Health Services













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UNDERSTANDING HEALTHWORKS

A child's physical health is a large part of their overall well-being. Caregivers and caseworkers not only have to insure that health needs are met, they are also responsible for keeping thorough records of exams and medical issues.

HealthWorks is the comprehensive system of health care developed by DCFS for all Illinois children in foster care to make sure they have:

- access to quality health care;
- routine and special health care they need; and
- documentation of health needs and care readily accessible to foster caregivers, other health care providers and DCFS.

All children who receive foster care services must be enrolled in HealthWorks.

HealthWorks is a collaborative effort of three Illinois governmental departments:

- Department of Children and Family Services (DCFS);
- Department of Healthcare and Family Services, formerly known as Public Aid; and
- Department of Human Services (DHS).

The HealthWorks Program is administered by 20 lead agencies which cover all the counties throughout the state of Illinois. (See page 3.)

HealthWorks provides access to and referrals for:

- primary health care physicians;
- initial health screenings;
- Comprehensive Health Evaluations;
- well-child examinations; and
- immunizations.

Call HealthWorks to:

- ask any questions about the HealthWorks program or how to get care for the children placed with you;
- find a HealthWorks primary care physician or request an exception to use another physician;
- verify the child is enrolled with HealthWorks; and
- verify that the physician listed in the child's Health Passport is registered with HealthWorks.

Enrolling in HealthWorks

All children in DCFS care must be enrolled in HealthWorks. Enrollment is easy — just call your local HealthWorks agency. (See page 3.)

Selecting a HealthWorks Physician

Each child must have a primary care physician registered with HealthWorks. DCFS has asked HealthWorks to keep records of each child and the name of his or her HealthWorks primary health care physician.

A primary care physician enrolled with HealthWorks:

- understands the health issues of abuse and neglect;
- specializes in caring for children;
- has agreed to record a child's ongoing medical history and treatment;
- provides all routine checkups and treats the child when sick; and
- makes referrals to specialists.

If you are interested in taking a child to a doctor who is *not* a HealthWorks physician, call HealthWorks and ask HealthWorks to contact the doctor to discuss enrolling. If the doctor is not willing to be enrolled with HealthWorks, you *must* find another doctor who is enrolled with HealthWorks or contact your local HealthWorks agency to request an exception. HealthWorks will review your request and either approve it or help you select a HealthWorks physician in your community.

CAREGIVERS MUST CALL HEALTHWORKS TO ENROLL A CHILD IN YOUR CARE AND TO SELECT THE CHILD'S PHYSICIAN.

HealthWorks Lead Agency Phonebook

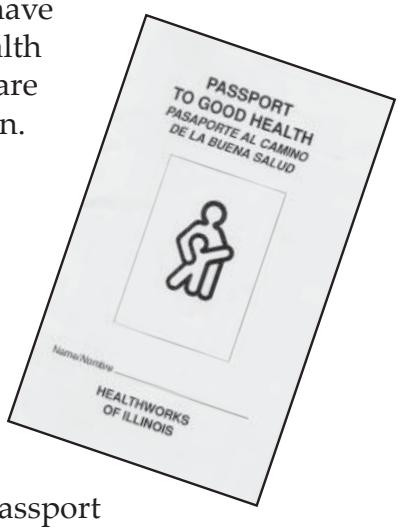
DCFS Region	Counties Served	Phone
	Cook	800-KID-4345
N	Kankakee	815-802-9324
N	McHenry	815-334-4510
C	Adams, Brown, Calhoun, Greene, Hancock, Jersey, Pike, Schuyler	217-222-8440
C	Champaign, Ford, Iroquois, Vermilion	217-531-4000
C	Logan, Cass, Christian, Fulton, Macoupin, Mason, Menard, Montgomery, Morgan, Sangamon, Scott, Tazewell, Woodford	217-735-2317
C	Macon, Clark, Coles, Cumberland, Douglas, Edgar, Shelby, Moultrie	217-423-6953
C	McLean, DeWitt, Livingston, Piatt	309-888-5461
C	Peoria, Marshall	309-673-3769
C	LaSalle	815-433-3366
N	DuPage	630-682-7979
N	Kane, Kendall	630-844-8517
N	Lake	847-377-8070
C	Rock Island, Bureau, Henderson, Henry, Knox, McDonough, Mercer, Putnam, Stark, Warren	309-588-2922
N	Will, Grundy	815-727-8863
N	Winnebago, Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside	800-355-8909
S	Effingham, Clay, Crawford, Edwards, Fayette, Hamilton, Jasper, Jefferson, Lawrence, Marion, Richland, Wabash, Wayne	217-342-9237
S	Jackson, Perry, Franklin, Williamson, Gallatin, Saline, White	618-684-3143
S	Alexander, Hardin, Johnson, Massac, Pope, Pulaski, Union	618-634-9405
S	Bond, Clinton, Madison, Monroe, Randolph, St. Clair, Washington	618-332-8917

The lead agencies listed here were correct at the time of printing. Because each agency listed is contracted to HealthWorks, changes may occur. If any entry listed here has changed, please contact the DCFS Office of Health Services at 217-557-2689 for the correct HealthWorks phone number.

C = Central N = Northern S = Southern

Health Passport Documents

The Health Passport is a hard copy summary of a child's medical records and history, as recorded by health care providers who have examined the child. Caregivers MUST take the Health Passport to all medical appointments for medical care providers to update with current health information.



At each Administrative Case Review (ACR), the child's most recent Health Passport entries will be photocopied for the child's case file. Caregivers must bring the Health Passport and related health documents to each ACR.

If a child moves to a new foster home placement, the Health Passport moves with the child. Foster caregivers are responsible for sending the Health Passport with the caseworker when the child leaves.

