 - Verify all current household members by selecting **yes** or **no**.
 - Forward the **SACWIS CFS 1410, Registration/Case Opening** by e-mail as an attachment and the **CFS 418-J, Checklist for Children at Initial Placement** to the CAPU Distribution Group (Cook County) or the Downstate CAPU Distribution Group (Downstate). **The CFS 418-J must also be faxed/e-mailed to the DCFS Specialized Gatekeeper at 312-814-1905 if any item other than “none” is selected on the form.**
 - The subject line of the e-mail must identify the case name and CYCIS ID number.
 - **For each child attending school, the worker must include in the e-mail the child’s school name and address.**
 - The placing worker must e-mail the **CFS 906** (with Placement Clearance number) to the CAPU Distribution Group (Cook County) or the Downstate CAPU Distribution Group (Downstate).
 - The **CFS 458-A, Affidavit of Relationship** must accompany the **CFS 906** for all HMR placements.
 - The investigation specialist shall complete all other activities as required in Rule and Procedures 300, or as instructed by the investigation supervisor.
- 2) CAPU is responsible for completing the following steps:
- A) **Traditional Placements:** To locate a placement and assign the case, CAPU needs the following information during the call-in process:
- Screening date/time

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- Child's current location
- School name/address
- Investigation specialist/supervisor name and phone number
- SACWIS Family Group ID#
- CYCIS case ID#
- Protective custody date/time
- Head of household's name, address, date of birth, language, race, SACWIS person ID#
- Child's name, date of birth, race, sex, SACWIS person ID#

CAPU will use **School Minder** software and the Statewide Case Assignment system to assign the case. School Minder is used to retrieve a listing of available foster homes in the youngest child's school catchment area. School Minder groups the identified foster homes based upon their proximity to the child's school. If the school address is unknown, the head of household address is used.

School Minder Groupings = In district; 1 mile; 1-5 miles; 5-10 miles; 10-20 miles

The following information is entered into School Minder to obtain the groupings:

- Cook or Downstate
- School or head of household address
- Age of children
- Language

CAPU also uses the Statewide Case Assignment (SCA) system to determine the case assignment for new intake and completes the following steps:

- Paste the appropriate grouping of foster homes in SCA to determine which foster home's supervising agency will be contacted for the placement referral. SCA ranks the agencies according to their traditional Percentage of Referral Opportunities (PROs);

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- Contact the designated licensing staff (DCFS) or Intake Liaison (POS) for the first three agencies within the first grouping informing them of their ranking on the call list. The grouping/contact process continues until an appropriate placement is located;
- CAPU and licensing staff inform the investigation specialist of the assigned agency/foster home;
- CAPU opens the case in CYCIS to the investigation specialist and transfers to an Unassigned Team ID# (DCFS) or an Agency Intake ID# (POS); and
- CAPU faxes case assignment information to the identified Intake Liaisons (DCFS/POS).

B) HMR Cases: The SCA system is used to identify a receiving agency.

- SCA ranks the agencies according to their HMR PROs. CAPU contacts the first three agencies identified and this process continues until an agency accepts the HMR referral.
- CAPU opens the case in CYCIS to the investigation specialist and transfers to an Unassigned Team ID# (DCFS) or an Intake ID# (POS).
- CAPU faxes case assignment information to the identified Intake Liaisons (DCFS/POS).
- CAPU informs the investigation specialist of the assigned agency/foster home.

C) Downstate Only: After 4:00 p.m., workers shall use the after hours referral process for traditional placement cases. CAPU will assign the case to the agency selected using the After Hours protocol.

Placement Cases Converting from Protective Custody to Intact Family Services

When protective custody of a child lapses during an investigation and intact family services are required, the investigation specialist shall:

- E-mail a final **CFS 906** for each child in protective custody to CAPU; and
- E-mail a **CFS 1425** to CAPU, closing each child's case and transferring the family case to an intact team.

Note: The "receiving" side of the CFS 1425 must include the receiving intact team's region/site/field, worker ID and date of transfer.

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e) Future Date Cases/Filing a Petition

This section applies to investigation and intact specialists who must screen cases when there is an active intact family case or a pending investigation and no active intact family case.

