Delaware Pre-Service Training Handouts Part 3

THE NEGATIVE EFFECTS OF PHYSICAL PUNISHMENT

1. It teaches children that bigger people use power and force to stop smaller people from certain behaviors. One rarely sees someone small using physical punishment on someone larger. It increases the chances that older or bigger children will hit younger, smaller children.

2. It teaches children that using force or violence is a way to solve problems and conflicts and a way to respond to someone when you are angry.

3. It increases the likelihood that the person that is physically punished will grow resentful.

4. It reinforces poor self-esteem by not treating the child and the child's body with dignity and respect. Children do not necessarily connect the event or the behavior that they are being punished for with the consequences. Instead, they may think they're "no good" and that others don't like them.

5. Research in child development and psychology has shown that physical punishment may stop a behavior immediately, but not for long. It just means that a child might stop doing a particular behavior around the parent.

6. Physical punishment tends to set the child against the parent who inflicts it on the child. It is important to remember that painful feelings can cause more lasting hurt than physical pain.

7. It teaches foremost the importance of not getting caught. So, the child, who before the punishment was open in his/her actions, now learns to hide them and becomes sneaky in the process.

POLICY:	Behavior Management/Discipline
POLICY #:	4:0
REFERENCE:	3700.36; 3700.63; 3680.21; 3680.21; 3680.43; DELACARE #103, #107, #171; COMAR 07.02.25.20
DATE:	August, 1986; Rev. 10/90, 5/97, 11/01, 05/08; 11/12; 06/14; 06/17
APPROVAL:	**COPY WITH SIGNATURE AVAILABLE IN OFFICE POLICY & PROCEDURE MANUAL** President/Chief Executive Officer

According to the therapeutic approach employed by Children's Choice (Dr. William Glasser's "Choice Theory"), punishment is not to be used with children. During a crisis and only in a behavior management context, passive restraint may be used judiciously. The logical consequences of a child's positive and negative behavior are to be stressed.

Behavior management techniques acceptable to Children's Choice for use with children include:

Preventative Measures:

1. Know the circumstances surrounding the child's placement in foster care and establish reasonable expectations of the child's behavior;
2. Discuss issues and problems at appropriate times in a calm productive, and positive manner;
3. Plan and participate in family counsel meetings at established dates/times weekly;
4. Post chores list;
5. Specify and consistently enforce rewards to be earned;
6. Permit input into planning for and participating in family activities;
7. Create daily private time and place for discussion of interactional problems.
8. Recognize, praise and encourage acceptable behavior.
9. Supervise with an attitude of understanding and firmness.
10. Give clear directions and provide guidance at the child's level of understanding.
11. Intervene quickly to ensure safety of others.
12. Redirect children by suggesting other acceptable behaviors rather than use punishment.
13. Speak so children understand their feelings are acceptable, but the behavior is not.

Logical Consequences of aberrant behavior can include:

1. Restitution of property damage at the rate of not more than one half the child's weekly allowance;

2. Time out administered for one minute per child's chronological age; etc:

   3-year-old child – 3 minutes
   10-year-old child – 10 minutes

Effective time out will begin when the child stops the unacceptable behavior, be specific, and conclude with a conversation with the child regarding the reason for the time out, discussion of acceptable behavior, and consequences for future infractions
Crisis Management for the child who is verbally or passively acting out:

1. Interrupt behavior, say "Stop";
2. Send child to a private place for "Time Out";
3. When child is calmer, encourage him/her to speak with you (resource parent);
4. If no positive results are achieved, telephone the Children's Choice caseworker; using the Emergency Call procedure if the event occurs after regular business hours.

Crisis Management for the child who is physically acting out:

1. Leave the area, having done whatever possible to keep the child safe (e.g. lock door to prevent escape); do not attempt to physically restrain the child; use a calm voice; don't yell or blame child for bad behavior;
2. Call local police;
3. Follow Children's Choice Emergency Call Procedures (CC 4:6).

THE FOLLOWING ACTIONS ARE PROHIBITED WITH FOSTER CHILDREN, MAY RESULT IN THE REMOVAL OF A CHILD FROM YOUR HOME, AND MAY CAUSE THE CLOSING OF YOUR HOME BY CHILDREN'S CHOICE:

A. Roughly handling a child or any type of physical punishment inflicted in any manner upon the child's body including, but not limited to shaking, striking, hair pulling, throwing, biting, pinching, slapping, hitting, kicking, or spanking;

B. Mental abuse such as name-calling or actions which subject the child to verbal abuse, ridicule, or humiliation;

C. Requiring or forcing the child to take a painfully uncomfortable position, such as squatting or bending, or requiring or forcing the child to repeat physical movements when used solely as a means of punishment;

D. Denial of elements of the service plan;

E. Delegation of discipline to any other person than a responsible adult made known to the child;

F. Assignment of physically strenuous exercise or physically strenuous work solely as punishment;

G. Denial of visiting or communication privileges with family solely as a means of punishment;

H. Withholding of any meals;

I. Denial of sufficient sleep or toilet use as a consequence of inappropriate behavior;

J. Requiring the child to remain silent or be isolated for long periods of time, locking a child in a room, or inappropriate use of time out;

K. Denial of shelter, clothing or bedding;

L. Extensive withholding of emotional response or stimulation;

M. Specific time limits must be attached to all discipline and the child must be aware of the consequences;

N. "Time Out" is intended for short periods of time and length of time should be discussed and approved by the caseworker;

O. Washing a child's mouth out with soap or other caustic substance is prohibited;

P. Hair-cutting or denial of personal hygiene is unacceptable;

Q. Biting a child back or instructing another child to do so as a teaching method is prohibited;

R. Use of foul language with foster children is highly inappropriate and does not present a positive role model;

S. Punishment of any kind for bedwetting, enuresis, or encopresis, failing to fall asleep, to eat all or part of food or to complete an activity;

T. Hand slapping and spanking are considered forms of physical punishment;

U. Physical restraint of a child

V. Humiliating (making negative comments about a child's looks, ability, ethnicity, family or other personal traits), frightening or verbally, physically, or sexually abusing a child;

W. Threatening removal from the foster home.

Remember: Foster children are not "bad kids" they are "good kids" exhibiting bad behaviors.

Resource Parent Signature	Date
Resource Parent Signature	Date
Children's Choice Representative	

Parenting and Positive Discipline Notes

Parenting and Positive Discipline Notes

Additional Information

Handout #2

DETERMINING REWARDS

Watch what the child does frequently.

Listen to what the child asks for or wants.

Ask the child for suggestions of what she would like to have as a reward.

Try to determine how the child feels "rewarded" for undesirable behavior, and when possible, attach that reward to the alternate desired behavior.

Use reinforcers that don't take a lot of time or money.

Use attention, praise, and affection liberally to build, reinforce, and sustain attachment.

Handout #3

SUGGESTED REINFORCERS

Care for pets
Choosing a favorite meal
Time with a favorite adult
Use of playground equipment
Use of "walkman" or tape recorder
Art supplies
Balloons
Bean bags
Book
Audio cassette tapes
Coloring books
Comics
Cosmetics
Crayons
Games
Grab-bag: toys, candy, decals
Jewelry
Magic markers
Model kits
Paintbrushes and paints
Posters
Small amounts of money
Self-stick skin tattoos
Stickers
Stuffed animals
Toys
Wax lips and teeth
Yo-yo
Invite a friend to dinner
Dinner out
Lunch out with parent (instead of school lunch)
Movie
Watch a video
Play video games
Trip to library
Play computer game
Extra television or computer time
Play a game with parent
Invite a friend to play
Trip to playground
Go for walk with parent and dog

Handout #5

Logical Consequences

At times, there is not an obvious natural consequence, which will serve as a lesson for an inappropriate behavior. In this case, it is necessary for the parent to determine and apply an appropriate consequence. A logical consequence is one, which the parent imposes that is clearly and directly related to the misbehavior. The relationship between the inappropriate behavior and the logical consequence must be evident to the child.

Examples of Logical Consequences

Inappropriate Behavior	Logical Consequence
• Writing on wall	• Cleaning wall
• Breaking object	• Working to pay for object
• Not going to bed on time	• Going to bed early
• Staying on the phone	• Losing phone privileges
• Leaving yard without permission	• Not being allowed to leave yard for one day
• Riding bicycle in area that is prohibited	• Not being allowed to ride bicycle for a specified time period
• Stealing	• Returning object and apologizing to owner
• Violating curfew	• Having an earlier curfew for next weekend
• Hitting or bullying others	• Being removed from play area

When to Use Logical Consequences

The guidelines listed below can be used to determine if a logical consequence is appropriate. If you answer "yes" to all of the questions it may indicate that a logical consequence could be helpful.

1. Is the behavior physically dangerous to the child or to others?
2. Is the behavior destructive to your property or someone else's property?
3. Have you exhausted positive or natural consequences to promote desired behavior?
4. Is the behavior among your priorities for change?
5. Have you used logical consequences sparingly in the past? Special contracting may be required in some cases where power struggles have worn down the efforts of both you and your child.

6. Does this behavior have little apparent or reasonable natural consequences that can help your child?

How to Use Logical Consequences

Step 1. Find an appropriate time (having allowed for a needed cooling-down period) to identify the specific behavior, which you wish to change by using logical consequences. If possible, it is a good idea to talk this over with another adult before talking to the child.

Step 2. Decide the consequence and the time limit. Clearly identify the way the child can earn back privileges or reinforcers you have taken away.

a. You cannot ride your bike for two days.
b. You have to stay in the house all day.
c. You cannot watch TV tonight.
d. You cannot go out and play in the afternoon until you meet these goals (outline specifically what child has to do).

Step 3. Explain the program to the child in a "matter-of-fact" fashion.

Step 4. Ask young children to repeat back the consequence to you (ignore side-tracking).

Step 5. Apply the consequence with the following guidelines:

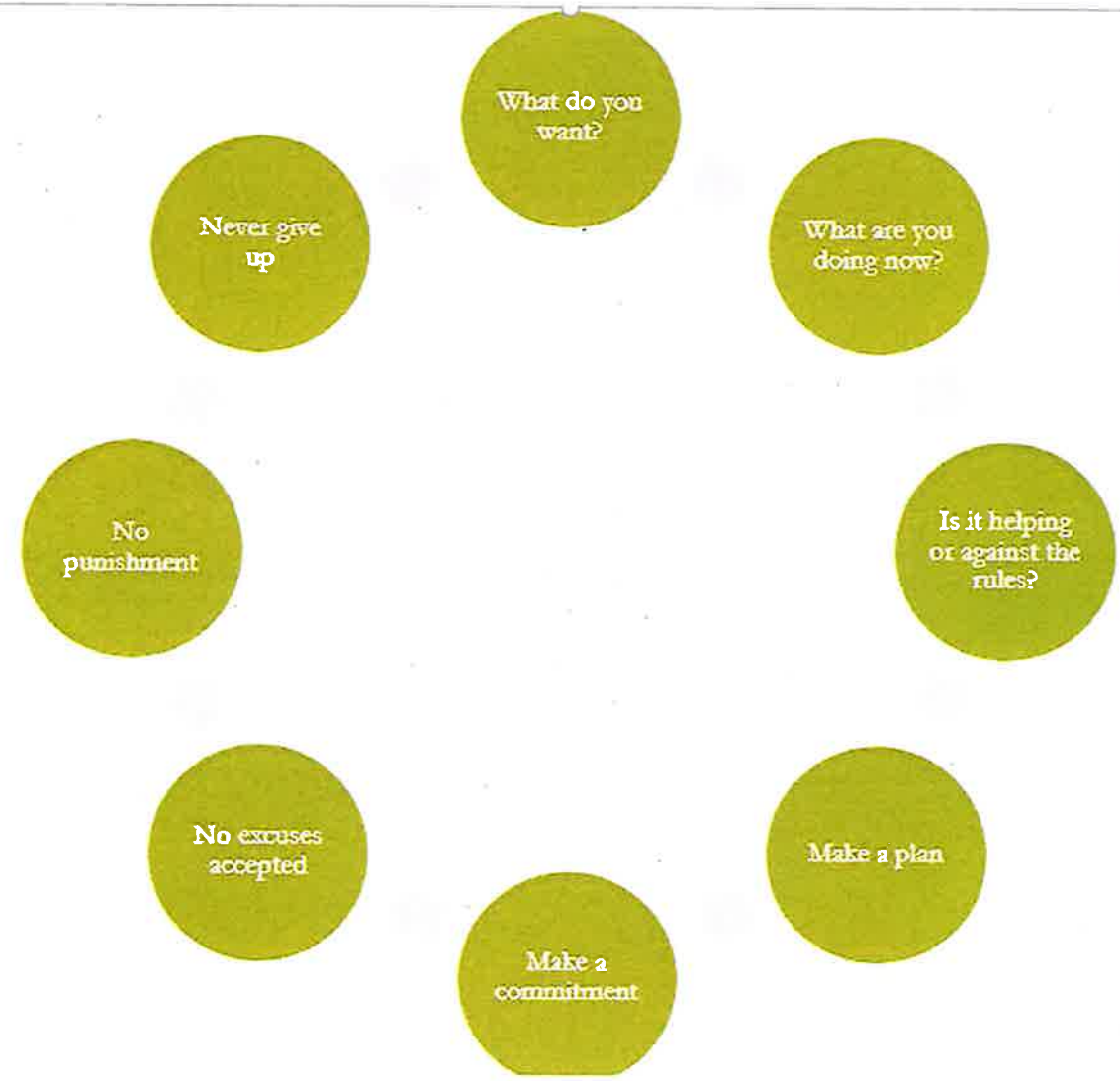
a. Have the logical consequence begin immediately or as soon as possible.
b. Apply the logical consequence consistently.
c. Be fair. Parents often "over" punish when using logical consequences. If the child leaves home without permission, don't ground him or her for a month. You'll probably not be consistent in "grounding" the child for a month. Even if you were consistent, by the end of the month, the child probably wouldn't remember the reason for the consequence.

