

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 1 of 14
Approved:	Christine Johnson, Deputy Commissioner	Effective: 2/27/2020
Supersedes:	Family Services Policy 77	Dated: 2/8/2018

## Purpose

To establish division policy regarding the authorization of medical care and the requirements for meeting the health needs of children and youth in DCF custody.

## Table of Contents

Purpose .....	1
Table of Contents .....	1
Related Policies .....	1
Introduction .....	2
Definitions .....	2
Policy.....	3
Authorization of Medical Care .....	3
Meeting Children and Youth’s Health and Dental Needs Upon Entering DCF Custody .....	4
Preventative Medical Care, Dental Care, and Immunizations/Vaccinations .....	7
Supervision of Children and Youth in Hospital Settings for Medical Treatment.....	8
Children and Youth with Medical Complexity .....	9
Parent Disagreement with Medically Recommended Treatment .....	11
Treatment for Serious Physical Injuries and Terminal Illnesses .....	11
End of Life Decisions .....	12
Documentation .....	13
Caregiver and Youth Access to Health Records.....	13
Payment for Health Care .....	13
Additional Resources.....	14

## Related Policies

Family Services [Policy 68](#): Serious Physical Injury – Investigation and Case Planning  
Family Services [Policy 75](#): Normalcy and the Reasonable and Prudent Parent Standard  
Family Services [Policy 76](#): Supporting and Affirming LGBTQ Children & Youth  
Family Services [Policy 134](#): Serving Families Affected by HIV  
Family Services [Policy 137](#): Antipsychotic Medications for Children in the Care of DCF  
Family Services [Policy 154](#): Children and Youth in DCF Custody Requiring Mental Health Screening, Mental Health Placement, or Psychiatric Hospitalization

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 2 of 14

## Introduction

Children who experience abuse or neglect are at heightened risk of developing health concerns throughout their lives. Data from the last 30 years demonstrating the high prevalence of health problems have led the American Academy of Pediatrics (AAP) to classify children in foster care as a population of children with special health care needs. This correlation may stem from the fact that:

- Most children in foster care have been abused or neglected and have not experienced a stable, nurturing environment during their early life.
- Many children in foster care may have experienced unrecognized fetal harm from prenatal exposure, poor prenatal nutrition, and sometimes from the toxic stresses experienced by the mother during her pregnancy.

## Definitions

**Children and Youth with Special Health Needs (CSHN):** Children or youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally (Maternal and Child Health Bureau).

**Infants:** Children 0-1 year of age (CDC).

**Local Health FHF Designee:** The public health nurse assigned to the work of the Fostering Healthy Families (FHF) program who contributes public health nursing knowledge and skills in support of the division’s work of improving the health and well-being of children and youth in DCF custody.

**Medical Complexity (or Medical Fragility):** Terms used to describe children or youth who have a serious and/or ongoing illness or chronic condition that requires prolonged hospital stays or medical treatments and monitoring. Children and youth with medical complexity or medical fragility may or may not be dependent on technology assistive devices.

**Medical Home:** Primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In a medical home, a child health care professional works in partnership with the family and patient to ensure that all the medical and non-medical needs of the patient are met. Medical homes address preventative, acute, and chronic care from birth through transition to adulthood. A medical home facilitates an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists and

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 3 of 14

subspecialists, hospitals and healthcare facilities, public health and the community. The medical home model was developed by the American Academy of Pediatrics (AAP).

**Medical Technology:** For the purposes of this policy, examples of medical technology include ventilators/respirators, tracheotomies, oxygen, intravenous nutrition, feeding tubes (G/J tubes), central venous catheters, infusions, cardio-respiratory monitoring, kidney dialysis, ostomy care, or other medical equipment or supportive technologies.

## Policy

### Authorization of Medical Care

Once a child or youth is in the custody of the Department for Children and Families (DCF), the Family Services Division has the responsibility to ensure that appropriate medical and dental services are provided for the young person. Each child’s medical care must include regular preventative care appropriate to the child’s age and condition, consistent with the *Bright Futures Guidelines*, including:

- Timely screenings, examinations, and routine medical care;
- Timely immunizations;
- Timely dental exams and cleanings;
- Timely treatment of non-emergency injuries and illnesses;
- Ongoing care for serious or chronic conditions; and
- Emergency treatment when necessary.