If the child is coming from another placement, the Health Passport should reflect the heath history and medical care of the child while in DCFS custody. Such history and medical care should include information about the Comprehensive Health Evaluation, immunizations, health visits, medical history and the child's physician(s) and dentist(s).

The placing worker and the prospective foster family should discuss the child's health needs prior to placement to determine if the family has the willingness, skills and current capabilities to meet the child's immediate and ongoing health needs.

Expect a Call

When a child initially comes into custody of DCFS, HealthWorks staff work to obtain the child's previous health care history within the first 45 days. These staff will also contact the child's caregiver to ensure:

- a HealthWorks primary care physician is selected; and
- the child has a Comprehensive Health Evaluation scheduled or completed.

After the 45 days, children under the age of six will be assigned to a medical case manager who will work with the child's caseworker and caregiver to monitor the child's health care to verify:

- the child is current on immunizations and well-child exams; and
- referrals to specialists are followed up.

For children six and older, this monitoring function is performed by the child's caseworker.

Illinois Department of Healthcare and Family Services Medical Card

All children in foster care are eligible for healthcare through the Illinois Department of Healthcare and Family Services medical card. Each child will receive his or her own medical card. Caregivers must use health providers who will accept the state medical card. To locate providers, call your HealthWorks Lead Agency shown on page 3.

The medical card must move with the child when the child moves to another foster placement. The card is only replaced if it is lost or stolen.

Foster caregivers should expect a temporary medical card from the placing caseworker when a child who has newly entered foster care is placed with them. The ongoing medical card will be mailed to the foster family, replacing the temporary medical card, within 10 days.

The ongoing medical card is designed to last for a year. The new annual card will be sent to the foster family home. The foster caregiver should always take the medical card to appointments, pharmacy visits, etc. as it will be needed to verify coverage each time.

If you do not receive the Illinois medical card

Notify your caseworker when you have not received an ongoing medical card if:

- the temporary medical card will expire within 15 days of the expiration date shown on the temporary medical card; or
- the placing caseworker did not bring a medical card at placement for a child who is not new to foster care.

You may also call the DCFS Medical Card Hotline at 1-800-228-6533.

If you receive a medical card for a child not living with you

Notify the caseworker immediately, Do NOT throw the card away. Another caregiver is waiting for this card.

If the medical card is lost or stolen

Call the child's caseworker to request a replacement card as soon as possible. You may also call the DCFS Medical Card Hotline at 800-228-6533.

Healthcare Documents and Discussion When a Child Is Placed

The placing caseworker should bring:

- a medical card for each child being placed;
- medication or prescriptions;
- health-related equipment or monitoring systems needed by the child (i.e. Apnea monitor, inhalers, wheelchairs); and
- a completed Consent for Ordinary and Routine Medical and Dental Care and a HealthWorks Encounter Form to be taken to the Comprehensive Health Evaluation for children new to DCFS.

The placing caseworker and foster caregiver should review:

- the child's current medical/health status;
- any known health conditions, such as asthma or allergies;
- pending health/medical appointments;
- use of medications, health-related equipment, monitoring systems and health procedures, as needed by the child;
- other needs of the child that may influence health, such as infant formula or dietary restrictions; and
- the name and number of the HealthWorks physician for the child.

If, for some reason, the placing caseworker does not bring all health documents or equipment at the time of placement, caregivers should follow up with the caseworker or supervisor the next day. If you believe needed information, documents, or equipment is being unnecessarily delayed and is endangering your child's health, contact the DCFS Advocacy Office for Children and Families for assistance at 800-232-3798.

Documents to be Given to Caregivers Upon Placement of a Child

Children NEW to Foster Care:

- Initial Health Screening Encounter Form and the medical record of the screening;
- medical card (temporary); and
- a Consent for Ordinary and Routine Medical and Dental Care and a HealthWorks Encounter Form to take to the child's Comprehensive Health Evaluation.

Children NOT NEW to Foster Care:

- Health Passport;
- medical card (ongoing); and
- previous health care documents.

Required Time Lines for Health Care

Initial Health Screening

Within 24 Hours of Child Entering Foster Care
A caseworker takes the child for an Initial Health Screening to determine his or her immediate health needs before a child is placed with a foster family. The Initial Health Screening provides information for the caseworker and the foster family about any conditions needing immediate attention and should help in making a good placement decision.

Primary Care Physician Selection

When a Child is Placed in Your Home for Foster Care
Call the HealthWorks Lead Agency to tell them the child is in your home and which HealthWorks physician you have selected, or ask for help in finding a HealthWorks physician. (See list, page 3.)

Comprehensive Health Evaluation

Within 21 Days of Child Entering Foster Care
If a child is placed with a foster family within this 21-day time frame, the foster caregivers are responsible for taking the child to a HealthWorks primary health care physician for the Comprehensive Health Evaluation. The child's caseworker should inform the caregiver, prior to the Comprehensive Health Evaluation, of the child's health history that has become known up to that point in time.

The child's primary health care physician is shown in the Health Passport. If a primary health care physician is not noted in the child's Health Passport, the foster caregiver must call HealthWorks to find a HealthWorks primary care physician who can give the child a comprehensive health evaluation within the 21-day time frame.