Adapted by Alan Dupre-Clark, D Min., LPCC

EVALUATING THE EFFECTIVENESS OF DISCIPLINE

	YES	NO
1. Has the disciplinary action protected and nurtured the child's physical and psychological (self-esteem) well-being?	_____	_____
2. Did it enhance the child's development?	_____	_____
3. Were the child's needs met in a responsible manner?	_____	_____
4. Has it taught the child ways to prevent and solve problems?	_____	_____
5. Will this action maintain and/or build the parent/child relationship?	_____	_____
6. Will this method build self-control and self-responsibility?	_____	_____
7. Has this action produced the desired behavior?	_____	_____
8. Was the method based on an understanding and appreciation of the child's developmental status and uniqueness?	_____	_____

8 Steps of Reality Therapy



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Choice Theory Notes

Choice Theory Notes

PUSHING THE LIMIT

Listed below are ten behaviors or situations that could occur with the children in your home.

On a scale from 1 to 10, rate these behaviors according to how challenging they would be for you to handle effectively, with 1 being the easiest, and 10 being the most difficult.

_____ Running Away

_____ Using foul language

_____ Feces Smearing

_____ Answering back

_____ Stealing

_____ Hoarding and hiding food

_____ Bed-wetting

_____ Fighting

_____ Violating curfew

_____ Sexual acting out

Survey of Level of Acceptance of a Special Needs Child

Indicates as honestly as possible your level of acceptance of a child who:

	Most Acceptable	Willing to Discuss	Least Acceptable
Has no significant health problems			
Has allergies or asthma			
Has a slight limp			
Needs a leg brace			
Has a missing limb			
Is in a wheelchair			
Is paraplegic			
Is quadriplegic			
Has mild Cerebral-palsy			
Has Cystic Fibrosis			
Is Hyperactive			
Hyperactive, requires medication but functions relatively normally			
Hyperactive, requires medication and special classroom setting			
Stutters			
Has a lisp			
Speech at age six is hard to understand			
Will always have trouble speaking and being understood			
Has partial hearing, surgery may help			
Has partial hearing surgery may not help			
Has hearing in one ear			
Speaks, with hearing loss older in life			
Is legally deaf			
Is deaf and does not speak			
Has limited vision in both eyes, special glasses needed			
Has sight in one eye only			
Is blind, but surgery may give partial sight			
Is legally blind			
Has a hare lip			
Has a cleft palate			
Has a hare lip and cleft palate			
Has a seizure disorder, controlled by medicine			
Has a seizure disorder not controlled by medicine, but infrequent			
Has a seizure disorder, not controlled, with			

	Most Acceptable	Willing to Discuss	Least Acceptable
Frequent seizures			
Has a blood disorder requiring transfusions every three months			
Has a blood disorder requiring monthly hospitalization			
Has a blood disorder, with limited life span			
Has a heart murmur, activity not curtailed			
Has a heart murmur, vigorous activity curtailed			
May require heart surgery at a later date			
Definitely will require open heart surgery			
Will require more than one operation			
Has a deformed hand			
Has a deformed arm			
Has a deformed leg			
Has a deformed face			
Has two deformed arms			
Has two deformed legs			
Is a sickle-cell carrier			
Has sickle-cell anemia but relatively controlled			
Has sickle-cell with frequent episodes			
Is Schizophrenic			
Is Schizophrenic, on medication			
Is Autistic			
Was born substance abused			
Is a high achiever in school			
Is achieving on grade level in regular classes			
Is achieving below grade level in regular classes			
Needs special education classes			
Needs learning disability classes			
Needs classes for the emotionally and behaviorally handicapped			
Needs tutoring in one or more subject			
Is disruptive in the classroom			
Has serious behavior problems at school			
Is retarded and will always need supervision such as a workshop			
Has Down's Syndrome			
Is generally quiet and shy			
Is generally outgoing and noisy			

	Most Acceptable	Willing to Discuss	Least Acceptable
Is emotionally damaged, very withdrawn, will require therapy for an extended period of time			
Is emotionally damaged, very abusive to his/her person, e.g. pulling out hair, pinching self			
Is emotionally damaged, abusive towards others and or animals			
Has a tendency to reject father figures			
Has a tendency to reject mother figures			
Has difficulty making friends and relating with other children			
Frequently wets the bed			
Frequently wets during the day			
Frequently soils him/herself			
Has poor social skills			
Lies moderately			
Lies continuously			
Steals			
Frequently starts physical fights with other children			
Abuses others, e.g. kicking, punching, biting			
Abuses him/herself			
Tends to abuse animals			
Kills small animals			
Tends to be destructive of clothing, or toys			
Tends to be destructive to furniture			
Frequently uses language you would consider foul or bad			
Has frequent temper tantrums			
Has difficulty accepting and obeying rules			
Has a history of inappropriate sexual behavior			
Masturbates openly and/or frequently			
Runs away once a week			
Runs away once a month			
Plays with matches for fun			
Plays with matches deliberately to burn			
Has strong ties to birth family			
Has strong ties to a previous foster family			
Will need continued contact with siblings in adoptive placement			

	Most Acceptable	Willing to Discuss	Least Acceptable
Had a previous adoption disruption			
Has been sexually abused			
Has been physically abused			
Has been exposed to promiscuous sexual behavior			
Was conceived as a result of a rape			
Was conceived as a result of prostitution			
One or both parents has an alcohol addiction			
One or both parents has a chemical dependency other than alcohol			
One or both parents has a criminal record			
One or both parents are mentally retarded			
One or both parents has a mental illness			
Agency has no information on one or both parents			
Other:			

Barriers to Placement Notes

Barriers to Placement Notes


CRISIS!
Immediate Danger?
NO Immediate Danger?
Deliberate?
Emotional?
Immediate Crisis Response
1. Redirect
2. Remove
3. Restrict
4. Resources
Corrective Response:
1. Reminder
2. Warning
3. Consequences
Counseling Response:
1. Give Space
2. Active Listening
3. Problem Solving

CRISIS CUES

Diagnostic Cue	Deliberate Misbehavior	Emotional Crisis
BEHAVIOR How characteristic is this behavior under normal circumstances?	•Normal •Usual	•Unusual •Uncharacteristic
EXPRESSIONS How intense are facial expressions, body language, posture, tone?	•Calm •Manipulative	•Intense
PEERS How are peers reacting to the problem behavior?	•Reinforcing •Encouraging •Approving	•Ridiculing •Disapproving
OUTSIDE STRESS What other stressful issues co-exist with the problem behavior?	•None	•Significant

Road Map of Mental Health Crisis

1. If safety is an issue, call 911 and follow their instructions. If not, contact Delaware Crisis Priority Response Line (1-800-969-4357) and follow their instructions.
2. Contact the Children's Choice on-call number (302-593-3053) to update on the situation and to receive guidance, or your Children's Choice worker if the crisis occurs during work hours.
3. Continue to engage with the child in attempts to de-escalate them and assure safety.
4. The police/EMT will arrive to the home or Crisis will talk to you over the phone and they will attempt to help de-escalate the situation.
5. If police, EMT, or Crisis feel it is needed, they will ask you to take the child to the nearest hospital ER for a psychiatric evaluation.
6. Contact the Children's Choice on-call phone so they can get consent to treat for the hospital from DFS.
7. Follow the child to the hospital and stay with them there.
8. Plan to be at the hospital for a long time-it could take hours, so make arrangements for other youth in your home.
9. A decision will be made whether the child should go home or go to an in-patient program. Contact the Children's Choice on-call worker to let them know if the child will be returning home with you, or if they will be admitted to an in-patient program (Rockford, Dover Behavioral Health). Once they are enrolled in the program, you can leave. Let Children's Choice know that the child has been enrolled.

Crisis Management Role Plays

1. 7-year-old Rich, a young boy who has been in your home for three months has just ended a visit with his birth mother, Ms. Johnson. As Ms. Johnson and Rich are saying their goodbyes, Rich begins to become upset. Ms. Johnson is also visibly upset, but tries to hide her emotions from Rich. Ms. Johnson says her final goodbyes and leaves to catch her. After Ms. Johnson has left, you sit down to talk with the caseworker briefly about how the visit went, and Rich's behaviors begin to escalate. Not only is her crying, but he is now screaming very loudly that he wants his mom. Rich begins wandering around the office and starts grabbing things and throwing them on the ground.

2. Krista, a 13-year-old girl who just joined your family last week, has reportedly been acting our in her new school. She has been disruptive in class, and has already been sent to the principal's office twice. You get a call from the school today, stating that Krista was fighting with another girl at the school, and ran away. About five minutes after you end your call with the school, Krista shows up at your home and refuses to go back to school.

3. You arrive at school to pick up Antonio, who is 10-years-old. As you walk into the school to pick him up, you can hear him coming down the hallway, as he seems to be shouting at someone else. As you approach, you can see that he is indeed yelling at another student, saying "It's none of your business who is picking me up from school!" The other student replies, "Well, it's not your mom, because she left you and doesn't love you." You can see that at this point Antonio's fists are clenched and he is getting closer and closer to the other student until he is only about six inches away.

Managing Behavioral Issues and Crisis Intervention Notes

Managing Behavioral Issues and Crisis Intervention Notes

Additional Information

Some Hints to Smooth the Road

Pay attention to how you receive the child. Whether it shows or not, the child is uneasy. Make him/her welcome, but don't force a response.

Receive him/her quietly. Don't put social demands on the child his/her first day by having friends or neighbors over to celebrate his/her arrival. Settle down first to a regular routine.

Respect the child's feelings for the past. Don't probe if the child prefers not to. Don't close the door either – let a child who wants to talk do so. Accept the fact that his/her past has been difficult, and that it is a part of him/her.

Respect his/her loyalty to his/her home. Even if you don't approve of them, the child's parents are very important. Never try to take their place in the child's heart.

Avoid frustrations when possible. Everything we have learned about child in recent years has emphasized the importance of sparing them experiences which make them feel unloved, deprived, and lonely at an early age. Later on in life they have to learn to take it, but when they are little, protect them from such experiences if you can.

Use household tasks constructively. Give the child responsibilities in line with the child's age, not too many, not too few. See that the child gets some sort of recognition for carrying out responsibilities properly.

Let the child have his/her prized possessions. Give the child a place to keep them.

Give the child a money allowance. This teaches responsible handling of money, and it gives dignity.

Provide the child with clothes like those of the other children. This is especially important for foster children.

Point out to other members of the family little things they can do to help the child feel more comfortable.

Answer questions truthfully but avoid unnecessary or hurtful details.

Don't push the child beyond his/her capability. Accept limitations while always encouraging the child.

Preventing Placement Disruption Notes

Preventing Placement Disruption Notes

Cultural Identity and Self-Esteem Notes

Cultural Identity and Self-Esteem Notes

Additional Information

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Definition of Terms

Note: Language is dynamic and ever changing and therefore these definitions vary based on several factors including time, place, culture, and society. No one term means the same to all people or describes all people, thus it is best to ask the person how the person identifies across sexuality and gender.

ALLY – someone who advocates for and supports members of a community other than their own, specifically the LGBTQ community.

ASEXUAL – a person who is not sexually attracted to anyone.

ASSIGNED SEX- the sex someone is assigned at birth based on their anatomy and/or genetics. Male, female, or intersex.

BIPHOBIA: a fear or dislike of bisexuals.

BISEXUAL - a person who is romantically attracted to men & women.