As custodian, the division is authorized to consent to medical, dental, psychiatric, and surgical treatment for children and youth in DCF custody. This authority is delegated as follows:

Major surgery and treatment related to serious injuries	Supervisor in consultation with the district director and operations manager; CIES after hours
Specialized tests, anesthesia, and minor surgery	FSW or supervisor
Changes in providers (primary care, therapist, etc.)	FSW
Psychiatric services and antipsychotic medications	FSW
Emergency medical care and treatment	Available FSW or supervisor; CIES after hours; or caregiver/substitute care provider
Routine medical and dental care	Caregiver/substitute care provider

When a young person in DCF custody is placed with a substitute care provider, the

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 4 of 14

caregivers are provided with the division’s *Caregiver Authorization Letter*. This letter permits the child’s foster or kinship parent(s) or residential treatment program staff to obtain routine and emergency medical, psychiatric, psychological, dental, ophthalmologic, or other specialized medical services or treatment recommended by a licensed physician. Caregivers are expected to notify the worker or other district office team member of all emergency medical care and medical decisions made with the authority of the letter. District staff will notify their assigned policy and operations manager of emergency medical care related to treatment of serious injuries.

The division supports children and youth receiving medical care as recommended by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Centers for Disease Control and Prevention (CDC), and the Vermont Department of Health (VDH). All children in DCF custody are required to have a medical and dental home. Children and youth in DCF custody are best served through a medical home with child health care professionals who specialize in or are trained in childhood trauma and adversity.

**Meeting Children and Youth’s Health and Dental Needs Upon Entering DCF Custody**

**Initial Health Assessment**

Best practice standards recommend that initial health assessments occur within 72 hours of a child entering foster care; however, this may not always be possible based on appointment availability or coordination of caregiver schedules. Division staff will coordinate with caregivers to refer, or otherwise cause a referral for a medical exam, within 7 days of the child entering DCF custody.

Similarly, division staff will coordinate with caregivers to schedule a dental appointment for the child as soon as feasible based on appointment availability. If the child has been seen by a dentist recently, their established dental appointment scheduling should be maintained.

When possible, efforts should be made to maintain continuity with the child’s primary care provider if one has been identified. If the child or youth will be seen by a new provider for the initial health assessment, efforts should be made to obtain their previous medical records (i.e., immunization and medication history) or sign releases for providers to share such records prior to the appointment.

Family services workers or members of the district office team should talk to the child’s medical and dental providers to understand if there are unmet medical needs and to create a plan to address those needs. Division staff will work with the child’s

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 5 of 14

pediatrician, dentist, parents, foster/kinship parents, and Vermont Department of Health partners as needed to ensure the child is attending routine medical and dental appointments and receiving the recommended care.

### **The Fostering Healthy Families (FHF) Program & the Health Information Questionnaire**

Through a [Memorandum of Understanding](#) between DCF-FSD and VDH-MCH, the Fostering Healthy Families (FHF) program aims to improve the health status of children in DCF custody. Desired outcomes are to:

- Ensure that the physical health, mental health, and dental health needs of children in DCF custody are assessed and addressed in a timely manner; and
- Ensure that children and youth who have experienced trauma have the necessary support and interventions to successfully navigate normal developmental stages and achieve emotional well-being.

In order to achieve these outcomes, collaborative work between division staff and the Vermont Department of Health’s Division of Maternal and Child Health is necessary. This collaboration is grounded in the federal [Early Periodic Screening Diagnosis and Treatment \(EPSDT\)](#) mandate which requires states to outreach and provide services to Medicaid-eligible children, coordinate care, and focus on vulnerable or underserved populations of these children.