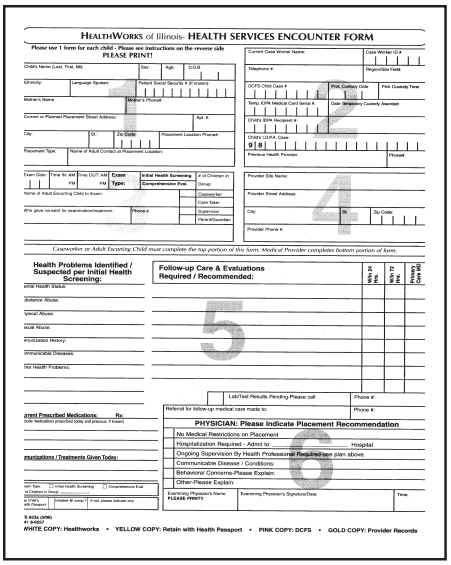
The Comprehensive Health Evaluation Includes:

- *an unclothed, physical exam;*
- *vision, hearing and dental screenings;*
- *needed immunizations;*
- *lab tests;*
- *developmental assessment;*
- *a health history assessment;*
- *health education; and*
- *mental health (age 5 and over).*

and, if needed, these screenings:

- *drug;*
- *alcohol; and*
- *Sexually Transmitted Diseases (STDs).*

TAKING A CHILD TO THE COMPREHENSIVE HEALTH EVALUATION



HEALTHWORKS of Illinois- HEALTH SERVICES ENCOUNTER FORM

Please use 1 form for each child - Please see instructions on the reverse side

PLEASE PRINT!

Caseworker or Adult Escorting Child must complete the top portion of this form. Medical Provider completes bottom portion of form.

Health Problems Identified / Suspected per Initial Health Screening:

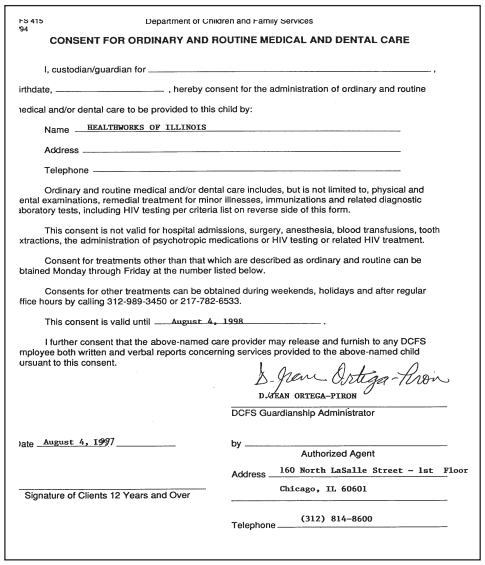
Follow-up Care & Evaluations Required / Recommended:

PHYSICIAN: Please Indicate Placement Recommendation

- No Medical Restrictions on Placement
- Hospitalization Required - Admit to _____ Hospital
- Ongoing Supervision By Health Professional Required-see plan above.
- Communicable Disease / Conditions:
- Behavioral Concerns-Please Explain:
- Other-Please Explain:

WHITE COPY: Healthworks • YELLOW COPY: Retain with Health Passport • PINK COPY: DCFS • GOLD COPY: Provider Records

#1 ENCOUNTER FORM
Yellow copy to be retained with Health Passport



Department of Children and Family Services

CFS 415
'94

CONSENT FOR ORDINARY AND ROUTINE MEDICAL AND DENTAL CARE

I, custodian/guardian for _____,

irthdate, _____, hereby consent for the administration of ordinary and routine

edical and/or dental care to be provided to this child by:

Name HEALTHWORKS OF ILLINOIS

Address _____

Telephone _____

Ordinary and routine medical and/or dental care includes, but is not limited to, physical and ental examinations, remedial treatment for minor illnesses, immunizations and related diagnostic aboratory tests, including HIV testing per criteria list on reverse side of this form.

This consent is not valid for hospital admissions, surgery, anesthesia, blood transfusions, tooth xtractions, the administration of psychotropic medications or HIV testing or related HIV treatment.

Consent for treatments other than that which are described as ordinary and routine can be btained Monday through Friday at the number listed below.

Consents for other treatments can be obtained during weekends, holidays and after regular ffice hours by calling 312-989-3450 or 217-782-6533.

This consent is valid until August 4, 1998.

I further consent that the above-named care provider may release and furnish to any DCFS mployee both written and verbal reports concerning services provided to the above-named child ursuant to this consent.

D. Jean Ortega-Piron

D.JEAN ORTEGA-PIRON
DCFS Guardianship Administrator

Date August 4, 1997

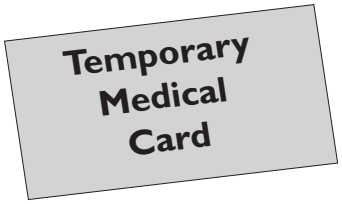
by _____
Authorized Agent

Address 160 North LaSalle Street - 1st Floor
Chicago, IL 60601

Signature of Clients 12 Years and Over

Telephone (312) 814-8600

#2 CONSENT FORM (CFS-415)



#3 MEDICAL ELIGIBILITY CARD

Examples of an Encounter Form and Consent Form are shown above and on page 9.

Caregivers taking a child for a Comprehensive Health Evaluation should:

- give information to the doctor about the child's behavior since the child has been in their care;
- listen to the doctor's instructions about taking the child to other specialists or experts he or she believes the child needs to see for further evaluation; and
- follow-up with the caseworker to discuss the child's health status and involve the caseworker in the process of completing the referrals and recommendations that resulted from the Comprehensive Health Evaluation.

Examples: Consent and Encounter Forms

CFS 415
Rev 4/2010

State of Illinois
Department of Children and Family Services

CONSENT FOR ORDINARY AND ROUTINE MEDICAL AND DENTAL CARE

As the legal custodian/guardian for the individual minor,_____, whose birth date is _____, I am authorized to act, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the minor in making health care related decisions, and I hereby consent to the administration of ordinary and routine medical and/or dental care to this child by:

Name: _____

Address: _____

_____

Telephone: _____

Ordinary and routine medical and/or dental care includes, but is not limited to, physical and dental examinations, remedial treatment for minor illnesses, immunizations and related diagnostics laboratory tests, including HIV testing when risk factors on reverse side of this form are present.