COMING OUT – personally and/or publicly sharing one's sexual orientation or gender identity.

GAY – a man who is romantically attracted to other men. Term can also be used in reference to the entire LGBTQ community.

GENDER IDENTITY – someone's personal sense of being male, female, both, or neither.

HETEROSEXISM - Assuming every person to be heterosexual therefore marginalizing persons who do not identify as heterosexual. It is also believing heterosexuality to be superior to homosexuality and all other sexual orientations.

HETEROSEXUAL – someone that is attracted to 'the opposite' sex. (straight)

HOMOPHOBIA – a fear or dislike of gay people

INTERSEX – A person whose biological sex falls between the medical standards of male and female.

LESBIAN – a woman who is romantically attracted to other women.

QUEER- sometimes used as derogatory; can also be used in reference to someone that sees themselves as being outside of the heterosexual (straight) norm in regards to their sexual and/or gender identity.

QUESTIONING – someone who is unsure of their sexual and/or gender identity.

SEXUAL ORIENTATION – to whom a person is attracted romantically.

TRANSGENDER – a person whose gender identity or expression is different from what is expected based on their assigned sex.

TRANSPHOBIA – a fear or dislike of transgender people.

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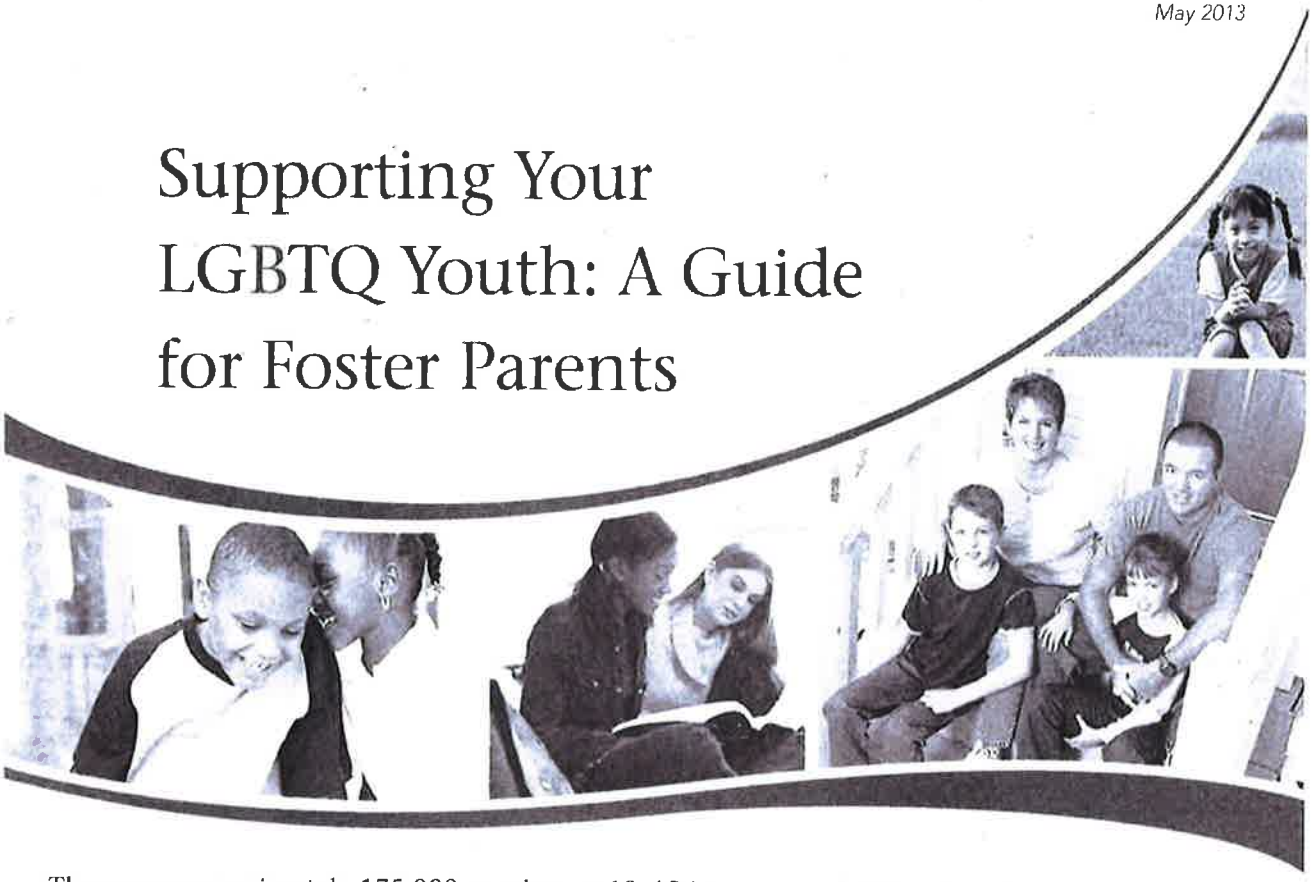
Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

FACTSHEET FOR FAMILIES

May 2013

Supporting Your LGBTQ Youth: A Guide for Foster Parents



There are approximately 175,000 youth ages 10–18 in foster care in the United States.[1] Of these youth, an estimated 5–10 percent—and likely more—are lesbian, gay, bisexual, transgender, or questioning (LGBTQ).[2]

[1] The total number of youth in care comes from *The AFCARS Report* (http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf). It is based on the number of youth ages 10–18 in care on September 30, 2011.

[2] The estimate comes from the assumption that 5–10 percent of the general population is LGBT. John C. Gonsiorek & James D. Weinrich, "The Definition and Scope of Sexual Orientation," in *Homosexuality: Research Implications for Public Policy* (Newbury Park, CA: Sage Publications, 1991); Courtney, Dworsky, Lee, and Raap, (2009) found a much higher percentage of youth in foster care who identified as something other than fully heterosexual (see http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth).

What's Inside:

Use your smartphone to access this factsheet online

Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF/ACF/HHS
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
800.394.3366
Email: info@childwelfare.gov
https://www.childwelfare.gov

Like all young people, LGBTQ youth in foster care need the support of a nurturing family to help them negotiate adolescence and grow into healthy adults. However, LGBTQ youth in foster care face additional challenges. These include the losses that brought them into care in the first place, as well as traumas they may have suffered while in foster care. They also include stressors unique to LGBTQ youth, including homophobia or transphobia[3] and the need to evaluate (often with little or no support) the safety of their communities, schools, social networks, and homes in order to decide whether to disclose their LGBTQ identity, when, and to whom.

Despite these challenges, LGBTQ youth—like all youth in the child welfare system—can heal and thrive when families commit to accepting, loving, and supporting them as they grow into their potential as adults. This factsheet was written to help families like yours understand what they need to know to provide a safe, supportive, and welcoming home for an LGBTQ youth in foster care.

In this factsheet, you will learn about LGBTQ youth in the child welfare system, the unique risks they face, and the important role that foster parents can play in reducing those risks. You will discover specific actions that you can take to create a welcoming home for all youth in your care and to promote your youth's health and well-being in the community. At the end of this factsheet are links to many resources for more information and support.

[3] *Transphobia* refers to fear of people who are transgender.

About LGBTQ Youth

The acronym *LGBTQ* is a general term used to describe people who are lesbian, gay, bisexual, transgender, or questioning their gender identity or sexual orientation.

Definitions

Lesbian, *gay*, and *bisexual* describe a person's *sexual orientation*—emotional, romantic, or sexual feelings toward other people. *Lesbian* refers specifically to women who love women, while gay can refer to any person who is attracted to people of the same sex. (The term *homosexual* is considered outdated and offensive by many gay people.) Bisexual people are attracted to men or women regardless of their anatomy. People do not need to have any particular sexual experience (or any sexual experience at all) to identify as bisexual, gay, or lesbian, because sexual orientation and sexual behavior are not the same thing.

Transgender refers to a person's *gender identity*—an internal understanding of one's own gender. A transgender person's gender identity does not match the sex (a biological characteristic) assigned to him or her at birth. Many, but not all, transgender people choose to alter their bodies hormonally and/or surgically to match their gender identity. Some people's experience, perception, or expression of their gender evolves and changes over time. Gender identity and sexual orientation are separate aspects of a person's identity: A transgender person may be bisexual, gay, or straight (or may identify in some other way).

Some youth (and adults) identify as *questioning* when they start to recognize that they may be part of the LGBT community. This does not mean that sexual orientation or gender identity is a choice. These youth may need time to process what being LGBT means for them; to reconcile any anti-LGBT stereotypes they have internalized; and to decide if, when, and how they should identify themselves as lesbian, gay, bisexual, or transgender to others.

Some people's *gender expression* (meaning, the ways in which they express their gender identity to others) does not conform to society's expectations for their sex. This might include choices in clothing, mannerisms, names, hairstyles, friends, and hobbies. It is important to understand that society's gender expectations are cultural, not biological, and they change over time (for example, women used to be expected to wear only dresses; now teens of both genders wear jeans, sweatshirts, and tennis shoes). In any case, not all *gender-variant* (or *gender nonconforming*) youth will continue to express themselves this way into adulthood, and many will never identify as gay, lesbian, bisexual, or transgender.

In other words, it is best not to make assumptions. Respecting your youth's self-identification is very important. As youth grow to trust their foster families, many will eventually share their feelings about gender identity or sexuality more openly.

"Gaining that trust takes time, patience, and consistency. That's what [my foster mother] gave me."
— *LGBTQ youth in foster care*

Addressing Common Misconceptions

There is a lot of misinformation about sexual orientation and gender identity. Here are some things that are important for you to know about LGBTQ youth in your home:

LGBTQ youth are a lot like other youth. In fact, the similarities that LGBTQ youth in foster care share with other youth in care far outweigh their differences. Most, if not all, youth in foster care have been affected by trauma and loss; they require acceptance and understanding. Making sure your home is welcoming to all differences, including race, ethnicity, disability, religion, gender, and sexual orientation, will help ensure that all youth in your home feel safe and that the youth in your care grow into adults who embrace diversity in all of its forms.

This is not "just a phase." LGBTQ people are coming out (acknowledging their sexual orientation/gender identity to themselves and others) at younger and younger ages. Studies by the Family Acceptance Project have found that most people report being attracted to another person around age 10 and identifying as lesbian, gay, or bisexual (on average) at age 13. Gender identity may begin to form as early as ages 2 to 4.[4] Someone who has reached the point of telling a foster parent that he or she is LGBTQ has likely given a great deal of thought to his or her own identity and the decision to share it.

No one caused your youth's LGBTQ identity. Sexual orientation and gender

[4] Ryan, C. (2009). *Helping families support their lesbian, gay, bisexual, and transgender (LGBT) children.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

identity are the result of complex genetic, biological, and environmental factors. Your youth's LGBTQ identity is not the result of anything you (or a birth parent, or any other person) did. LGBTQ people come from families of all religious, political, ethnic, and economic backgrounds. Experiencing childhood trauma or reading about, hearing about, or being friends with other LGBTQ people did not "make" the youth become LGBTQ.

LGBTQ youth are no more likely than other youth to be mentally ill or dangerous. These unfortunate myths and stereotypes have no basis in truth. Gay or transgender people are not more likely than heterosexuals or gender-conforming people to molest or otherwise pose a threat to children. And although it is true that LGBTQ people experience higher rates of anxiety, depression, and related behaviors (including alcohol and drug abuse) than the general population, studies show that this is a result of the stress of being LGBTQ in an often-hostile environment, rather than a factor of a person's LGBTQ identity itself.[5] Professional mental health organizations agree that homosexuality is not a mental disorder and is a natural part of the human condition.

Your youth's LGBTQ identity cannot be changed. Medical and psychological experts agree that attempting to change someone's sexual orientation or gender identity does not work and often causes harm.

Many religious groups embrace LGBTQ people. Some people fear that they will have to choose between their faith and supporting their youth's LGBTQ identity—but this is not always the case. Many religious communities welcome LGBTQ youth, adults, and their families. It may be important to know that there are other options if your family does not feel welcomed or comfortable at your place of worship.

LGBTQ Youth and the Child Welfare System

LGBTQ youth are overrepresented in the child welfare system: While approximately 5 to 10 percent of the general population is estimated to be gay, a study conducted in three Midwestern States found that a greater percentage of those aging out of the child welfare system reported a sexual orientation other than heterosexual (24 percent of females and 10 percent of males). These numbers are likely to be underreported because youth who come out often risk harassment and abuse.