The role of division staff in the Fostering Healthy Families (FHF) program includes:

<b>Task</b>	<b>Timeframe</b>
Providing notification to the local health FHF designee when a child enters DCF custody, including copies of the following: <ul style="list-style-type: none"> <li>• FS-201 <a href="#">Initial Application for Federal Funding</a></li> <li>• FS-580 <a href="#">Placement Form</a></li> <li>• FS-302 <a href="#">VDH Fostering Healthy Families HIPAA Release</a></li> <li>• FS-303 <a href="#">VDH Fostering Healthy Families FERPA Release</a></li> <li>• <a href="#">Placement Checklist</a> (including any known information about the child’s medical providers)</li> <li>• Contact information for the child’s caregiver(s)</li> </ul>	Within <u>3 business days</u> of a child entering DCF custody
Providing notification to the local health FHF designee when a child’s placement changes or there is a change in custody status by sharing the FS-580 (Placement Form)	Within <u>3 business days</u> of the change in placement or status
Communicating with the local health FHF designee	Regularly and as often as needed to support the child’s medical needs

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 6 of 14

Responsibilities of the local health FHF designee include:

- Assisting with gathering and interpreting information about children’s health status and needs;
- Gathering information about children’s medical and dental homes and, if necessary, assisting with finding and communicating with appropriate providers;
- Documenting children’s immediate and short-term health needs;
- Entering all gathered information from the [Health Information Questionnaire](#) into the HIQ tab of FSDNet;
- Serving as a liaison between division staff and the medical home to interpret needs;
- Serving as a consultant to the division on health issues as needed.

VDH-MCH partners may release full copies of Child Development Clinic (CDC) reports to the division as part of the FHF program. CDC reports contain sensitive information about the family’s history and protected health information which should be redacted when records are being viewed or requested.

**Promoting Parents’ Involvement in their Children’s Health Care**

Parents will be kept informed of their child’s medical care and included in medical decisions and appointments when possible. Strategies of involving parents in their children’s health care may include, but are not limited to:

- Interviewing parents about their child’s health and/or discussing this topic at the *Initial Caregiver Meeting* or *Shared Parenting Meetings*;
- Routinely inviting parents and encouraging attendance/participation in health visits, developmental screenings, and other appointments when it can be done safely;
- Sharing the outcomes of medical appointments, medical recommendations, screenings, or assessments (i.e., a doctor’s recommendations or test results) and discussing them with parents;
- Reviewing a child’s developmental milestones and achievements with their parents; and
- Routinely including parents in their children’s health care planning or treatment discussions.

When a child is in DCF custody, the division’s records are accessible to the parties of the CHINS proceeding. Therefore, the child’s parents should have the same access to the child’s medical providers and medical records as division staff (i.e., parents may ask questions or request information/documentation from the child’s medical home and their attorneys may request the division’s medical records for the child). In order to

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 7 of 14

withhold a child’s medical information from their parents, the division must seek a protective order from the court. Without a protective order, the division does not have the authority to withhold a child’s medical information from their parents.

**Preventative Medical Care, Dental Care, and Immunizations/Vaccinations**

**Medical**

Children and youth in DCF custody shall receive preventive medical examinations and screenings to ensure that medical and dental needs are identified and addressed. Routine medical examinations and required well-child checks will occur based on the age and needs of the child. See the *Bright Futures Guidelines* and/or American Academy of Pediatrics [Recommendations for Preventative Pediatric Health Care](#) for a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

If a potential physical or developmental condition is identified for a child, referrals to specialists or the medically recommended supports should be made within one week. The division may coordinate with caregivers to facilitate referrals and subsequent appointments.

**Dental**

The American Academy of Pediatric Dentistry (AAPD) recommends that a child go to the dentist by age 1 or within six months after the first tooth erupts; however, this may not always be possible based on the availability of pediatric dentistry throughout the state. Dental appointments should begin at the age recommended by the child’s pediatrician. Vermont Department of Health district offices maintain up-to-date lists of Medicaid dental providers.

**Immunizations & Vaccinations**

Preventive medical care for children includes vaccination and immunization. Some children may require alternate immunization schedules due to individual medical needs. Additionally, children may be behind on immunizations when they come into DCF custody. In all instances of special medical issues and/or delayed or interrupted immunization schedules, division staff should follow the child’s medical home’s recommendations. A foster or kinship caregiver cannot make the decision to delay or not immunize a child or youth in DCF custody.