- The investigation specialist acquires a temporary custody hearing date (Cook County) or a screening date for filing the petition (Downstate).
- If a family case is not currently open, a family case must be created in SACWIS.
- The investigation specialist shall send the **SACWIS CFS 1410, Registration/Case Opening** via e-mail as an attachment to CAPU. The **SACWIS CFS 1410** shall identify the date and time of the temporary custody hearing. **For each child attending school, the worker must include the child's school name and address when contacting CAPU for case assignment /opening.**
- CAPU will assign the case to a DCFS permanency team or POS agency and inform them of the temporary custody hearing date and time.
- Downstate - Cases will be created in SACWIS after the court decides whether the children will be placed with DCFS.
- If temporary custody is granted, the permanency worker will access the case record on the SACWIS desktop (not the investigative file for Child Protection Staff), and open the child case.
- CAPU will open and transfer the child case to the permanency team or private agency that was assigned the family.
- If temporary custody is not granted and intact family services are needed, the investigation specialist will follow the process for opening a case for intact family services if the family agrees to comply with services or if services have been court ordered.

Future Date Cases/Filing a Petition - Case Opening Requirements:

- 1) If temporary custody is granted, the investigation supervisor shall ensure that the following steps are completed:
 - Create the child case in SACWIS.
 - From the SACWIS Create Case Window, select “Create Child Case.”
 - Check the CYCIS Family Member indicator “yes” for **each child case** to be opened in CYCIS.

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- Update the family relationship and address information.
 - Verify all current household members by selecting **yes** or **no**.
 - Forward the **SACWIS CFS 1410, Registration/Case Opening** by e-mail as an attachment and the **CFS 418-J, Checklist for Children at Initial Placement** to the CAPU Distribution Group (Cook County) or the Downstate CAPU Distribution Group (Downstate). **The CFS 418-J must also be faxed to the DCFS Specialized Gatekeeper at 312-814-1905, if any item other than “none” is selected on the form.**
 - The subject line of the e-mail must identify the case name and CYCIS ID number. **For each child attending school, the worker must include the child’s school name and address when contacting CAPU for case assignment /opening.**
 - The placing worker must e-mail the **CFS 906** (with Placement Clearance number) to CAPU.
- 2) CAPU is responsible for completing the following steps:
- Follow the guidelines used for making a traditional/HMR case assignment.
 - Open the family case in CYCIS to the screening worker and transfer the case to an Unassigned Team ID# (DCFS) or and Intake ID# (POS).
 - Inform the assigned agency of the scheduled temporary custody hearing date/time.
 - If temporary custody is granted, open the child case in CYCIS to the screening worker and transfer to an Unassigned Team ID# (DCFS) or an Intake ID# (POS).

f) Placement Case Opening Procedures

When protective custody is taken, the investigation specialist creates in SACWIS a case for each child taken into protective custody and a family case.

If a traditional foster care placement is needed, the investigation specialist must call CAPU intake personnel to request an assignment.

- Cook County - The assigned investigation specialist or supervisor must contact CAPU prior to screening the case with the Assistant State’s Attorney to determine and document the assigned agency.
- The **SACWIS CFS 1410, Registration/Case Opening** must be sent by e-mail as an attachment to CAPU. The **SACWIS CFS 1410** must be sent to CAPU by noon the day prior to the legal screening (Cook County only).

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- If the child is initially placed at ERC or in a hospital, the investigation specialist must also e-mail the **CFS 906** to CAPU.
- If a POS worker initially places the child, the worker must complete the **CFS 906** and e-mail it to CAPU.
- **For each child attending school, the worker must include the child's school name and address when contacting CAPU for case assignment/opening.**

If the child is placed in the home of a relative (HMR), the investigation specialist is not required to call CAPU. The investigation specialist must e-mail the **SACWIS CFS 1410** and **CFS 906** to CAPU. CAPU will assign the case to a DCFS or POS Permanency team. CAPU shall immediately notify the investigation and permanency teams of the assignment.

The **CFS 1425-L, Legal History Maintenance Form** must be e-mailed or faxed to CAPU immediately following the shelter care hearing.

If temporary custody was not granted but protective custody was taken, investigation specialist **must** complete a **CFS 1425, Change of Status Form** and a final **CFS 906** to close each child case. The family case shall be open for intact services, when appropriate.