Some LGBTQ youth enter the child welfare system for the same reasons that other children and youth enter care: Their birth families are unable to provide a safe, stable, and nurturing home for them due to a parent's incarceration, drug or alcohol abuse, mental illness, or other reasons unrelated to the youth's LGBTQ identity. Others, however, are rejected (and in some cases, neglected or abused) by their families of origin when their families learn that they identify as LGBTQ. Some youth experience

[5] Schlatter, E., & Steinback, R. (2010). 10 anti-gay myths debunked. *Intelligence Report, no. 140*. Retrieved from http://www.splcenter.org/get-informed/intelligence-report/browse-all-issues/2010/winter

repeated losses—originally adopted as babies or toddlers, they are returned to the system by their adoptive families when they come out.

Youth who are rejected by their families may experience greater risks than other youth in care. Studies show that these youth have lower self-esteem and a much greater chance of health and mental health problems as adults. Compared to other LGBTQ youth, those who are highly rejected by their families because of their sexual orientation or gender identity are:

- More than three times as likely to use illegal drugs or be at high risk for contracting HIV and other STDs
- Nearly six times as likely to experience high levels of depression
- More than eight times as likely to attempt suicide[6]

Unfortunately, a high percentage of LGBTQ youth in foster care experience further verbal harassment or even physical violence after they are placed in out-of-home care. As a result, many of these youth experience multiple disrupted placements, compounding the trauma associated with leaving their families of origin. In one study, as many as 56 percent of LGBTQ youth in care spent some time homeless because they felt safer on the streets than in their group or foster home.[7] This maltreatment is partially responsible for the fact that LGBTQ youth make up as many as 40 percent of homeless teens.[8] Homelessness, in turn, increases the youth's risk of substance abuse, risky sexual behavior, victimization, and contact with the criminal justice system.

The good news is that these risks can be mitigated by foster and adoptive families who are willing to nurture and protect the health, safety, and well-being of these young people. It is essential for child welfare agencies to identify and ensure access to family foster homes that can provide stable, supportive, and welcoming families for LGBTQ adolescents, where youth can develop the strength and self-confidence they need to become successful adults.

Creating a Welcoming Home for Youth

All youth in care need nurturing homes that provide them with a safe place to process their feelings of grief and loss, freedom to express who they are, and structure to support them in becoming responsible, healthy adults. Creating a welcoming foster home for LGBTQ youth is not much

[6] Ryan, C. (2009). *Helping families support their lesbian, gay, bisexual, and transgender (LGBT) children*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

[7] Mallon, G. P. (1998). *We don't exactly get the welcome wagon: The experience of gay and lesbian adolescents in North America's child welfare system*. New York: Columbia University Press. Cited in Wilber, S., Ryan, C., & Marksamer, J. (2006). *CWLA Best Practice Guidelines: Serving LGBT Youth in Out of Home Care*. Washington, DC: Child Welfare League of America. http://www.nclrights.org/site/DocServer/bestpracticeslgbtyouth.pdf?docID=1322

[8] Administration on Children, Youth and Families. (2011). *Information memorandum: Lesbian, gay, bisexual, transgender and questioning youth in foster care*. Washington, DC: U.S. Department of Health and Human Services.

different from creating a safe and supportive home for any youth.

> "The most important thing is to allow any youth to feel safe enough to blossom into whoever they are meant to be."
> — *Foster parent*

In fact, youth in care may have difficulty trusting adults (many with good reason), so you may not know a youth's gender identity or sexual orientation until he or she has spent some time in your home and has grown to trust you. Avoid making assumptions about gender identity or sexual orientation. Any steps you take to make your home welcoming to LGBTQ youth will benefit all children and youth in your care—both by giving LGBTQ youth the freedom to express themselves and by helping heterosexual and gender-conforming youth learn to respect and embrace diversity.

Behaviors that openly reject a youth's LGBTQ identity must be avoided and not tolerated. This includes slurs or jokes about gender or sexuality and forcing youth to attend activities (including religious activities) that are openly hostile or unsupportive of LGBTQ people. Well-meaning attempts to protect youth from potential harassment, such as "steering" them toward hobbies more typical for their sex (football for boys, for example) or isolating them for the sake of safety, also are experienced as rejection by LGBTQ youth and can have devastating consequences for their self-esteem and well-being.

Consider the following suggestions to make your home a welcoming one,

whether or not a youth in your care openly identifies as LGBTQ:

- Make it clear that slurs or jokes based on gender, gender identity, or sexual orientation are not tolerated in your house. Express your disapproval of these types of jokes or slurs when you encounter them in the community or media.
- Display "hate-free zone" signs or other symbols indicating an LGBTQ-friendly environment (pink triangle, rainbow flag).
- Use gender-neutral language when asking about relationships. For example, instead of, "Do you have a girlfriend?" ask, "Is there anyone special in your life?"
- Celebrate diversity in all forms. Provide access to a variety of books, movies, and materials—including those that positively represent same-sex relationships. Point out LGBTQ celebrities, role models who stand up for the LGBTQ community, and people who demonstrate bravery in the face of social stigma.
- Let youth in your care know that you are willing to listen and talk about anything.
- Support your youth's self-expression through choices of clothing, jewelry, hairstyle, friends, and room decoration.
- Insist that other family members include and respect all youth in your home.
- Allow youth to participate in activities that interest them, regardless of whether these activities are stereotypically male or female.
- Educate yourself about LGBTQ history, issues, and resources.

"At [my foster mother's] house, I was able to feel safe and focus on being who I was."
— *LGBTQ youth in foster care*

If a youth in your care discloses his or her LGBTQ identity, you can show your support in the following ways:

- When a youth discloses his or her LGBTQ identity to you, respond in an affirming, supportive way.
- Understand that the way people identify their sexual orientation or gender identity may change over time.
- Use the name and pronoun (he/she) your youth prefers. (If unclear, ask how he or she prefers to be addressed.)
- Respect your youth's privacy. Allow him or her to decide when to come out and to whom.
- Avoid double standards: Allow your LGBTQ youth to discuss feelings of attraction and engage in age-appropriate romantic relationships, just as you would a heterosexual youth.
- Welcome your youth's LGBTQ friends or partner at family get-togethers.
- Connect your youth with LGBTQ organizations, resources, and events. Consider seeking an LGBTQ adult role model for your youth, if possible.
- Reach out for education, resources, and support if you feel the need to deepen your understanding of LGBTQ youth experiences.
- Stand up for your youth when he or she is mistreated.

LGBTQ youth in foster care need permanent homes; they do not need additional disrupted placements. If you are being asked to consider providing foster care to an LGBTQ youth and you feel—for any reason—that you are not able to provide a safe and supportive environment, be honest with your child welfare worker for the sake of both the youth and your family. If you are able to provide an affirming environment, remember that you can talk with your child welfare worker about any questions you may have or support you may need.

Supporting Your Youth in the Community

The support your LGBTQ youth receives in your home is important. However, you also must be prepared to advocate for your youth when needed to ensure that she or he receives appropriate child welfare, health care, mental health, and education services to promote healthy development and self-esteem.

Working With the Child Welfare System

The overwhelming majority of child welfare workers, like foster parents, have the best interest of the children and youth they serve at heart. However, workers are human, and they have their own feelings and biases. While there is no need to assume problems

will arise, it is important to be aware of your youth's rights.[9] For example:

- **Your youth has the right to confidentiality.** Agencies should not disclose information regarding his or her sexual orientation or gender identity without good reason (e.g., development of a service plan) and the youth's permission.
- **Your youth has the right to an appropriate service plan.** This should include the same permanency planning services provided to heterosexual or gender-conforming youth: The youth's sexual orientation or gender identity alone should not be a reason for a worker to forego attempts to reunite the youth with his or her birth family or seek a permanent adoptive placement. It also includes helping the youth access LGBTQ community programs, if desired.
- **Your youth should be supported in expressing his or her gender identity.** The child welfare agency should respect your youth's preferred pronoun and name.
- **Your youth has the right to request that a new caseworker be assigned,** if the current worker is not addressing his or her needs appropriately.

Health Care and Mental Health Providers

Your youth, like all youth in foster care, has the right to health care and mental health services that address his or her individual needs. In the case of a lesbian, gay, bisexual, or transgender youth, finding a competent, supportive provider may require some additional research. Consider the following:

- **Check with your youth to see whether he or she feels comfortable at agency-recommended service providers.** Although your agency may have preferred providers, you can inquire about other options that work better for your youth. Begin with those who accept Medicaid; however, if the provider your youth needs does not accept Medicaid, the child welfare agency may be able to authorize additional funding for necessary services.
- **Sexual health should be part of every youth's wellness exam.** Competent health-care providers will be able to offer frank, nonjudgmental, and comprehensive education about sexual health that is relevant to LGBTQ youth.
- **Transgender youth need health-care providers who are appropriately trained to address their health concerns.** This includes the ability to discuss, provide, and obtain authorization for medically necessary transition-related treatment, if desired.
- **Be aware of the possibility that your youth might benefit from mental health counseling** about issues that may or may not be related to sexual orientation or gender identity. In addition to typical adolescent concerns, many LBGTQ youth struggle with depression or anxiety as a result of experiencing stigma, discrimination, or harassment. If that is the case, seek a provider who is experienced and

[9] For more information, see Wilber, Ryan, & Marksamer, 2006, in note on page 5.

competent in helping LGBTQ youth cope with trauma.

- **Under no circumstances should your LGBTQ youth be forced or encouraged to undergo "conversion therapy."** Practices intended to change a person's sexual orientation or gender identity have been condemned by every major medical and mental health association.

Your Youth at School

Unfortunately, bullying and harassment at school are everyday experiences for many LGBTQ youth. In many schools, negative remarks about sexual orientation or gender identity are common from other students, and even faculty or staff. A 2011 survey of more than 8,500 students between the ages of 13 and 20 found that nearly two-thirds of students felt unsafe at school because of their sexual orientation, and 44 percent felt unsafe because of their gender expression.[10] School harassment can have devastating consequences for youth's education and general well-being. Absenteeism and dropout rates are higher and grade point averages lower among LGBTQ youth experiencing harassment at school.[11]

If your youth is being bullied or harassed, you may need to work with his or her caseworker, school administrators, school board, and/or PTSA to address the problem.

The following practices have proven effective for preventing anti-gay harassment and improving school climate for LGBTQ youth:

- **Gay-straight alliances (GSAs).** Students at schools with GSAs hear fewer homophobic remarks, experience less harassment, feel safer at school, and are more likely to receive help when reporting bullying to school personnel.[12]
- **Anti-bullying policies that specifically reference sexual orientation and gender identity.** Students in States with comprehensive safe school laws report fewer suicide attempts.[13]
- **LGBTQ-friendly teachers, curriculum, and resources.** Students in schools with an inclusive curriculum were about twice as likely to report that classmates were somewhat or very accepting of LGBTQ people.[14]

Conclusion

The evidence shows that LGBTQ youth are overrepresented in the foster care system and that these youth face serious risks and challenges beyond those experienced by other youth. Rejection by their families and other caregivers exacerbates these risks. If LGBTQ youth are to reach their full

[10] The Gay, Lesbian & Straight Education Network [GLSEN]. (2012). *The 2011 national school climate survey: Executive summary.* New York: Author.

[11] Ibid. Also see, for example, Lambda Legal. (n.d.) *Facts: Gay and lesbian youth in schools.* New York: Author; and Mental Health America (2012). Bullying and Gay Youth [webpage]. http://www.nmha.org/index.cfm?objectid=CA866DCF-1372-4D20-C8EB26EEB30B9982

[12] GLSEN, 2012.

[13] Espelage, D. L. (2011). Bullying & the lesbian, gay, bisexual, transgender, questioning (LGBTQ) community. Proceedings of the White House Conference on Bullying Prevention. Retrieved from: http://www.stopbullying.gov/at-risk/groups/lgbt/white_house_conference_materials.pdf

[14] GLSEN, 2012.

potential and become healthy, happy adults, they—like all youth in care—need families who can provide permanent, supportive homes during their critical adolescent years. With a little additional education and training, your family can successfully provide a welcoming home to LGBTQ youth in need.