The [Vermont Recommended Child & Teen Vaccination Schedule](#) is compatible with the current recommendations of the CDC. The CDC’s [Recommended Immunization Schedules for Persons Aged 0 Through 18 Years](#) is approved by the Advisory Committee

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 8 of 14

on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists.

### **Gynecology**

The division follows the medically recommended schedule for gynecological or obstetrics appointments. The [American College of Obstetricians and Gynecologists](#) (ACOG) recommends that females first see a gynecologist between the ages of 13 and 15. For females of this age, coordination with the medical home should occur regarding the individualized need and timing of gynecology visits. This first appointment may occur earlier or later based on the medical need or as requested by the youth.

### **Complementary or Alternative Medicine and Natural Therapies**

Division staff and/or foster or kinship caregivers are expected to consult with the child or youth’s medical home prior to supporting or administering any natural therapies or complementary or alternative medicine to children and youth in DCF custody.

The division follows the recommendations of the American Academy of Pediatrics (AAP) regarding CBD products. Additional research is needed to evaluate the potential role of medical cannabinoids in children and adolescents as safety and effectiveness have not been established for this age group. CBD products in any form (oil, drops, capsules, gummies, roll-on, vape, etc.) will **not** be administered to children or youth in DCF custody.

### **Supervision of Children and Youth in Hospital Settings for Medical Treatment**

When a child or youth in DCF custody is hospitalized due to medical reasons (injuries, surgeries, or other treatment), division staff will arrange for someone to be with the child at the hospital. Supports and supervision while the child is in the hospital will likely include the collaborative efforts of the child’s caregiver(s) and parent(s), along with division presence as needed. It is reasonable to expect that a parent or caregiver may briefly step away while the child is sleeping or leave to eat meals, take a shower or change clothing, etc. However, children and youth should not be left alone in hospitals for long periods of time while receiving medical treatment unless it is a specialized circumstance and the hospital’s recommendation.

Hospital staff will likely seek instruction from the division regarding which individuals are allowed and/or expected to be bedside and present with the child. If there are safety concerns pertaining to any individuals or visitation restrictions that need to be in place, those need to be communicated to the hospital.

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<span style="font-size: 48pt;">77</span>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 9 of 14

In instances where children are placed out-of-state in foster homes through the [Interstate Compact on the Placement of Children](#) (ICPC), the family services worker or supervisor may need to clarify support and supervision expectations to the caregivers as the minimum expectations may differ by state.

See Family Services [Policy 154](#) for information about the supervision of children and youth in emergency departments due to mental health screening, placement, or psychiatric hospitalization.

#### **Children and Youth with Medical Complexity**

Children and youth in DCF custody who have medical complexity or require specialized care from UVM Medical Center, Dartmouth-Hitchcock Medical Center, or another Level II or Level III specialty center are at greater risk of injury and death. The division must ensure all necessary actions are taken to promote the health and safety of these children and youth. Because of their special health needs, they require a heightened level of awareness, planning, coordination, and communication.

Children with medical complexity should always have a medical care team. The Vermont Department of Health CSHN nurses and medical social workers may be a resource for division staff and families. Additionally, The Child Safe Program at UVM Medical Center may be accessed for consultations via email ([childprotectionteam@uvmhealth.org](mailto:childprotectionteam@uvmhealth.org)) or phone (802-847-2700).

#### **Use of Case Note Alert to Document Medical Complexity**

A case note alert shall be applied in FSDNet to alert other division staff of a child or youth’s medical complexity and any critical care instructions. Additionally, a medical alert should be applied to the outside of the family’s file within the district office to signify medical complexity.

#### **Placement Considerations for Medically Complex Children**

Medically complex children and youth, particularly those with compromised immune systems, will only be placed within homes where everyone in the home (foster parents, adult household members, and other children) have received medically recommended vaccinations. Medical staff may further advise on the matter based on the child’s individualized needs and vulnerabilities.

Use of the Caregiver Responsibility Form (CRF) should be considered for children and youth with complex medical needs as the responsibilities and caretaking requirements of the caregivers are often significant.