Placement Case Opening Requirements:

- 1) The investigation supervisor shall ensure that the following steps are completed:
 - If traditional foster care is required, the investigation specialist shall contact CAPU at 312-808-5160 (select option 2) for an agency assignment or page 312-250-5625 (Cook County) or 888-609-0052 (Downstate).
 - Create the family case and corresponding child cases in SACWIS.
 - Access the Create Case Window by clicking on the “Create Case” hyperlink from the investigation
 - From the SACWIS Create Case Window, select the radio button “Create Family and Child Case(s)”
 - Add a row to the Child Cases table and select the children for which the cases are to be created
 - Select Opening Reason
 - Select Opening Date
 - Check the CYCIS Family Member indicator **yes** for **each child case** to be opened in CYCIS
 - Update family relationship and address information.
 - Verify all current household members by selecting **yes** or **no**

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- Forward the **SACWIS CFS-1410, Registration/Case Opening** by e-mail as an attachment and the **CFS 418-J, Checklist for Children at Initial Placement** to the CAPU Distribution Group (Cook County) or the Downstate CAPU Distribution Group (Downstate). **The CFS 418-J must also be faxed to the DCFs Specialized Gatekeeper at 312-814-1905 if any item other than “none” is selected on the form.**
 - The subject line of the e-mail must identify the case name and CYCIS ID number.
 - The placing worker must e-mail the **CFS 906** (with Placement Clearance number) to CAPU.
 - The investigation specialist shall complete all other activities as required in Rule and Procedures 300, or as instructed by the investigation supervisor.
- 2) CAPU is responsible for completing the following steps:
- A) **Traditional Placements:** To locate a placement and assign the case, CAPU needs the following information during the call-in process:
- Screening date/time
 - Child’s current location
 - School name/address
 - Investigation specialist/supervisor name and phone number
 - SACWIS Family Group ID#
 - CYCIS case ID#
 - Protective custody date/time
 - Head of household’s name, address, date of birth, language, race, SACWIS person ID#
 - Child’s name, date of birth, race, sex, SACWIS person ID#

CAPU will use **School Minder** software and the Statewide Case Assignment system to assign the case. School Minder is used to retrieve a listing of available foster homes in the youngest child’s school catchment area. School Minder groups the identified foster homes based upon their proximity to the child’s school. If the school address is unknown, the head of household address is used.

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School Minder Groupings = In district; 1 mile; 1-5 miles; 5-10 miles; 10-20 miles

The following information is entered into School Minder to obtain the groupings:

- Cook or Downstate
- School or head of household address
- Age of children
- Language

CAPU also uses the Statewide Case Assignment (SCA) system to determine the case assignment for new intake and completes the following steps:

- Paste the appropriate grouping of foster homes in SCA to determine which foster home's supervising agency will be contacted for the placement referral. SCA ranks the agencies according to their traditional Percentage of Referral Opportunities (PROs);
- Contact the designated licensing staff (DCFS) or Intake Liaison (POS) for the first three agencies within the first grouping informing them of their ranking on the call list. The grouping/contact process continues until an appropriate placement is located;
- CAPU and licensing staff inform the investigation specialist of the assigned agency/foster home;
- CAPU opens the case in CYCIS to the investigation specialist and transfer to an Unassigned Team ID# (DCFS) or an Agency Intake ID# (POS);
- CAPU faxes case assignment information to the identified Intake Liaisons (DCFS/POS); and
- CAPU informs the investigation specialist of the assigned agency/foster home.

B) **HMR Cases:** The SCA system is used to identify a receiving agency.

- SCA ranks the agencies according to their HMR PROs. CAPU contacts the first three agencies identified and this process continues until an agency accepts the HMR referral.

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- CAPU opens the case in CYCIS to the investigation specialist and transfer to an Unassigned Team ID# (DCFS) or an Intake ID# (POS).
 - CAPU faxes case assignment information to the identified Intake Liaisons (DCFS/POS).
 - CAPU informs the investigation specialist of the assigned agency/foster home.
- C) **Downstate Only:** After 4:00 p.m., workers shall use the after hours referral process for traditional placement cases. CAPU will assign the case to the agency selected using the After Hours protocol.

Note: All cases opened in CYCIS will initially reflect the assigned investigation specialist before being transferred to a DCFS or POS permanency team.

Special Case Opening Add-Ons to Open Placement Cases

These procedures are for open placement cases when the Department receives legal custody or guardianship of an additional child as part of an already open family case, which also has an open child case.

Note: Case assignment will be directed to the agency providing services to the sibling.

- **Department placement cases.** The placement worker and supervisor are responsible for making the case opening decision and completing the case opening in SACWIS.
- **POS placement cases.** The POS placement worker and supervisor must contact the Cook County Child Welfare Intake team for all POS placement cases with add-ons (statewide). The Cook County Child Welfare Intake staff will be responsible for completing the case opening in SACWIS and submitting the opening packet to CAPU.