Resources

For Families

- **Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children.** Research showing that families have a major impact on their LGBT children's health, mental health, and well-being. http://www11.georgetown.edu/research/gucchd/nccc/documents/LGBT_Brief.pdf
- **Family Acceptance Project.** A research-based, culturally grounded approach to help ethnically, socially, and religiously diverse families increase support for their LGBT children. http://familyproject.sfsu.edu
- **PFLAG.** A national nonprofit organization that supports families through more than 350 chapters in major urban centers, small cities, and rural areas in all 50 States. Selected resources include:
  - **Coming Out Help for Families, Friends, and Allies** http://community.pflag.org/page.aspx?pid=539
  - **Our Trans Children.** Answers to frequently asked questions and support for family members just learning of their loved one's gender differences. http://www.pflag.org/fileadmin/user_upload/Publications/OTC_5thedition.pdf
  - **Be Not Afraid: Help Is on the Way!** A faith-based resource from PFLAG's Straight for Equality program. http://community.pflag.org/sfe-test/document.doc?id=649
- **Advocates for Youth: GLBTQ Issues Info for Parents.** Tips for parents of LGBTQ youth, including resources on talking about sexuality. http://www.advocatesforyouth.org/glbtq-issues-info-for-parents
- **LGBTQ Youth Resources for Families.** Resource list from the Maternal & Child Health Library at Georgetown University. http://www.mchlibrary.info/families/frb_LGBTQ.html
- **Centers for Disease Control and Prevention.** Education, information, resources, and health services for LGBTQ youth and adults. http://www.cdc.gov/lgbthealth/
- **American Psychological Association.** Answers to questions about...
  - **Transgender People, Gender Identity, and Gender Expression.** http://www.apa.org/topics/sexuality/transgender.aspx
  - **Sexual Orientation and Homosexuality.** http://www.apa.org/topics/sexuality/orientation.aspx

- **LGBTQ Youth in the Foster Care System and Legal Rights of Lesbian, Gay, Bisexual, and Transgender Youth in the Child Welfare System.** Factsheets from the National Center for Lesbian Rights. http://www.nclrights.org/site/DocServer/LGBTQ_Youth_In_Foster_Care_System.pdf?docID=1341 and http://www.nclrights.org/site/DocServer/LGBTQ_Youth_In_Child_Welfare_System.pdf?docID=1581
- **Getting Down to Basics.** Toolkit from Lambda Legal with resources for those supporting LGBTQ youth in foster care. http://www.lambdalegal.org/publications/getting-down-to-basics

For LGBTQ Youth

- **Be Yourself: Questions & Answers for Gay, Lesbian, Bisexual & Transgender Youth.** Clear, straightforward answers for LGBTQ youth. http://www.pflag.org/fileadmin/user_upload/Publications/Be_Yourself.pdf
- **Represent and *YCteen* Stories.** Personal stories from youth in foster care. http://www.representmag.org/topics/gay+slash+lesbian.html
- **The Trevor Project.** Crisis intervention and suicide prevention services for LGBTQ youth. http://www.thetrevorproject.org
- **It Gets Better Project.** Videos created to show LGBTQ youth that they are not alone and that they have the potential for happy, positive futures, if they can just get through their teen years. http://www.itgetsbetter.org
- **Get Busy. Get Equal.** ACLU resources for LBGT youth about their rights at school and how to advocate for themselves effectively. http://www.aclu.org/lgbt-rights
- **Know Your Rights: Youth.** Legal resources regarding out-of-home care and school issues for LGBTQ youth (from Lambda Legal). http://www.lambdalegal.org/issues/teens
- **Gay, Lesbian, and Straight Education Network.** The leading national education organization focused on ensuring safe schools for all students. http://www.glsen.org/cgi-bin/iowa/all/student/index.html

Acknowledgment: This factsheet was developed by Child Welfare Information Gateway, in partnership with Jill Rivera Greene.

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What to Do When a Teen Comes Out to You

"Coming Out" is when a person tells someone else that he or she is gay, lesbian, bisexual, or transgender. Someone who is coming out feels close enough to you and trusts you enough to be honest and risk losing you as a friend and ally. What can you do to support a teen who comes out? Here are some suggestions that you may wish to consider...

Thank them for having the courage to tell you. Choosing to tell you means that this teen respects & trusts you.

Respect the teen's confidentiality. You may be the only person the teen is ready to tell. Telling others, friends or family must be done on the teen's time schedule.

Recognize that this is not something that does not necessarily need to be reported to other parents, caseworkers, or the teen's peers. You can provide the teen with support and ask about who else they have told, but it is neither your responsibility nor your right to tell others.

Let the teen know that you still care for him or her. Be the support you have always been. The main fear for people coming out is that they will be rejected by their friends & family.

Do not say "Are you sure?" When people come out to you, it most likely means they have gone over this question thousands of times in their own mind, and they are sure!

It's okay if you feel uncomfortable or upset. It is important to separate your own feelings of discomfort from what you convey to the teen. Do your best to convey that the teen is a valuable and important member of the community.

Learn about organizations and publications that might help provide support to the teen. It might be important for the teen to know that such support exists. (GLSEN and PFLAG all have resources and links on their websites.)

It's never too late. If someone has come out to you before and you feel badly about how you handled it, you can always go back & try again

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The Bryson Institute of The Attic Youth Center
www.brysoninstitute.org • brysoninstitute@atticyouthcenter.org
255 South 16th Street • Philadelphia, PA 19102 • (215) 545-4331 x 104

CONFIDENTIALITY AGREEMENT FOR RESOURCE PARENTS

I/We _____ have received the following information regarding the child named _____. I/We understand that all information (including information received today and all additional information in the future) regarding this child, his/her birth family, and their life experiences are to be held in the strictest confidence. As a member of the treatment team, I/We understand that I/We am not to discuss any information/details regarding the child's life or that of his/her birth family with anyone else outside of this particular child's treatment team including other resource parents, social workers not assigned to this particular child's case, neighbors, friends, media/press, and/or anyone else not directly involved in the care of this child.

To be Completed & Returned:

Notification of Placement
Pre-Placement Reports
Clothing Inventory
Visitation Restrictions (if any)
Children's Choice Rules
Universal Precautions

To be Read In Office:

Psychological Evaluation
Psychiatric Evaluation
Family Service Plan

Retained (As Available)

Social Summary
Previous Resource Parent Monthly Reports
Medical History
Educational History
(Report cards, progress reports)
Birth Certificate
Face Sheet
Parental Travel Consent
Needs Analysis/Interim Service Plan

Previous Quarterly
Individual Service Plan
Medical Assistance/Access Card
Telephone Referral Sheet

Date/Location – 1st ISP
Medical/Dental Consent
Child Interest Survey
Child Grievance Letter

Witness _____ Resource Parent _____

Date _____ Resource Parent _____

INSTRUCTIONS: Caseworker complete list with dates that items are given. Original to child file and copy to resource parent.

CC 4:5B
Rev. 01/07

POLICY:	Religious Training, Participation and Education
POLICY #:	4:12
REFERENCE:	3680.46; DELACARE #104, CWLA 2.10; 3.18; 4.12
DATE:	August, 1986; Rev. 10/90, 5/96, 11/01, 06/14, 06/17
APPROVAL:	**COPY WITH SIGNATURE AVAILABLE IN OFFICE POLICY & PROCEDURE MANUAL** President/Chief Executive Officer

In keeping with the Christian identity of Children's Choice, religious practice and spirituality will be listed in each child's Individual Service Plan with progress and participation noted on the Resource Parent Monthly Report of Foster Child Progress (CC 3:5B, CC 3:5C, CC 3:5D, CC 3:5E) and the quarterly report sent to the referring agency. Each foster child will be encouraged to participate in religious practice in keeping with the identified denomination of the birth parents and/or the child's own personal religious preference. Each foster child will be provided with a regular opportunity to practice his or her faith or denomination, such as enabling him to or her to regularly participate in a religious activity such as a service, ceremony, rite, ritual, or receive a sacrament.

Foster children are not required to nor can be coerced to attend the religious services of the resource parents, but can be required to attend religious service of their parent's denomination and/or their own personal religious preference.

Parochial education or other non-public schools may be permitted for the foster child as recommended by the caseworker with the agreement in writing by the birth parents if the resource parents or birth parents assume financial responsibility for tuition, uniforms, and costs. Any non-public school must be accredited by the appropriate state agencies. Parochial or non-public education cannot be mandated for the child without concurrence of the child, the birth parents, the Children's Choice caseworker, and the referring agency caseworker. The foster child may not participate in any religious activity such as a service, ceremony, rite, ritual, or receive a sacrament based on a different faith or denomination other than the one practiced by the child or his or her birth parent or guardian.

A foster child cannot be disciplined, discriminated against or be denied a privilege for choosing not to participate in a religious activity and rewards cannot be used as a means to influence his or her participation in religious activities.

A foster child may not be required to contribute a portion of his/her allowance or other money to any religious institution or denomination. Likewise, a foster child may not be required to perform services to or for any such institution against his/her will.

Resource Parent Signature	Date
Resource Parent Signature	Date
Children's Choice Representative	

RESOURCE FAMILY AGREEMENT
CCDE 3:3A

Agency Purpose

Children's Choice, Inc. is a Christian child welfare agency whose purpose is to provide homes and guidance for children who might otherwise be residing in group living situations or institutional settings, because of special needs and problems. Some of these children have behavioral problems, emotional disturbances, pre-natal drug exposure, medical needs, developmental delays, and physical disabilities. Our primary goal is to reunite the child with his/her birth family and to participate in concurrent/permanency planning that is in the best interest of the child. The child's safety and stability are secured by providing intensive casework, counseling or psychiatrist consultation, and the coordination of medical services in a caring family environment.

Agency Responsibilities

As an approved licensed child welfare agency, Children's Choice will:

Provide agency policies and procedures, applicable state regulations, emergency and non-emergency agency contact information, and instructions on how to receive services;

Work in conjunction and partnership with the resource families, providing on-going direction, supervision, and training;

Share fully any information concerning a child's physical condition, mental disabilities, emotional problems, past behaviors, relationship between the child and his/her parents, educational history, life experiences, or previous and prospective placement circumstances;

Provide 24 hour per day, seven days per week, casework services to resource families and children in placement;

Provide personal caseworker contact with children in placement and resource families according to state regulations and contract requirements. Telephone contact will be made at least twice monthly;

Visit in the resource family home at least once a month to meet with the resource parents and meet with the foster children placed in the home in accordance with service delivery requirements;

Act as liaison with referring agencies to develop and carry out individual service plans for each child in placement;

Provide appropriate resources and services to birth families as designated in the Family Service Plan and Individual Service Plans of children in placement;

Deal with any grievance or problems received directly from resource families according to Children's Choice grievance procedures in a fair and responsible manner;

Insure compliance with the regulations, and negotiated, signed agreements with County Offices of Children and Youth Services and other contractors;

Provide the name, address and phone number of the resource parents to the birth parents of the foster child in their home, unless doing so is restricted, threatens, or there is basis for refusing such disclosure;

Follow protocols in reporting allegations of child abuse and ensuring the safety of the child. As well as ensuring that information pertaining to the report is kept confidential;

Provide monthly resource family support/training sessions;

Provide ongoing enhancement training to assist resource parents in developing the skills needed to parent children with specialized and mental health needs; and

Notify resource parents of any court proceedings related to the child(ren) in their care and ensure that the resource parents are given the opportunity to be heard in any court proceedings related to the child(ren). Resource parents will also be given the opportunity to be heard regarding agency decisions or practices involving child(ren) in their home.

Resource Family Responsibilities

As an approved foster/kinship family, we agree to abide by the directive of Children's Choice to:

Maintain a safe and nurturing environment for the child in our home by maintaining full compliance with the Children's Choice list of mandatory safety items;

Assure that all clients, regardless of age, have independent sleeping arrangements (crib or developmentally appropriate) not shared with adults or other children. With the exception of a crib, the child's bed must include both a mattress and a box spring. No sleeper sofas or futons are permitted. Clients of the opposite sex who are 5 years of age or older will not share the same bedroom and children over the age of one year will not share a bedroom with an adult without written mandate from the child's physician. All clients' bedrooms will be located in the main living areas of the home. No child's bedroom may be located in a basement or attic area, regardless of its condition;

Obtain prior approval from Children's Choice before allowing anyone to move into the home for a period time that will extend beyond 2 weeks. Necessary documentation will be required according to state regulations and an addendum to the home study will be completed;

_____ / _____

RP Initials Date

Provide service as a resource parent exclusively with Children's Choice while approved and active as a Children's Choice resource home (i.e. no affiliation with another foster care agency at the same time);

Attend Children's Choice Resource Family Pre-Service Training Sessions of 32 hours for both primary and secondary caregiver, before placement;

Attend Children's Choice Resource Family Support/Training Sessions of 20 hours for primary caregiver and 20 hours for the secondary caregiver per year;

To participate fully in the Choice Theory learning process;

Maintain current CPR and First Aid certification;

Attend trainings that meet with specific needs of the child(ren) placed in the resource home;

Attend and participate in semi-annual Individual Service Plan Meetings and other required meetings for each child;

Assist children as far as possible in maintaining relations with their birth parents, unless contraindicated by the child's court ordered permanency goal;

Refer to the child by his or her legal name or familiar nickname and ensure that his or her legal name is used on all documents and records. The child will not be referred to by a different name without permission from the birth parent and referring agency or as documented in the child's Child Plan until an adoption is finalized;

File grievances according to Children's Choice procedure (see Grievance Procedure);