This consent is not valid for hospital admissions, surgery, anesthesia, blood transfusions, tooth extractions, the administration of psychotropic medications or any kind of medical research.

Consent for treatments other than that which are described as ordinary and routine can be obtained from the Authorized Agent Monday through Friday at the number listed below. Consents for other treatments can be obtained during weekends, holidays and after regular office hours by calling 773-538-8800 (Cook County) or 217-782-6533 (Downstate).

This consent is valid until: _____

_____
DCFS Guardianship Administrator

By: _____
Authorized Agent

Date: _____

Address: _____

_____

Telephone: _____

Distribution: One copy to Service Provider One copy to: Case Record One copy to Substitute Caregiver

Medical/Dental Consent Form (CFS 415)

Encounter Form

HEALTHWORKS of Illinois- HEALTH SERVICES ENCOUNTER FORM

Please use 1 form for each child - Please see instructions on the reverse side
PLEASE PRINT!

Child's Name (Last, First, MI): | Sex: | Age: | D.O.B.
Ethnicity: | Language Spoken: | Patient Social Security # (If known):
Mother's Name | Mother's Phone#:
Current or Planned Placement Street Address: | Apt. #:
City: | St.: | Zip Code: | Placement Location Phone#:
Placement Type: | Name of Adult Contact at Placement Location:

Exam Date: | Time IN: AM PM | Time OUT: AM PM | Exam Type: | Initial Health Screening | Comprehensive Eval. | # of Children in Group
Name of Adult Escorting Child to Exam: | Caseworker | Care Taker
Who gave consent for examination/treatment: | Phone #: | Supervisor | Parent/Guardian

Current Case Worker Name: | Case Worker ID #
Telephone #: | Region/Site Field:
DCFS Child Case # | Prot. Custody Date | Prot. Custody Time
Temp. IDPA Medical Card Serial #: | Date Temporary Custody Awarded:
Child's IDPA Recipient #:
Child's I.D.P.A. Case: 9 8
Previous Health Provider | Phone#

Provider Site Name:
Provider Street Address:
City: | St: | Zip Code:
Provider Phone #:

Caseworker or Adult Escorting Child must complete the top portion of this form. Medical Provider completes bottom portion of form.

Health Problems Identified / Suspected per Initial Health Screening:	Follow-up Care & Evaluations Required / Recommended:	Wiln 24 Hrs.	Wiln 72 Hrs.	Primary Care MD
Mental Health Status:				
Substance Abuse:				
Physical Abuse:				
Sexual Abuse:				
Immunization History:				
Communicable Diseases:				
Other Health Problems:				

Lab/Test Results Pending-Please call | Phone #:
Referral for follow-up medical care made to: | Phone #:

Current Prescribed Medications: Rx:
(Include medications prescribed today and previous, if known)

Immunizations / Treatments Given Today:

Exam Type: ☐ Initial Health Screening ☐ Comprehensive Eval.
# of Children in Group:
Was Child's Health Passport: | Initiated @ comp.? | If not, please indicate why:

PHYSICIAN: Please Indicate Placement Recommendation

- ☐ No Medical Restrictions on Placement
- ☐ Hospitalization Required - Admit to _____ Hospital
- ☐ Ongoing Supervision By Health Professional Required-see plan above.
- ☐ Communicable Disease / Conditions:
- ☐ Behavioral Concerns-Please Explain:
- ☐ Other-Please Explain:

Examining Physician's Name **PLEASE PRINT!** | Examining Physician's Signature/Date: | Time:

CFS 653a (5/96)
IL 41 0-0557

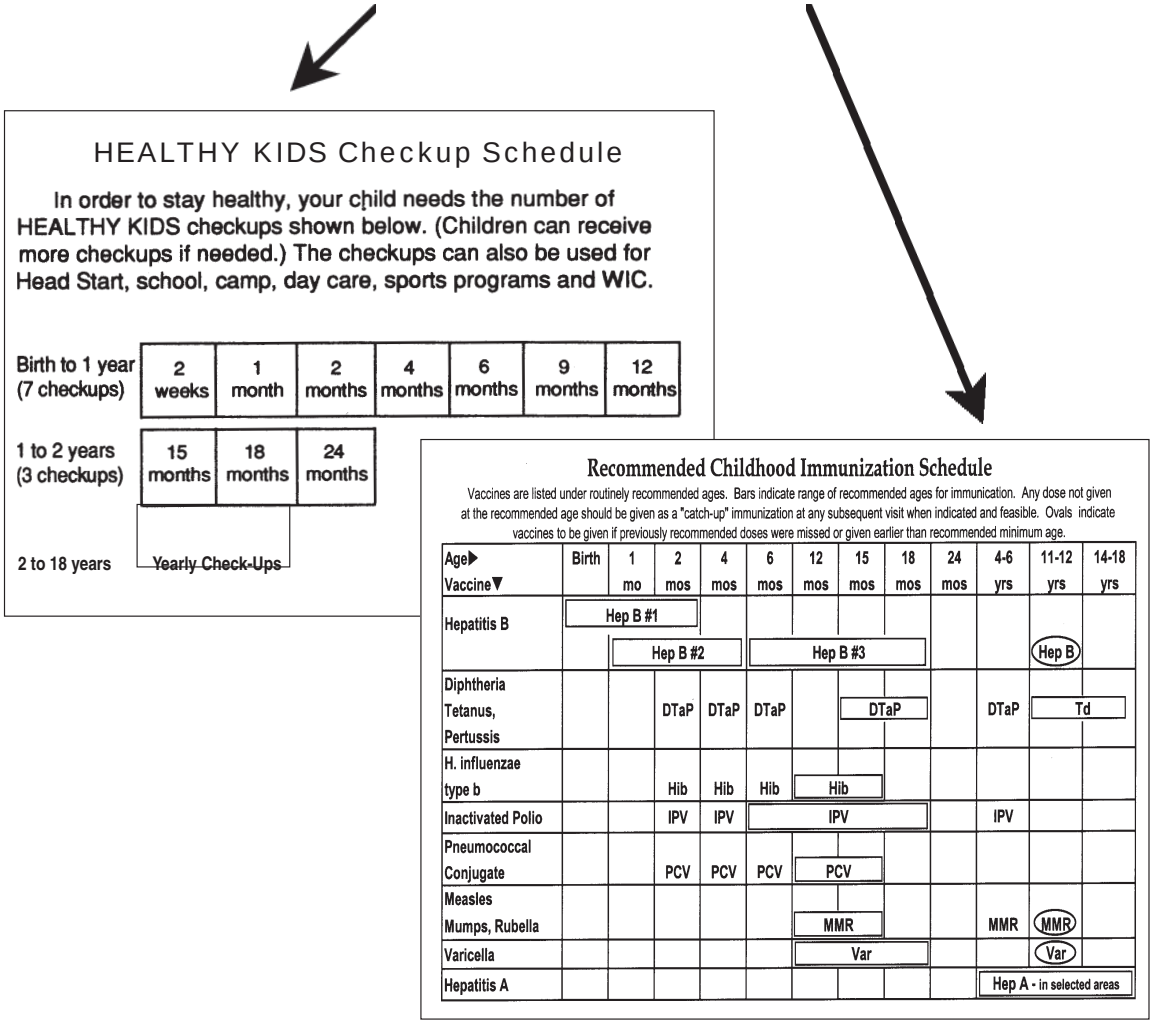
WHITE COPY: Healthworks • YELLOW COPY: Retain with Health Passport • PINK COPY: DCFS • GOLD COPY: Provider Records

Well-Child Checkup and Immunization Schedules

Responsibilities of Foster Caregivers

1. **Obtaining medical consents from caseworkers.** The child's physician and dentist must have a medical consent, signed by an authorized agent of the DCFS guardian, on file in order to treat him or her. You must obtain this consent from the child's caseworker prior to medical appointments. See page 11 for additional information.

2. **Taking children for checkups and immunizations, according to age.**



HEALTHY KIDS Checkup Schedule

In order to stay healthy, your child needs the number of HEALTHY KIDS checkups shown below. (Children can receive more checkups if needed.) The checkups can also be used for Head Start, school, camp, day care, sports programs and WIC.

Birth to 1 year (7 checkups)	2 weeks	1 month	2 months	4 months	6 months	9 months	12 months
1 to 2 years (3 checkups)	15 months	18 months	24 months				
2 to 18 years	Yearly Check-Ups						

Recommended Childhood Immunization Schedule

Vaccines are listed under routinely recommended ages. Bars indicate range of recommended ages for immunication. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than recommended minimum age.

Age▶ Vaccine▼	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	14-18 yrs
Hepatitis B	Hep B #1	Hep B #2			Hep B #3						Hep B	
Diphtheria Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Td	
H. influenzae type b			Hib	Hib	Hib	Hib						
Inactivated Polio			IPV	IPV	IPV					IPV		
Pneumococcal Conjugate			PCV	PCV	PCV	PCV						
Measles Mumps, Rubella						MMR				MMR	MMR	
Varicella						Var					Var	
Hepatitis A										Hep A - in selected areas		

3. **Making appointments with specialists or experts and taking children as soon as possible after the primary care physician's referral.** The child's HealthWorks primary care physician may refer him to a specialist to meet his individual health or medical needs. Be sure to make an appointment immediately and take the child as soon as possible. Update the caseworker on the child's health status; obtain any consents needed for additional evaluations; and request assistance from your child's caseworker, as needed.

ON-GOING HEALTH RESPONSIBILITIES

Administrative Case Review (ACR) Input

Caseworkers need to be informed about a child's medical and health needs as they occur, but a foster caregiver's firsthand review of the child's health and medical history can be very helpful at the six-month ACR.

Caregivers should always bring the Health Passport and other health records to every ACR. The caseworker will make photocopies of any new notations in the child's Health Passport to be included in the ACR file.

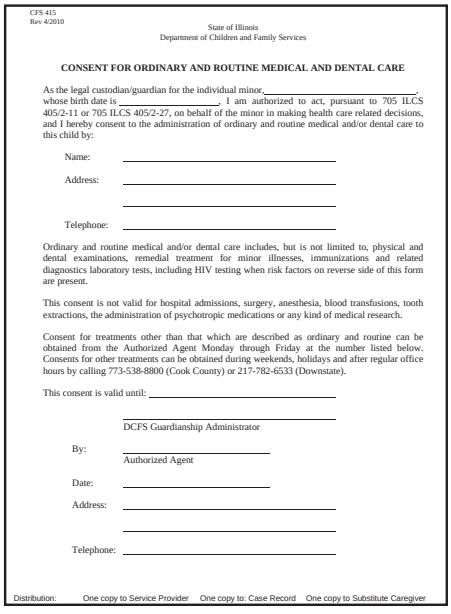
The caregiver should also discuss the child's health or medical needs with the caseworker to allow the caseworker to accurately discuss the child's health needs at the ACR.

ACRs give caregivers an opportunity to:

- report on the child's health;
- request medical or health services;
- request health-related equipment; and
- plan transportation to appointments.