After Hours Placements:

The current after hour process for placing children will continue in Cook County and Downstate. Downstate staff will begin using the after hour process at 4:00 p.m. Case opening information must be sent to CAPU the following business day.

g) Resolving Case Opening Problems with Open Post Adoption Cases

This section includes:

- Pending Investigations: protective custody and/or court custody.

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- Open DCP Intact Cases: protective custody and/or court custody.
- Child Welfare: protective custody and/or court custody, change of guardianship, and return home.

Before a post-adoption case can be opened for protective custody, temporary custody, or guardianship, the case must first be closed in CYCIS and then in SACWIS. To close the post-adoption case the worker must contact the post-adoption unit by e-mail only. The requesting worker must include the child's name, CYCIS number, date of new custody and type of custody, and include a **CFS 1425-L, Legal History Maintenance Form** as an attachment in the e-mail for the child whose case is be closed.

Post-adoption staff will immediately close out the child's case in CYCIS for the day before the new custody. After the overnight interface between CYCIS and SACWIS, the CYCIS closure will be appear in SACWIS as "closed in CYCIS." Post-adoption staff will then be able to close the case in SACWIS.

After the CYCIS and SACWIS case is closed, the requesting worker will then be able to open the new case with the new custody date.

Contact for Post-Adoption Cases:

For Cook County cases, e-mail requests to Legertha Barner or Warren Kunstler. Include the **CFS 1425-L**.

Outside of Cook County, e-mail requests to the assigned worker as shown on the CM-06 screen in CYCIS. Include the **CFS 1425-L**.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Distribution: X and Z

POLICY GUIDE 2013.02

CREATING AND OPENING INTACT FAMILY AND PAYMENT ONLY CASES

RELEASE DATE: June 13, 2013

TO: Rules and Procedures Bookholders, DCFS Child Protection Staff, DCFS Child Welfare Staff, and DCFS Clerical Support/CYCIS Data Entry Staff

FROM: Richard H. Calica, Director



EFFECTIVE: Immediately

I. PURPOSE

The purpose of this policy guide is to issue instructions to Field Office Clerical Support staff who perform the functions of creating and opening Intact Family Services and Payment Only cases in SACWIS and CYCIS. Comprehensive revisions to Procedures 302, Appendix R, Case Opening Protocol will be issued in the near future.

II. PRIMARY USERS

Primary users of this policy guide are DCFS child welfare and child protection workers, supervisors, and clerical support/CYCIS data entry staff.

III. BACKGROUND

In order to streamline and more effectively manage case opening functions the Department is returning some case opening data entry responsibilities back to the field. Specifically, effective May 15, DCFS field clerical statewide are responsible for opening Intact Family cases (DCFS “high risk” and POS) and “payment only” cases (e.g. Norman). On June 1st, CAPU will no longer accept documents to open intact family and payment only cases and any received at CAPU will be returned to the sender. Placement cases will continue to be opened at CAPU.

Each local field office has identified clerical staff who will perform case opening data entry functions. Identified clerical staff have been given access to add/delete/update/change data entry capability for some CYCIS screens, and SACWIS “read only” access in order to complete the case opening process. Please refer to Policy Guide 2006.02, Creating and Opening Cases in SACWIS for specific case opening instructions.



IV. PROCEDURES

a) **Creating New Intact Family Service (IFS) Cases in SACWIS**

The following steps must be completed to open a new IFS case:

- A data check must be completed;
- A new family case must be created in SACWIS from the CA/N investigation or CWS intake;
- A **SACWIS 1410**, Case registration/Opening Form must be generated in SACWIS;
- A **CFS 1425**, Change of Status Form, must be completed; including completion of both sides of the “Transfer” section (i.e. the sending and receiving agency and worker must be entered);
- An email to which is attached the **SACWIS 1410** and the **CFS 1425** must be addressed and sent to the appropriate regional clerical person who will open the case in CYCIS.

Note: The IFS case opening date in SACWIS must be the date of when the Transitional Visit occurs.

If a new intact family case is opened as the result of an investigation of a report of abuse or neglect so the family may receive “Norman services”, the assigned child protection specialist is responsible for completing the required procedures listed above.

If the new intact family service case is being opened due to a lapsed protective custody, the assigned child protection specialist is responsible for completing the procedures list above. The child protection specialist must ALSO complete a **CFS 1425**, Change of Status Form, to close the child’s placement case.

If a new intact family case is opened as the result of a child welfare service intake evaluation by Department staff, the assigned intact family service/high risk specialist is responsible for completing the procedures listed above.