Inform Children's Choice caseworker and Program Coordinator about all problems relating to children in placement or circumstances in the family as they affect the children placed in your care;

Maintain confidentiality regarding any information concerning the children in placement, their families, or Children's Choice;

Provide children in placement with multiple opportunities to promote their health emotional stability, cultural awareness and identity;

Provide for child's safety during transportation by maintaining valid car insurance, valid

_____/_____
RP Initials Date

te in which they currently reside, current
afety restraints;

Insure that the child abides by police curfews and state and federal laws;

Be responsible for, and not hold Children's Choice responsible for, any damage to property or vehicles resulting from children placed in the home;

Obtain and certify adequate homeowner's or tenant's insurance;

Declare in writing any offensive weapons owned or stored in the home, specifying that such weapons are properly licensed, locked, and secured to prevent improper use and/or abuse;

Provide proper care and 24 hour approved supervision for any child placed in our home (refer to Child Care Guidelines CC 4:2);

Refrain from allowing birth children or any other children under the age of 18 years to babysit or provide child care for any child in placement including diaper changes, feedings, or supervising play even when adults are present;

Provide a minimum of three meals per day with snack which meet nutritional needs (can be adjusted for special needs);

Provide adequate room and board, basic personal hygiene and cosmetic items, (i.e. shampoo, deodorant, toothbrush and toothpaste, feminine hygiene supplies, soap, brush and comb; haircuts);

Work in conjunction with Children's Choice to provide care as determined appropriate by Children's Choice, the referring agency, and the child's Individual Service Plan;

Cooperate with Children's Choice staff, the Division of Family Services and/or any other contracted provider identified in the child's Child Plan when requesting information;

Grant access to any part of the resource home, structure on the resource parent's property, other household members, and the child as related to determining compliance with regulations, or during evaluation, ongoing supervision, inspection, or investigation;

Not to use any form of physical punishment for any reason, but to use only those disciplinary methods approved by Children's Choice;

Be responsible not to alter a child's hairstyle or have ears pierced without written permission from birth parent;

_____/_____
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e when requesting that a child in placement
ance for medical level children);

Follow Children's Choice regulations in reporting suspected abuse, runaway or rules violations, emergency medical treatment, or hospitalization;

Inform Children's Choice 30 days in advance of vacations or trips, specifying plans and requesting permission to take the child in placement along or to request Children's Choice respite for the child while absent;

Participate fully in the child's psychological and emotional health by providing transportation to therapy appointments and participating in therapy when requested and appropriate;
Schedule appointments and provide transportation for medical and dental care as required by Children's Choice, its referring agencies, and the child's primary physician. Immunizations must be up to date, and dental examinations to begin by age three;

Medical: A medical examination should be conducted within 30 days of placement unless written documentation of prior timely medical examination has been provided to Children's Choice. Otherwise, examinations should take place as follows:

Birth through 6 months.....Once every 6 weeks
7 months through 23 months.....Once every 3 months
24 months and older .....Once a year

Dental: A dental exam should be conducted within 60 days of placement for children over 3 unless prior timely dental documentation of dental examination has been provided to Children's Choice. For children over 3, dental exams should take place every six months;

Provide transportation for the child's visits with his/her birth family at the birth family home, Children's Choice office, referring agency, or otherwise identified location;

Provide transportation for other appointments or functions determined beneficial to the child;

Comply with Children's Choice directives regarding child's education. In Delaware, foster children are not permitted to be home schooled;

Actively participate in the education process by attendance at IEP meetings, parent/teacher conferences, school functions, etc.;

Provide good quality out and under garments which are seasonably appropriate utilizing the child's clothing allowance. The child's clothing will not distinguish him/her from other members of the community. Provide child with the opportunity to have some say in his/her clothing selection. Once clothing is purchased, it will become the child's

Submit Monthly Billing and Expense forms with required documented receipts and a narrative Resource Parent's Monthly Report of Child's in Placement's Progress for each child in care during the preceding month, no later than the 5th day of each month;

Administer and supervise distribution and spending of child in placement's personal allowance and clothing allowance; and

Express approval and affection in an appropriate family oriented manner.

Reimbursement

As the expectations and demands upon our resource parents differ with the types of care deemed appropriate, reimbursement rates also differ. At placement, the resource parents will be advised, in writing, as to the reimbursement rate they should expect.

When a child is placed in a resource home, the resource parent will be informed of the category designated for that child. Every six months, each child designated PBC, Regular, Specialized, Mental Health or Medical Care will be evaluated by the courts and the resource parent will be informed of any changes in classification of a child in their home. While a medical level child is hospitalized, resource parents receive $13.00/day for up to one week until the child returns to the home.

The child's Medical Assistance/HMO covers most prescriptions for children. Children's Choice will reimburse resource families for prescription medication not covered by medical assistance only when pre-approval has been obtained from the Program Coordinator in writing.

Resource families will be reimbursed at the current mileage rate per mile (which is adjusted quarterly) for all mileage in excess of 200 documented and approved miles per month per child for necessary and beneficial transportation provided specifically for children in placement and for travel to Children's Choice functions, such as training sessions or Individual Service Plan meetings.

Children who are not capable of receiving their allowance directly will have a savings account opened by the Children's Choice caseworker into which the resource family will deposit the child's personal allowance. If a child is transferred to another Children's Choice Resource Home, the balance of the child's personal and clothing allowances are forwarded to the Resource Home receiving the child. At discharge, the balance of these funds follows the child.

Clothing purchases must be documented by annotated receipt (date, item and name of child written on back of receipt from store) and on each child's Basic Clothing List Inventory (CC 3:5M).

_____ / _____

RP Initials Date

Resource Parent Monthly Billing Reports must be completed and submitted to the individual offices by the 5th of each month. Failure to complete billing for 2 consecutive months will result in only room and board rate being released until verification of expenditures is documented. Miscellaneous, personal allowance and clothing allowance expenditures must be documented to the Program Coordinator's satisfaction with receipts and will be paid within 30 days of the receipt of documented expenditures or the end of the next resource parent billing cycle, whichever is first.

Grievance Procedure

Any resource family member or resource parent who takes issue with a Children's Choice decision may appeal the decision. Requests for consideration should be made in the following order: Caseworker, Program Coordinator, State Director, Chief Executive Officer, President, Board of Directors, then the referring agency. At each level, the request for reconsideration will be answered as soon as feasible, with a maximum time limit of 14 days. A meeting will be scheduled to consider each issue, to which the complainant may invite an advocate to accompany him/her. A written decision will be supplied to the complainant upon request. Failure to follow this grievance procedure will necessitate corrective action by Children's Choice, up to and including termination of the Treatment Family Agreement and closure of the Resource Home.

Discrimination Policy

No child in placement with Children's Choice and no member of a resource family will be the object of discrimination due to his/her race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age or sex.

Agreement

I/We have read and understand the above listed purpose of Children's Choice, Inc., Children's Choice Responsibilities, Resource Family Responsibilities, Compensation and Grievance Procedure. We understand that we are agreeing to enter into an arrangement with Children's Choice to provide for the room, board, supervision, religious training opportunities, cultural, educational, therapeutic, and recreational opportunities for children who will be placed in our home.

I/We agree to cooperate with Children's Choice and the referring agencies in every way possible to meet the child in placement's needs and to fulfill the Individual Service Plan for each child.

Signature of Resource Parent	Date
Signature of Resource Parent	Date
Children's Choice Representative	Date

You Received a Foster Care Placement- Now What?

- Schedule the medical and dental appointments within 30 days
- Clothing inventory and go shopping
- Make arrangements to get the child to their school
- Talk to your caseworker about birth family contact
- Set up therapy or special services needed

15

RESOURCE PARENT MONTHLY REPORT OF CHILD'S PROGRESS

TO: Children's Choice, Inc.

FROM: _____
Resource Parents' Name

RE: Resource Parent's Monthly Report of Foster Child's Progress
for the month of _____, 20_____

_____ _____ _____
Child's Name Age Date of Placement

INSTRUCTIONS: Please complete each item.

A. MEDICAL

Was a physical exam/well child visit completed this month?
_____ No _____ Yes Date Completed: _____
(Attach Report of Physical Examination CC 2:8C and EPSDT Screen, if completed)

Name of Physician/Hospital: _____

Diagnosis/Prognosis/Medication: _____

_____

Are follow-up appointments needed?
_____ No _____ Yes Date(s) scheduled with whom: _____

Were any medications given to child this month (Prescription or non-prescription)?
_____ No _____ Yes (Attach Medication Log CC 2:8F)

Did other medical/psychiatric care occur this month?
_____ No _____ Yes Date(s) Completed: _____
(Attach Medical Treatment Form CC 2:8D)

Date: _____ Physician/Hospital _____

Diagnosis/Prognosis/Medication: _____

Are follow-up appointments needed?
_____ No _____ Yes Date(s) scheduled with whom: _____

Date: _____ Physician/Hospital _____

Diagnosis/Prognosis/Medication _____

02

Are follow-up appointments needed?
_____ No _____ Yes Date(s) scheduled with whom: _____

Date: _____ Physician/Hospital _____

Diagnosis/Prognosis/Medication _____

Are follow-up appointments needed?
_____ No _____ Yes Date(s) scheduled with whom: _____

Date: _____ Physician/Hospital _____

Diagnosis/Prognosis/Medication _____

B. DENTAL

Was a dental examination/treatment completed this month?
_____ No _____ Yes Date(s) Completed _____ (Attach Dental Report CC 2:9B)

Are follow-up appointments needed?
_____ No _____ Yes Date(s) Scheduled _____

C. DEVELOPMENTAL SKILLS

A. Progress (Language, social, fine motor and gross motor skills attained)

_____

_____

B. Difficulties

_____

_____

_____

C. Pre-school/Headstart Programs Attended: _____

_____

Was a progress report issued this month? _____ No _____ Yes (Please Attach Copy)

C. EDUCATIONAL

Was report card/progress report issued this month? _____No _____Yes (Please attach copy).

Were meetings with school personnel held this month? _____No _____Yes
List purpose and dates (i.e., Parent/Teacher Conference, etc.):

_____

_____

List achievements/difficulties/attitude toward homework:

_____

_____

_____

D. THERAPEUTIC INTERVENTIONS

List types of interventions, dates, length of appointments, and with whom (i.e. visiting nurse, early intervention, occupational, physical or speech therapy, psychotherapy, wrap-around services, therapeutic daycare, etc.): (Individual, group or family counseling; TSS; Behavior specialist, Mobile Therapy, Tutoring, Therapeutic After School Programs, Adolescent Initiative Program, etc.)

Date(s): _____ Service Performed by: _____

Summary of Service: _____

_____

_____

Date(s): _____ Service Performed by: _____

Summary of Service: _____

_____

_____

Date(s): _____ Service Performed by: _____

Summary of Service: _____

_____

_____

E. SOCIAL/EXTRA-CURRICULAR ACTIVITIES

List types and frequency of participation (i.e. any organized group activities such as Scouts, Clubs, Athletics, Camp, After-School Programs, Sunday School, Youth Group, Dance, Music, Art, Drama, etc.):

_____

_____

_____

F. FUN

List activities (i.e. parties, vacations, special trips, peer play, etc.):

_____

_____

_____

G. CULTURAL ACTIVITIES

List activities (i.e. holiday celebrations, community events, visits to museums, participation in the arts {music & dance} etc.):

_____

_____

_____

H. INTERACTIVE BEHAVIOR (Strengths/Challenges)

Within the Resource Family: _____

_____

_____

With Peers: _____

_____

_____

I. BIRTH FAMILY INTERACTION

Resource Parent's assessment of child's behavior before, during (if Resource Parent was present), and after visits (please note locations, dates and duration of each visit) with Birth Family:

Phone and letter/card contacts with birth family this month (state date and who initiated contact):

J. RELIGIOUS LIFE

K. LIFE SKILLS

(Discuss money management and household skills/tasks, if applicable)

L. RESPITE CARE

List dates and with whom respite was provided:

lele

M. PHYSICAL PLANT/SAFETY

Monthly smoke detector battery check performed: _____
(date)

Monthly fire drill performed, Date: _____

Any safety item remediations (if needed): _____

N. VISITS WITH CHILDREN'S CHOICE CASEWORKER

List dates of visits completed: _____ _____ _____ _____

GOALS FOR NEXT MONTH

_____

_____

_____

Report Completed by: _____

WAIVER OF MEDICAL RESPITE CARE – If applicable

Respite care for medical level children is defined as care given to a child in placement in the absence of the child's regular caregiver. Respite care providers must meet the agency's requirements as outlined in CC 4:13. Suggested minimum respite care per level on a monthly basis is as follows: Medical I, forty (40) hours; Medical II, sixty (60) hours; Medical III, eighty (80) hours; Medical IV, ninety-six (96) hours. A voluntary partial or full waiver of monthly respite care must be indicated by signature of the regular resource parent on the line below.