Medical Consents

DCFS, as the legal guardian of children in foster care, must give consent for medical treatment. The child's physicians and dentist must have a medical consent on file, signed by an authorized agent of the DCFS guardian, in order to treat him or her. A separate consent is required for ordinary routine medical care, major medical care and psychotropic medications. Consents are time-limited and must be updated, as needed. Except in medical emergencies, consents are obtained by contacting your child's caseworker who is responsible for requesting the proper consent for the health service. It is important for the caregiver to provide the caseworker with as much advance notice as possible when requesting a new consent to allow the caseworker sufficient time to get the consent from an authorized agent of the DCFS guardian.



CFS 415
Rev 4/2010

State of Illinois
Department of Children and Family Services

CONSENT FOR ORDINARY AND ROUTINE MEDICAL AND DENTAL CARE

As the legal custodian/guardian for the individual minor,_____, whose birth date is _____, I am authorized to act, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the minor in making health care related decisions, and I hereby consent to the administration of ordinary and routine medical and/or dental care to this child by:

Name: _____

Address: _____

_____

Telephone: _____

Ordinary and routine medical and/or dental care includes, but is not limited to, physical and dental examinations, remedial treatment for minor illnesses, immunizations and related diagnostics laboratory tests, including HIV testing when risk factors on reverse side of this form are present.

This consent is not valid for hospital admissions, surgery, anesthesia, blood transfusions, tooth extractions, the administration of psychotropic medications or any kind of medical research.

Consent for treatments other than that which are described as ordinary and routine can be obtained from the Authorized Agent Monday through Friday at the number listed below. Consents for other treatments can be obtained during weekends, holidays and after regular office hours by calling 773-538-8800 (Cook County) or 217-782-6533 (Downstate).

This consent is valid until: _____

_____
DCFS Guardianship Administrator

By: _____
Authorized Agent

Date: _____

Address: _____

_____

Telephone: _____

Distribution: One copy to Service Provider One copy to: Case Record One copy to Substitute Caregiver

Medical Consent

HANDLING MEDICAL EMERGENCIES

Obviously, the hospital emergency room is no substitute for a HealthWorks primary care physician and good routine medical care. But, when a medical emergency occurs, seeking immediate emergency care is crucial to the child's health.

Guidelines for Seeking Emergency Room Treatment

Take the child's medical card and Health Passport to the emergency room.

You should:

- be able to list any medications your child is taking;
- notify your agency, according to the agency's after-hours procedure; and
- keep any paperwork given to you from the emergency room for future reference.

Tip from experienced caregivers: If you have an accident report from a pre-school, school, or following a traffic accident, take it to the emergency room to explain the injuries and avoid any suspicion or allegations of abuse.

Only an authorized agent of the DCFS guardian can consent to medical treatment. If a child has a medical emergency, the physician has the right and responsibility to treat the child without consent of the DCFS guardian. If the physician determines that the child needs care but it is not an emergency, a consent must be obtained prior to treatment. The child's caseworker must obtain this consent.

After business hours, on weekends and holidays consents for emergency medical treatment are provided to medical personnel, in Cook County, by contacting 773-538-8800, or outside of Cook, 217-782-6533.

Emergency Treatment Away from Home

Caregivers taking children out of state or the country must first obtain a signed, written consent from the child's caseworker. Take it with you when you travel.

Be sure to pack: the child's medical card; the child's Health Passport; your agency's day and after-hours phone and fax numbers; and adequate supplies of medications.

The caregiver should follow the same process outlined above in "Guidelines for Seeking Emergency Room Treatment" to obtain urgent medical consent when traveling out of state or out of the country.

HEALTH-RELATED RESPONSIBILITIES OF FOSTER CAREGIVERS

Caregivers of youth in foster care are responsible for:

- alerting the caseworker and agency *immediately* to:
  - significant medical issues
  - shanges in the child's health status
  - trips to the emergency room or hospitalization;
- ensuring each child has a medical card;
- selecting and using a HealthWorks-enrolled primary care physician for each child in their care;
- maintaining the Medication Log (CFS 534) for all prescription and nonprescription medications given to the child;
- taking each child for regular health and medical appointments, according to their age and individual needs;
- keeping each child's immunizations up-to-date;
- taking each child to any specialist, or for any special service, from a referral made by the child's primary health care physician;
- carrying out all recommendations and instructions made by the child's primary care physician and/or specialists;
- bringing the child's Health Passport to each medical visit;
- keeping each child's Health Passport and other documentation on health and medical care services provided and recommended;
- bringing copies of the Health Passport and other health records, to each Administrative Case Review (ACR) to be copied for the child's file, or make these records available to the caseworker for copying prior to the ACR; and
- sending the medical card, Health Passport and other health records with the caseworker if the child leaves your home.

Medical Supports Available for Caregivers

DCFS Nursing Staff: Each DCFS region has nurses who are directly available to DCFS and private agency caregivers and staff for consultation on children's medical issues and obtaining services. The DCFS nurse can help caregivers access needed health or specialized health care services, understand the actions of medications or interactions of multiple medications a child may be taking, find help in managing specific health conditions in the home, or advocate for in-home services or equipment needed to meet a child's specific needs. To find your DCFS nurse, call your child's caseworker or your DCFS regional office.

Routine Dental Care and Braces: DentaQuest (888-286-2447) can refer caregivers to dentists and orthodontists statewide who take the child's medical card. If a child needs braces, he or she must be referred to an orthodontist by a dentist, and both must be Medicaid providers.