If a court orders a family to cooperate with services provided by the Department, the intact family service/high risk specialist assigned to the family is responsible for completing the procedures listed above.

b) **Opening Intact Family Cases in CYCIS**

Designated Department clerical staff in each region will, upon receipt of correct, complete information, open all intact family cases in CYCIS. Regional clerical staff will enter all required information into CYCIS. Regional clerical staff will also notify by e-mail all of the following staff of the case opening information and, as applicable, case assignment information: the staff who submitted the information; each person listed as a “Cc” (carbon copy) on the original e-mail submitting the information; and the DCFS or POS agency caseworker to which a case has been assigned.

c) **Submittal of Intact Family and Payment Only Case Opening Forms**

All forms required for opening new intact family cases, payment only cases, including but not limited to Norman cases, or other payment only intact family cases, must be submitted as attachments to an e-mail addressed to clerical staff authorized to open cases in CYCIS in each Department region. The subject line of the e-mail must always include the type of case being opened (i.e., New Family Case) the last name of the case being opened and the CYCIS number of the case as listed on the **SACWIS 1410**, Registration/Opening form. Further, the supervisor of the staff submitting the e-mail should always be included as "Cc" (carbon copy) recipient of the e-mail.

For the purpose of these procedures, the following situations are considered to be a new intact family case, for which all required case opening forms must be submitted to authorized regional clerical staff:

- A new intact family service case resulting from an investigation of a report of abuse or neglect and no child subject in the report was taken into protective custody and placed in substitute care; or
- A new intact family service case resulting from an order by a court that a family cooperate with services, but the court does not award custody or guardianship of a child member of the family to the Department; or
- A new intact family service case resulting from a child welfare services intake evaluation; or
- A new intact family service case is required to make a payment to or on behalf of a family (e.g. a Norman program cash assistance payment.)

Conversely, the following are **NOT** considered to be new intact family service cases because each involves the establishment of a legal relationship between a child and the Department.

- An intact family service case that results from a lapsed protective custody; or
- A court awards the Department custody or guardianship of a child, but orders the child(ren) to remain at home.

Forms and other information required to open a new case(s) in either of these situations must be submitted to the Case Assignment Placement Unit (CAPU).

d) **Resolving Problems Related to Creating Cases in SACWIS or Opening Cases in CYCIS**

1) **Resolving Problems Related to Creating Cases in SACWIS**

To report and receive assistance in resolving *computer related* problems with creating cases in SACWIS and/or Opening Cases in CYCIS staff should contact the **OITS Help Desk** via email or call (800) 610-2089.

To receive assistance with investigation merges and person merges, staff should go to the D-Net, OITS, Request Services, SACWIS/SCR Request Forms and/or contact the SCR Mailbox.

2) Procedures for Regional Clerical Staff Resolving Problems with Intact Family Service Case Openings

If regional clerical staff identifies a problem with information submitted for a new intact family service case opening, clerical staff will immediately e-mail the staff who submitted the information and all staff included as a “Cc” on the original e-mail submitting the information. Clerical staff will explain in the e-mail what problem must be corrected before the case may be opened.

Within 1 working day of being notified by regional clerical staff of a problem with a requested intact family service case opening, the supervisor of the staff who originally submitted the forms will direct the staff to create a corrected version of the problematic form and re-submit the corrected form(s) to regional clerical staff.

V. QUESTIONS

Questions about the new case opening process may be directed to the following individuals who have been identified as the regional clerical liaisons:

- Cook: Katherine Bonner (Maywood FO: 708-338-6727)
- Northern: Sandra Rodebeck (Elgin FO: 847-888-7651)
- Central: Faith Stutsman (Champaign FO: 309-828-0022)
- Southern: Theresa Ile (Mount Vernon FO: 618-244-8400)

Questions regarding this Policy Guide may also be directed to the Office of Child and Family Policy at 217-524-1983 or via Outlook at OCFP – Mailbox. Non Outlook users may e-mail questions to cfpolicy@idcfs.state.il.us.

VI. FILING INSTRUCTIONS

File this Policy Guide immediately following Procedures 302, Appendix R, Case Opening Protocol.

SERVICES DELIVERED BY THE DEPARTMENT
March 26, 2015 – PT 2015.05

302.Appendix S – Education and Training Voucher Program

[Moved to Procedures 314.75, Post High School Education Programs]

SERVICES DELIVERED BY THE DEPARTMENT
March 26, 2015 – PT 2015.05

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