_____
Period Covered (month/year)

_____
Resource Parent's Signature

_____
Resource Parent's Signature

Report Reviewed by Children's Choice: _____
Caseworker/Program Coordinator Initials

Resource Parent Responsibilities Notes

Resource Parent Responsibilities Notes

Children's Choice
Resource Family Safety Item Checklist

For the Home of: _____ Office: _____

Date: _____

The following information must be provided by each resource home with which Children's Choice places children. If an item is not in compliance, a date by which compliance will be met must be established and a second site visit must be completed by a respresentative of Children's Choice in order to confirm compliance. ***Items mandated by the state for resource parents are indicated by a *, all others are mandated by Children's Choice.***

Please check the appropriate box

BATHROOM	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***One flushing toilet**				
***One wash basin**				
***One bath/shower with hot and cold running water**				
Bathtubs/showers used by client have a skid proof surface or covering				
***Household plumbing fixtures are in working order. Hot water does not exceed 120 degrees (Fahrenheit)**	Actual Temp _____ degrees F	Actual Temp _____ degrees F		Actual Temp _____ degrees F
Bath temperature device provided for children ages 0 to 5 years				

KITCHEN	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***Portable "ABC" fire extinguisher in the kitchen area**	Exp Date:			
***Medications, poisonous, caustic, toxic, flammable or other dangerous materials are labeled as hazardous and stored in an area inaccessible to children under 5 years of age**				
***Drinking water from sources other than public, must be tested and deemed potable by a qualified laboratory (if home has public water, mark n/a in box - if tested, attach documentation)**				

Please check the appropriate box

KITCHEN (Continued)	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***Refridgerator and stove in working condition.**				
***Adequate food (evidence of a minimum of three days of balanced meal preparations/edible items to feed all members of the household)**				
***Kitchen, food preparation, storage, serving utensils are clean.**				

BEDROOMS	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
There is a separate bed for each child				
***No children of opposite sex, 5 years of age or older, share a bedroom**				
***No children over the age of one, can share a bedroom with an adult.**				
No child's bedroom may be located in a basement or attic area, regardless of its condition				
Clean mattress and box spring, linens, blankets and pillows provided for each child - No sofa beds or futons are permitted				
Child has adequate storage for personal belongings (as evidenced by storage sufficient to hold all the child's personal belongings)				
STAIRS	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
Expandable gates are provided on stairways (for homes with children under the age of 5 years). ASTM approved (store bought).				
Hand railing on open interior and exterior staircases are in place and secure				

Please check the appropriate box

LIVING SPACE	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***A First Aid kit**				
***An operable telephone and emergency telephone numbers posted on each phone (list includes mobile crisis, suicide prevention, poison control, police/fire, drug/alcohol prevention numbers).**				
***Child safety caps on all outlets and power strips (for homes with children under the age of 5 years)**				
***Operating smoke detectors on each level of the home**				
Plastic bags and mini-blind cords/strings out of the reach of children, 5 years and younger.				
***One operating carbon monoxide detector in the home**				
***The living spaces are complete with walls, floors and ceilings having a finished and complete surface**				
***Paint on the interior surfaces of the home is not chipping, flaking or peeling**				
***The interior of the home is clean and in good repair. Common areas are free from litter that may pose hazard**				
There is adequate lighting in the living areas of the home				
***There are no observable electrical hazards in the home, no exposed wiring in the home**				
***Fireplace(s), woodstove(s), inserts and freestanding heaters are screened and appear to be installed properly**				
***Air conditioner units and fans are operational, and appear to be properly installed and covered by shields/encasements.**				

Please check the appropriate box

LIVING SPACE (Continued)	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***There is an operable heating system capable of maintaining 69 degrees (Fahrenheit)**				
The temperature of the living area(s) of the home does not jeopardize the health of the client				
***Combustible/flammable materials are not stored near the heating source**				
There is at least one window, per room, which can open for ventilation				
***The windows in the living and sleeping areas have intact screening**				
***Fire escape route documented and members of the home aware of the route, as it is used in drills 2x/year and on the date of placement**				
***Fire escape route(s) in home are not obstructed**				
***All offensive weapons are placed in a locked safe, locked cabinet or locked rack that is not accessible to children. Projectiles associated with the weapon are stored separate from the corresponding weapon**	Denied			
***There is no evidence of insect or rodent infestation**				
Garbage storage and removal practices do not present health risk				

PETS	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
Pet(s) do not present a health risk or pose potential danger to the cilent or worker (if no pets, mark n/a in box). No snakes or poisonous animals.				

Please check the appropriate box

OUTDOORS	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
A home of three or more stories has outside access to the ground via fire escape, a ladder, etc.				
There are a minimum of two independent means of egress from the home that lead directly to the outside				
All exterior doors used for ventilation have screening				
The exterior structure of the home is maintained to provide protection against rodent and insect infestation, water infusion, excessive draft or heat loss during inclement weather				
The exterior of the home is clean, in good repair and free from any clutter or objects that might pose potential health risk to the client or worker				
***Outdoor equipment and surroundings areas are safeguarded as age-appropriate for clients. Play equipment is anchored**				
***All pools have adequate fencing and above ground pools have a ladder that can be stored and locked out of reach of children (if applicable, complete CC DE 3:2Bb)**				
Shed (if present) is locked and intact so as to deny access				

OTHER	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***All household members have signed CC 4:19 Use of Tobacco Policy stating that they are aware that smoking and vaping is prohibited in a home or vehicle in the presence of children**				
***No Smoking Sign is posted**				

Please check the appropriate box

OTHER (Continued)	Item In Compliance	Item is **NOT** in Compliance	Expected Date of Remediation	Date Completed
***There are appropriate, unexpired car seats for foster children living in the home ages 0 to 8 years of age**				
***Current registration, insurance and valid driver's license.**				

We have been informed as to the status of each of these proceeding items. We are aware that if an item has been marked as NOT IN COMPLIANCE, it is our responsibility to make the necessary alterations prior to placement of a client in the home, or if the child is already placed, within 30 days of notification. We are aware that any correction must be visually confirmed by a representative of Children's Choice.

Resource Parent's Signature: _____ Date: _____

Resource Parent's Signature: _____ Date: _____

Children's Choice Rep. Signature: _____

UNIVERSAL PRECAUTIONS FOR DISEASE CONTROL

At the time of placement, Children's Choice may not be fully aware of a child's communicable disease or infection status and/or the risk of acquiring opportunistic infections as the result of a compromised immune system due to HIV infection or AIDS. Therefore, Children's Choice is advocating the use of Universal Precautions for Disease Control be followed for all clients and staff.

1. Care should be taken not to share bodily secretions, particularly blood or semen. In order for bodily secretions to be shared, there must be a point of entry into another person's body. Rubber gloves (latex or vinyl) should be worn whenever handling any bodily secretions including blood, semen, vaginal secretions, mucus, urine and feces. Saliva cannot transmit Hepatitis or HIV unless it is contaminated with blood. There is no reason why persons who are HIV+ cannot have the usual casual social contacts with people.

2. Maintaining a state of personal cleanliness is helpful to all people whether they are HIV+ or not. This includes bathing regularly, washing hands after the use of bathroom facilities or contact with one's own bodily fluids (such as semen, blood, mucus, feces or urine), and washing hands before preparing food.

   Hand Washing Techniques

   - Wet hands/leave water running
   - Soap hands
   - Apply friction/rub vigorously front and back of hands, including between fingers
   - Rinse hands
   - Dry hands with paper towel
   - Turn off faucet with paper towel

3. Kitchen and bathroom facilities may be shared. Normal sanitary practices in any household will prevent the growth of fungi and bacteria that may potentially cause illness to both immunocompromised and immunocompetent people.

   These sanitary practices include:

   - Clean kitchen counters with scouring powder to remove food particles. Sponges used to clean in the kitchen where food is prepared should NOT be the same sponges used to clean up bathroom-type spills. Dirty looking sponges should not be used to wash dishes or clean food preparation areas.

   - Clean inside of refrigerator with soap and water to control molds.

- Mop bathroom floor at least weekly and clean up spills. Bleach 1:10 strength (1 part to 10 parts water) or full-strength Lysol liquid can be used to disinfect floor and shower floor (athletes foot is caused by a fungus which bleach will kill). 1:10 bleach can also be used in the sink. A little full-strength bleach can be poured into the toiled bowl for disinfection. Any spills of body fluids or waste (blood, urine, stool, vomit, etc.) should be cleaned up first with an approved cleansing disinfecting agent (Vestal LPH) and then the surface disinfected with 1:10 bleach.

- Sponges used to clean the floor or any body fluid spills SHOULD NOT BE USED TO WASH DISHES OR CLEAN FOOD PREPARATION AREAS. Mop water should NOT be poured down the sink where food is prepared. Sponges and mops can be disinfected by soaking in the Vestal LPH in a bucket.

4. Dishes may be shared with others provided they are washed in HOT soapy water (hot enough to require gloves). A disinfectant does not need to be used. The use of a dishwasher is ideal.

5. People with HIV infection can safely cook for others provided they wash their hands before beginning. It is also a good idea to not lick your fingers or taste from the mixing spoon while cooking. (Advice for everyone).

6. Since unpasteurized milk and milk products have been associated with Salmonella infections in the past, these should not be included in the diet. Salmonella infections are not well tolerated by people with AIDS.

7. If organically grown food is used (composted with human or animal feces, i.e. mushrooms), food should be cooked thoroughly and fruits should be peeled. "Organic" lettuce is not safe for immunocompromised people.

8. Towels and wash cloths should not be shared without laundering in between people. Toothbrushes, razors, enema equipment, or sexual devices should not be shared.

9. Trash disposal should be the same for any household. Body wastes are flushed down the toilet. Other trash may be adequately handled by normal means (weekly trash pickups from cans lined with a plastic bag and tight-fitting lid to keep out rodents). In the event of large amounts of sputum, wound drainage, etc. on Kleenex or dressings, it is a good idea to collect them in a lined trash can in the house and dispose of them daily.

10. Pets: Gloves should be used when cleaning birdcages (psittacosis) and cat litter boxes (Toxoplasmosis). Tropical fish tanks may contain organisms in the Mycobatrium family, which are not well tolerated by person with AIDS. Get someone else to clean your tank.

11. Keep living quarters well ventilated. Airborne diseases are less likely to be a problem when diluted by lots of air.

12. Persons who are coughing should cover their mouths with tissues or handkerchiefs. Tissues are preferable as they are disposable. Encourage people with colds, etc. to wash their hands often, especially after blowing their nose.

13. The disinfection procedures for skin exposed to potentially virus-bearing fluids are:

- Wash hands with an antimicrobial soap. Using Hibiclens is preferred (follow hand washing directions on the bottle).

- Open cuts or wounds exposed to virus-bearing fluids may be washed with either a solution of 3% hydrogen peroxide in water or a solution of 10% household bleach in water.

- Skin not lacerated may be washed with either a 70% or higher solution of ethyl or isopropyl alcohol or a solution of 3% hydrogen peroxide.

14. After gloves are worn, they should be pulled off the hand so they are inside out and then disposed. This will keep any contamination that is on the gloves from touching the skin. WASH HANDS BEFORE PUTTING ON THE GLOVES AND AFTER TAKING THEM OFF.

15. Gloves should be worn for housecleaning activities, particularly bathroom and kitchen cleaning.

Adapted from an article prepared by Grace Lusby, MS, RN, Infection Control Coordinator, San Francisco General Hospital and Helen Schietinger, MA, RN, Director, Shanti AIDS Resident Program. Distributed by Berks AIDS Health Crisis. Revised and approved by Larry Horn, MD, ReMed's Medical Director and Estelle Ingenito, ,Ph.D., Infection Control Coordinator, Magee Rehabilitation Hospital, Philadelphia, PA.

In the event of any staff or client are exposed to potentially live contagion, it must be treated as a serious event, requiring a written incident report and the immediate notification of the Regional Director and State Director. The employee or client must then follow the procedure below entitled Live Contagion Response Protocol.

Procedure: Live Contagion Response Protocol

Upon receiving notification of a probable or possible live exposure within one of the agency's buildings, the following steps will be taken to ensure care of our clients, staff and premises.

1) Notification of possible exposure will immediately be provided to the administrative chain of command.
2) Verbal notification of possible exposure will be provided to all staff, clients, families and/or visitors, if there is a reasonable belief that they may have been at risk for potential exposure within 24 hours. Any notification will ensure the

confidentiality of all involved persons. In addition, dialogue will occur to ensure appropriate medical care, if necessary, is obtained or that professional medical advice is sought, if applicable.