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 10 of 14

### **Medical Records and Care Instructions for Medically Complex Children**

Clear and instructive communication between the hospital or specialty care provider, division staff, the foster parents, parents, and the child’s medical home is critical for ensuring that all specialized medical plans and care instructions transfers with the child to all key people in the child’s life. Critical medical records, care instructions, and information about circumstances that could be life threatening must transfer with the child or youth during transitions.

If specialized care training is provided to foster parents by a hospital prior to the child’s discharge from the hospital, all subsequent caregivers are required to receive the same training and instruction from the hospital. Placement changes for children with complex medical needs should not occur without planning and coordinating specialized care instructions.

### **Transitions for Medically Complex Children**

One of the greatest safety precautions that can be taken for children with complex medical needs is planning for transitions, such as:

- The initial transition out of a hospital setting;
- Ongoing transitions into and out of hospital settings;
- Transitions among specialty care providers;
- Changes in the child’s medical home/primary care provider;
- Transitions within childcare or school settings;
- Changes in foster/kinship care placements;
- The addition of or change in respite providers or babysitters; and
- Reunification with a custodial or non-custodial parent.

Caregivers of children with medical complexity should receive:

- The child’s complete medical history and pertinent records;
- A current list of diagnoses and medications; and
- Care instructions detailing:
  - Daily routines and specific treatment protocols for the child based on their needs;
  - Mealtime accommodations, if applicable;
  - The location, use, and storage of any medical technology equipment; and
  - The emergency plan for the child.

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<span style="font-size: 48pt;">77</span>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 11 of 14

**Parent Disagreement with Medically Recommended Treatment**

There may be times in medical decision-making when a child or youth’s parents disagree with the division, the medical provider, or the youth regarding the medical treatment plan. In all instances where medical decisions are required, division staff along with the child’s parents should consult with the medical provider who has expertise on the matter to ascertain the standard treatment recommendations and facts of the situation.

The best strategy to prevent misunderstanding or disagreement about treatment options is to encourage the parents to be present for all discussions with the medical team when updates or treatment are discussed. Division staff should set the expectation with the medical team to include the child’s parents in all discussions. The child’s parents should have the same access to the medical team and medical records as division staff.

The medical team is best suited to explain to the parents the recommended treatment, the benefit to child or youth, and the potential harm that could result if the treatment is not received. In instances where a treatment is medically necessary and the parent continues to oppose that course of treatment, the assigned assistant attorney general (AAG) should be consulted on the matter and the situation may be discussed in court.

In instances where parents are opposed to their children receiving immunizations or vaccinations, written recommendation from the medical provider should be obtained. For children and youth who attend childcare or school, certain immunizations are required for attendance. Division staff must provide parents with ample notice of plans to seek the medically recommended treatment. Parents may take the matter to their attorney if they wish for it to be considered in court.

**Treatment for Serious Physical Injuries and Terminal Illnesses**

Hospitals may perform emergency surgeries without explicit consent based on necessity. In all other circumstances, hospitals will be seeking consent from the department prior to performing any medical procedures.

When possible, parents and division staff should be present together when receiving information from medical providers about treatment for serious physical injuries, terminal illnesses, or medical treatment requiring extended hospitalization. This safeguards against information being altered in translation and may reduce disagreements about medically necessary treatments. If parents are unable to be located or cannot be reached, division staff will notify their attorneys and ask them to reach their clients. The notice should indicate that the department plans to consent to medical

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<b>77</b>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 12 of 14

treatment and that we would like to confirm their agreement with the treatment plan.

Division staff must notify parents of the dates, times, and locations of all appointments with doctors or specialists when a significant treatment with long-term consequences is being discussed. Parents should have access to the medical records, all written recommendations, and notice of what the department plans to consent to.

In non-emergency circumstances and in instances where there is enough time prior to the scheduled treatment, procedure or surgery, the matter may be discussed in court. If parents disagree with the medically recommended treatment for significant injuries and illnesses, they may take the matter to their attorney if they wish for it to be considered in court.