Vision Screening and Obtaining Eyeglasses*:* A child's vision should be checked at the Comprehensive Health Evaluation during the first 21 days in foster care and periodically thereafter, at well-child checkups. Often schools also test vision. To find information on vision providers that accept the Medicaid card, call the AllKids hotline at 800-226-0768 and select Option 2. AllKids is a state program offering health insurance premiums based on family income and other eligibility requirements. The child's HealthWorks primary care physician will refer the child to an eye care specialist, if needed.

Medicine: Medicine prescribed by a doctor is available for children through any pharmacy registered as a Department of Healthcare and Family Services provider. Take the Illinois medical card with the doctor's prescription. The pharmacy needs the child's Illinois medical card as proof of eligibility to receive medicine paid for by the state. The pharmacy will fill the prescription and bill DHFS. Nonprescription medicine, such as aspirin or cough syrup, is not covered by the medical card. Caregivers should pay for this by using the monthly board payment they receive.

Exception: **Psychotropic medication** is prescribed for the purpose of altering mood, emotion, thought processes, or behavior. Example: Ritalin. When a physician prescribes a psychotropic medication, the caregiver must notify the child's caseworker. The caseworker is responsible for securing consent for the specific psychotropic medication. The psychotropic medication should not be administered until the consent is approved. Consents for psychotropic medications are valid for no more than 180 days.

Medical Billing Help: Caregivers should not receive bills for medical services provided by HealthWorks physicians or other Medicaid providers. If bills are sent in error, contact the child's caseworker and agency for help. Be sure to

provide them with copies of the bill, as well as any other useful documentation. Your caseworker and agency will contact the DCFS Office of Health Services, 217-557-2689, for assistance. Use of a Medicaid-enrolled provider usually eliminates billing problems.

Support from Private Agency Foster Care Programs: The foster care private agency should give foster families the agency's policy and procedure about how to report a child's emergency and ongoing health and medical needs to the caseworker and agency. Caseworkers and agencies are responsible for taking care of the health/medical needs of each child whose case they manage. Therefore, if the agency cannot find a way to meet the child's health/medical needs, the agency must ask DCFS for help in obtaining health-related equipment or services for the child.

Behavior/Mental Health Support Services

Consultation to caregivers concerning day-to-day parenting of children in DCFS care is available at all levels from a variety of professionals. The caseworker and agency can also request behavioral health services for children and families. Caregivers should expect to be full participants in the planning for, and delivery of, behavioral/mental health services both prior to placement and after placement of the child in their home.

Determining appropriate services may often begin with the use of a variety of behavioral and mental health screenings. In addition, Level of Care screenings are used to determine which services are appropriate to assist children with special needs.

On the following pages you will find descriptions of the support programs and services available to you and the children placed in your care.

Counseling

Abuse, neglect and placement in foster care can cause a child to have *adjustment problems* in various areas of his/her life. Some examples of adjustment are:

- getting along in the foster family;
- fitting in at school;
- acting inappropriately for his age; and
- getting along with family and friends.

Counseling can help a child get through adjustment problems more quickly. Counselors can provide a foster family with specific strategies to help the child work through his feelings and personal problems. Professional counselors or therapists can also separate adjustment problems from problems caused by severe emotional disturbance.

To Request Counseling

Call the child's caseworker. Private agencies are responsible for providing counseling and therapy for children and their parents. Counseling services for children placed with foster families through private agencies are either provided through subcontracts with outside community agencies, or by the private agency's own treatment staff. Counseling services for children in DCFS-supervised foster homes are provided through contracts with community agencies.

If Your Request for Counseling Services is Denied

Caregivers who disagree with the child's caseworker and supervisor about the child's need for counseling or mental health assessment should continue up the agency's chain of command until you reach the administration. A caregiver may also file a service appeal through the DCFS appeal system. (See Section 8, pages 26-29)

DCFS System of Care (SOC) Program

What is SOC?

SOC stands for System of Care. It is a community and outreach-based service system that focuses on stabilizing children whose placements are at risk due to emotional or behavioral issues.

SOC serves:

- a child in a home of relative or traditional foster care placement who needs clinically intensive services to stabilize the placement; or
- a child in a more restrictive placement who needs additional services to step down to a foster home.

System of Care (SOC) providers will work with the caseworker to help deliver and coordinate services, including:

- individualized assessments;
- 24-hour crisis intervention;
- Child & Family Team meeting facilitation and wraparound planning;
- individual and family counseling/therapy;
- placement stabilization support;
- linkage to community resources; and
- assistance in obtaining services/goods (as necessary) that will help stabilize the placement.

How do I get SOC services for my child?

- talk to the child's caseworker about your concerns and what you think you need to help keep the child with you. Any caseworker who has a child residing in a foster home can make a referral for SOC services by completing the SOC referral form and forwarding it to the local SOC agency assigned to the neighborhood in which you and the child live; and
- caregivers and caseworkers can call the CARES line at (800) 345-9049 to request immediate crisis intervention services from SOC.

How long will SOC be involved?

It is important to know that SOC does not take the place of your caseworker and is only going to be involved for as long as the placement is at risk. For some children, that might mean a month or even less - for other children it could be much longer. Each child is different and SOC will work with you and the caseworker to figure out what is best for your child.

SASS: Screening, Assessment, and Support Services

DCFS has contracts with community-based agencies statewide to provide mental health Screening, Assessment and Support Services (SASS) for children who appear to be ready to harm themselves or others. In addition to providing crisis intervention services to stabilize a child, SASS can provide counseling and case management services designed to link the child with ongoing care.

Referrals to SASS may come from:

- caregivers calling the CARES 24-hour line **(800-345-9049)**;
- the child's caseworker;
- Placement Stabilization;
- System of Care (SOC); and
- teachers.