3) Verbal notification to the county agency and/or other agencies involved in the service provisional of the children or families that may have been exposed, will occur within 24 hours with a written notification follow-up within 48 hours. Any notification will ensure that confidentiality of all involved persons.
4) Possible exposed areas will be closed off and no clients or visitors will be permitted access to those areas for approximately 48 hours, unless circumstances deem otherwise.
5) Alternative arrangements will be attempted, whenever possible, during this time to ensure that services can continue to be provided in different locations. If every effort is made and there is no appropriate alternative location available, then arrangements will be made to reschedule the service.
6) An immediate cleaning action plan will be created to address the specific possible contagion and the appropriate methods to ensure elimination. If elimination of a particular contagion on a particular piece of agency property cannot be ensured, then that specific property/furniture item may need to be disposed of by contacting the local waste management removal company at the recommendation of the Business Services Director.
7) A client who received medical treatment for a live contagion would need to show documentation from the doctor that the client's needs have been addressed.

By signing this statement, you are agreeing that you have been provided with the instructions for Universal Precautions for Disease Control and that you have reviewed this information and recommendation.

_____ _____

Resource Parent or Employee Signature Date

_____ _____

Resource Parent Signature Date

_____

Witness

Safety Notes

Safety Notes

Additional Information

BASIC CAR SEAT SAFETY

Be sure to buckle up the right way on every ride!

SAFE KIDS WORLDWIDE

All children must use a car seat, booster seat or seat belt.

- My child always rides in a back seat and never in front of an airbag.
- Everyone in my car buckles up on every ride using the right car seat, booster seat or seat belt for each person's age and size.
- My child's car seat has all of its parts, labels and instructions and has never been in a crash.
- I follow the instructions for my car and my car seat so that my child is buckled in right and tight.
- My child's car seat has never been in a crash.
- I never leave my child alone in a car.

Use our online Ultimate Car Seat Guide for information on all your car seat needs.
www.safekids.org/ultimate-car-seat-guide

Babies under 2 use rear-facing car seats

- My child always rides in a back seat and never in front of an air bag.
- My child always rides in a car seat made for his or her size and age.
- My child sits facing the back of the car in his or her car seat.
- The harness straps are snug on my child, and I can't pinch the buckled strap at the shoulder.
- My child's car seat is buckled tightly in the car and doesn't move more than one inch when I pull it where the seatbelt is buckled/attached.
- My child uses a bigger rear-facing car seat until he or she outgrows the harness. Many harnesses go to 35, 40 or 45 pounds.
- I never leave my child alone in a car.

Toddlers and big kids use forward-facing car seats with a top tether

If my child is over age 2 AND has outgrown the weight or height limits for the rear-facing seat:

- My child always rides in a back seat.
- My child always rides in a car seat made for his or her size and age.
- The harness straps are snug on my child, and I can't pinch the buckled strap at the shoulder.
- My child's car seat is buckled tightly in the car and doesn't move more than one inch when I pull it at the belt path. I use the top tether.
- My child uses this car seat until he or she outgrows the harness. Many harnesses go to 50 pounds or more.

Older, bigger kids use booster seats with lap and shoulder seat belts

If my child has outgrown the weight or height limit of the forward-facing car seat:

- My child always rides in a back seat.
- My child always rides on a booster seat using a lap and shoulder seat belt.
- The lap belt sits low on his or her hips, not the stomach.
- The shoulder belt is on my child's shoulder – not on the neck, under the arm or behind the back.
- The seat belt is snug, flat and comfortable on my child.
- My child may be between 8-12 years of age before the seat belt fits without a booster.

Kids ready for seat belts

If my child has outgrown the booster seat:

- My child always rides in a back seat until age 13.
- My child always uses a lap and shoulder seat belt.
- The lap belt sits low on my child's hips, not the stomach.
- The shoulder belt is on my child's shoulder – not on the neck, under the arm or behind the back.
- My child's back is firmly against the vehicle seat back, his or her knees bend at the front edge of the vehicle seat, and he or she can sit this way for the whole ride.
- The seat belt is snug, flat and comfortable on my child. If the seat belt does not fit right, my child must use a booster seat.

SAFE KIDS WORLDWIDE

Car Seat Checkup

Top 5 Things to Do at Home

☐ **Right Seat.** This is an easy one. Check the label on your car seat to make sure it's appropriate for your child's age, weight and height. Like milk, your car seat has an expiration date. Just double check the label on your car seat to make sure it is still safe.

☐ **Right Place.** Kids are VIPs, just ask them. We know all VIPs ride in a back seat, so keep all children in a back seat until they are 13.

☐ **Right Direction.** Keep your child in a rear-facing car seat for as long as possible, until they reach the highest weight or height allowed by your car seat manufacturer. Many kids will be 2 years or more when they outgrow their rear-facing car seat. Move your child to a forward-facing car seat when they are too tall or heavy for a rear-facing convertible seat. Make sure to adjust the harness straps and attach the top tether after you tighten and lock the seat belt or lower attachments (LATCH) after making the change.

☐ **Inch Test.** Once your car seat is installed, give it a good shake at the base. Can you move it more than an inch side-to-side or front-to-back? A properly installed seat will not move more than an inch.

☐ **Pinch Test.** Make sure the harness is tightly buckled and coming from the correct slots (check car seat manual). Now, with the chest clip placed at armpit level, pinch the strap at your child's shoulder. If you are unable to pinch any excess webbing, you're good to go

Please read the vehicle and car seat instruction manuals to help you with this checklist. If you are having even the slightest trouble, questions or concerns, don't worry. Certified child passenger safety technicians are waiting to help or even double check your work.

Visit safekids.org to find a car seat inspection event in your community.

Reviewed 2019

SAFE KIDS WORLDWIDE™

Car Seat Safety Tips

Everything you need to know to keep your kids safe in cars.

Engineers are working hard to ensure that cars and car seats are designed to keep kids as safe as possible. But it's up to every parent to take full advantage of these innovations by making sure car seats and booster seats are used and installed correctly. Here's what you need to know to ensure that your most precious cargo is safe in cars.

Choose the Right Direction: Rear- or Forward-Facing

- For the best protection, keep your baby in a rear-facing car seat until 2 years old or more. You can find the exact height and weight limit on the side or back of your car seat. Kids who ride in rear-facing seats have the best protection for the head, neck and spine. It is especially important for rear-facing children to ride in a back seat away from the airbag.
- When your children outgrow a rear-facing seat after age 2, move them to a forward-facing car seat. Keep the seat in the back and make sure to attach the top tether after you tighten and lock the seat belt or lower anchors (LATCH). Use the top tether at all times. Top tethers greatly reduce your car seat's forward motion in a crash.
- Kids can remain in some forward-facing car seats until they're 65 pounds or more depending on the car seat limits. Check labels to find the exact measurements for your seat. Discontinue use of lower attachment when your child reaches the limits set by your car seat and car manufacturers. Continue to use the top tether. You must read both manuals to know about those limits. Not to worry: Once your child meets the lower anchor weight limits, you will switch to a seat belt. Seat belts are designed and tested to protect all adults as well as children in car seats and booster seats.

Check Car Seat Labels

- Look at the label on your car seat to make sure it's appropriate for your child's age, weight and height.
- Your car seat has an expiration date. Find and double check the label to make sure it's still safe. Discard a seat that is expired in a dark trash bag so that it cannot be pulled from the trash and reused.

Know Your Car Seat's History

- Buy a used car seat only if you know its full crash history. That means you must buy it from someone you know, not from a thrift store or over the internet. Once a car seat has been in a crash, or is expired, it needs to be replaced.

Road injuries are the leading cause of preventable deaths and injuries to children in the United States. Correctly used child safety seats can reduce the risk of death by as much as 71 percent.

Register Your Car Seat

- Register your new or currently used car seat, ensuring that you are promptly notified about future recalls. You can register online with your car seat manufacturer, using the information found on the label on your car seat at safercar.gov. You can also register by filling out the registration card that came with your car seat. It's filled out with your car seat's information. Mail the card; no postage required.

Make Sure Your Car Seat is Installed Correctly

- Inch Test. Once your car seat is installed, give it a good tug at the base where the seat belt goes through it. Can you move it more than an inch side to side or front to back? A properly installed seat will not move more than an inch.
- Pinch Test. Make sure the harness is tightly buckled and coming from the correct slots (check your car seat manual). With the chest clip placed at armpit level, pinch the strap at your child's shoulder. If you are unable to pinch any excess webbing, you're good to go.
- For both rear- and forward-facing car seats, use either the car's seat belt or the lower anchors and for forward-facing seats, also use the top tether to lock the car seat in place. Don't use both the lower anchors and seat belt at the same time. They are equally safe- so pick the one that gives you the best fit.
- If you are having even the slightest trouble, questions or concerns, certified child passenger safety technicians are able to help or even double check your work. Visit a certified technician to make sure your car seat is properly installed. Find a technician or car seat checkup event near you.

Check Your Car Seat

- Seventy-three percent of car seats are not used or installed correctly, so before you hit the road, check your car seat. Here's a quick car seat checklist to help you out. It takes only 15 minutes.
- Learn how to install your car seat for free. Safe Kids hosts car seat inspection events across the country where certified technicians can help make sure your car seat is properly installed. They also serve in fixed locations called inspection stations during specific days and times in some communities. You may find an inspection station with certified technicians at a GM dealership, a hospital or even a fire house. They will teach you so that you can always be sure your car seat is used correctly. Find a Safe Kids car seat checkup event where we use only certified technicians, near you.

Is it Time for a Booster Seat?

- Take the next step to a booster seat when you answer "yes" to any of these questions:
  - Does your child exceed the forward-facing car seat's height or weight limits?
  - Are your child's shoulders above the forward-facing car seat's top harness slots?
  - Are the tops of your child's ears above the top of the car seat?

- If the forward-facing car seat with a harness still fits, and your child is within the weight or height limits, continue to use it until it is outgrown. It provides more protection than a booster seat or seat belt for a small child.

Be Wary of Toys

- Toys can injure your child in a crash, so be extra careful to choose ones that are soft and will not hurt your child. Secure loose objects and toys to protect everyone in the car.

Buckle Up

- We know that when adults wear seat belts, kids wear seat belts. So be a good example and buckle up for every ride. Be sure everyone in the vehicle buckles up, too.
- Buckling up the right way on every ride is the single most important thing a family can do to stay safe in the car.

Prevent Heatstroke

- Never leave your child alone in a car, not even for a minute. While it may be tempting to dash out for a quick errand while your babies are sleeping in their car seats, the temperature inside your car can rise 20 degrees and cause heatstroke in the time it takes for you to run in and out of the store.
- Leaving a child alone in a car is against the law in many states.

Child Nutrition Notes

Child Nutrition Notes

Hotlines

- National Human Trafficking Hotline
  - 1-888-373-7888
- Polaris BeFree Textline
  - Text "BeFree" (233733)
- Homeland Security Investigations Tip Line
  - 1-866-347-2423

References: www.polarisproject.org and
www.ag.nv.gov/Human_Trafficking/HT-Signs

Human Trafficking Notes

Human Trafficking Notes

Reasonable and Prudent Parenting Notes

Reasonable and Prudent Parenting Notes

Additional Information

Rights of Children In DSCYF Custody*

Knowledge

- To be told why I am in foster care
- To know the people on my planning team
- To participate in plans about me in foster care, independent living, and transition
- If I am 14 or older to have two people of my choice be part of my planning team
- To have regular private contact with my DFS worker
- To have regular private contact with my attorney and/or Court-Appointed Special Advocate (CASA)
- To be told about and participate in my court hearings and to speak to my Judge about the decisions being made about me

Safety

- To live in a safe place without abuse or neglect
- To receive water, food, shelter, and clothing to meet my own individual needs
- To receive appropriate placement services
- To contact and visit my parents, brothers and sisters in foster care, my own child in foster care, and other individuals. If I can't see my family, I have the right to know why
- To have information about me kept private, as required by law

Support

- To have help getting needed medical, vision, and dental care
- To have help getting mental health care or substance abuse treatment if I need it
- To have help getting an education
- To stay in the school I am attending when I first come into foster care, if possible, and to remain in that school if any changes in placement occur
- To receive independent living services and supports at age 16 if eligible and if resources are available
- To have help getting my credit history report beginning at age 14
- To have help to participate in activities and events that support my interests and development
- To be given my birth certificate, social security card, driver's license or identification card, health records, and credit history report when I leave foster care
- To report any violation of my rights or the rights of others without punishment
- To get help with any violation of my rights by telling my attorney, CASA, or Judge

My rights were explained to me and I was given a copy to keep.

Youth: _____ Date: _____

DFS Worker: _____ Date: _____