### **Special Considerations When a Parent is the Alleged Perpetrator of the Injury**

If the child’s parent is the alleged perpetrator of abuse which caused injury, thoughtful planning about the parent’s access to the child and their medical information should occur. Division staff will closely coordinate with and follow the recommendations of the medical team regarding the need for specialized tests, child abuse evaluations, skeletal surveys, blood work, or other imaging that may be required to assess the injuries, their cause, and best course of treatment. If there is a joint investigation with law enforcement and there is imminent danger, the officer may put immediate restrictions in place. If there is a need to withhold access or information for an extended time, the division must seek a protective order from the court.

See Family Services [Policy 68](#) for additional information about serious physical injury investigations.

### **End of Life Decisions**

As soon as division staff are aware of a situation where end of life decisions need to be made, the assigned policy and operations manager will be notified immediately. End of life decisions are made by the Commissioner of the Department for Children and Families. When end of life decisions are required for a child in DCF custody (such as permission for removal of life supports or DNR orders), the division will make every effort to engage the child’s parents in the decision-making process and to ensure judicial review of such decisions. If neither effort is successful, the Commissioner has the authority to make such decisions. The Commissioner will engage the services of an independent pediatric consultant to inform these decisions.

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<span style="font-size: 48pt;">77</span>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 13 of 14

### Documentation

Information regarding children’s medical care and needs shall be documented in case notes and included in the case plan. To the extent available and accessible, the child’s health records should be up-to-date and included in the family’s case file as required by the Social Security Act § 475(1)(C). Federal law requires the child’s health record maintained by the division to include:

- The names and addresses of the child’s health providers;
- A record of the child’s immunizations;
- The child’s known medical problems;
- The child’s medications; and
- Any other relevant health information concerning the child.

### Caregiver and Youth Access to Health Records

The Social Security Act § 475(5)(D) requires the division to supply a copy of the child’s health record maintained by the division (outlined in the above section) to the foster parent at the time of each placement, and to the youth at no cost prior to exiting foster care at age 18.

The division’s method of providing this information to caregivers includes:

- Sharing health and medical information documented on the *Child Information & Placement Checklist* at the time a placement is made; and
- Providing caregivers with copies of case plans (which includes the child’s health information).

In instances where children or youth have complex medical needs or significant medical history, it may be appropriate for caregivers to have access to the child’s full medical record. Family services workers may sign a release to the Health Department or the child’s medical provider to provide caregivers with the full medical records.

### Payment for Health Care

The Department of Vermont Health Access (DVHA) is responsible for the management of Vermont’s publicly funded health insurance programs, including Medicaid. For children in DCF custody who live in Vermont and are eligible for Medicaid, the division will use health care professionals approved by DVHA or its contractors. Children and youth in DCF custody are enrolled in Medicaid through the FS-201 FC-M (Initial Application for Federal Funding) – completed by the district office and sent to the Revenue Enhancement Unit in central office. Members of the Revenue Enhancement

 <b>VERMONT</b> DEPARTMENT FOR CHILDREN AND FAMILIES <b>Family Services Policy Manual</b>		<span style="font-size: 2em;">77</span>
Chapter:	Working with Youth and Families	
Subject:	Medical Care for Children and Youth in DCF Custody	Page 14 of 14

Unit are available to support district staff with issues related to health care coverage and payment.

The division may expend state funds to provide medical care for children not covered by Medicaid or other health insurance. Payments for services delivered by Vermont providers will not exceed Medicaid rates. Requests to pay for medical care not covered by Medicaid are reviewed, and decisions made by members of the Family Services Management Team (FSMT). Requests will be directed to the revenue enhancement director.

Children in DCF custody continue to be eligible for Medicaid coverage after their return home for a period defined in regulation by the department’s Economic Services Division. After that time, continued eligibility is based upon the child and family's income.

Youth who reach their 18th birthday while in DCF custody are responsible for their own medical care, even when the division continues other financial supports. Youth must apply for Medicaid as individuals. Division staff shall ensure youth have information about reapplying for Medicaid before turning 18. [The Affordable Care Act](#) guarantees Medicaid eligibility for youth who leave foster care at age 18 until they turn 26, regardless of income.

**Additional Resources**

The Centers for Disease Control and Prevention (CDC) – <http://www.cdc.gov/>  
American Academy of Pediatrics (AAP) – <https://www.aap.org>  
Vermont Department of Health (VDH) – <http://healthvermont.gov/>