SASS Inpatient Services for Children in Psychiatric Hospitals

If a SASS evaluation indicates that the child should be hospitalized, the child will be admitted for inpatient treatment. Caregivers should be fully involved in the treatment and discharge planning for these children. They have critical information concerning the history of problems which led to the admission of the child to the hospital. This key information must be shared with the treatment team to plan for the child's care. Additionally, it is critical that the caregivers remain involved with the child, as this generally helps the child make progress.

Input from the caregiver is also important in deciding on a discharge plan which meets both the child's and family's needs. If the child cannot return to the same family after discharge, it is important for the caregivers, SASS worker and child's caseworker to plan a meeting prior to discharge for the caregivers to say good-bye and the child to be told where he or she will go to live after leaving the hospital.

Supports Available to Facilitate Caregiver's Involvement

SASS has the primary responsibility of facilitating a caregiver's involvement while a child is in the hospital. SASS can help with transportation, child care and other support which will allow foster caregivers to participate. If you need assistance in participating while the child is in a psychiatric hospital, ask the SASS agency.

SASS can also connect you with a Family Resource Developer (FRD), which is someone who has also had a child involved in a social service system. The FRD can offer you support and encouragement, and can also help you identify resources.

Children and Youth with Sexually Problematic Behaviors

Few events cause as much concern, alarm and bewilderment as sexual misbehavior by a child. For many of us, it can sometimes be difficult to tell the difference between sexual behavior that is normal and sexual behavior that is developmentally unexpected. Behavior which is not usual or expected for the child's age or level of development requires our attention; it is usually a child's distress signal about previous sexual abuse, about the loss or separation from parents or siblings, or other difficulties that children encounter in substitute care.

Appropriate intervention and treatment are essential for children who exhibit sexual behavior problems. If untreated, a small number of children will progress to sexual behaviors which may be harmful to other children. Caregivers need to alert the child's caseworker to any unusual sexual behavior of a child in care. Caseworkers can ask for a professional assessment of the child's behavior. Getting help early can help the child and protect others living in the home. As a mandated reporter for children living in the home, caregivers are required to call the DCFS Hotline if they have reason to believe a child living with them sexually abused another child.

Normal Sexual Behavior of Children

Sexuality in Young Children

It is natural for young children (ages 0-5) to be sexual. They are curious about their bodies and what their bodies do. Small children may playfully engage in many different activities as a means of sexual exploration and learning. Some examples include interest in bathroom activities, touching their genitals, interest in seeing and touching genitals of others or playing "doctor." Very young children usually do whatever they want to do at any given time and in any particular place. Children depend on adults to guide them in their sexual behavior. Without our help, they cannot learn. Fortunately, at this age they also don't have a very long attention span. When their behavior is inappropriate, they can usually be directed to other activities without too much difficulty. Example: It would not be unusual for a 4-year-old girl to lift her dress in church to proudly show off her panties. However, most children at this age will respond to redirection of their behavior and accept the adult's explanation of their behavior being inappropriate in public.

Sexuality in Elementary School-Age Children

As children start school, they become more social. As this happens, their sexual interest increases. However, they become more shy and embarrassed about their behavior. They no longer want adults around when they are in the bathroom or getting dressed. They may touch themselves sexually, but this usually occurs in private. They become interested in looking at pictures of bodies, using sex

words and telling dirty jokes. You may even see them holding hands or "play kissing" other children. This occurs between children of the opposite sex as well as children of the same sex, and usually with friends and peers rather than strangers. Most importantly, sexual exploration is usually only one of many activities in which they are interested and they can be easily redirected.

Sexuality in Teenagers

Teenagers can engage in a wide range of sexual behaviors. Some of these activities may be playful, such as "mooning" or "streaking" their friends. Or, they may be involved in more serious sexual activities with their peers. It is not unusual for teenagers to engage in deep kissing or "petting", fondling, "dry rubbing" or "humping" behaviors, or even intercourse. While we may not like it, or think it is "right," these behaviors are not unusual for some children during adolescence. Some teenagers will also engage in sexual activity with members of the same sex. However, once again, these activities usually occur with friends in their own age group.

Usual Sexual Development Expected in Children

PRESCHOOL	LATENCY (5-10)	ADOLESCENCE & TEENS
Limited peer contact	Increased peer contact	Increased peer contact
Discovers genitals; pleasure in random self-touching	Experimentation with self-discovery evolves into masturbation	Puberty and rapid physical changes; increased sexual intensity
Interest in difference between boys and girls	Attracted to and also repulsed by opposite sex	Same-sex and opposite sex attraction
Uninhibited, interest in showing off their own body	Need for privacy; modest in bathing/dressing; secrecy w/self-touching	Playful "exhibitionism" such as "mooning" or "streaking"
Interest in bathroom activities; verbal play around elimination	Interest in sex words and dirty jokes; looks at nude pictures	Looking at sexual photographs and "soft" porn
Curious to see and touch genitals of others	Sexual game-playing; "you show me and I'll show you"	Sexual touching and experimenting with others
Play house/doctor	Kissing/holding hands w/same and opposite sex; "adult kissing"	Petting: deep-kissing, fondling, rubbing, humping
Short attention span easily redirected	Intermittent interest in sexual areas and other play	Increased focus on sexuality

Signs of Sexual Behavioral Problems

Any caregiver who observes any of the behaviors listed below, or any other type of worrisome behavior, should talk to the caseworker. These sexual behaviors may be indications of problems which need immediate attention. The child's caseworker will assist you in obtaining appropriate treatment for the behavior problems.

While you are waiting for assessment of the child's sexual behavior problem, you should provide closer supervision – especially in the bathroom and at night. This child should not be left unsupervised with other younger, smaller, or less mature children until the treatment provider approves doing so.

Classroom and digital training are both available on this topic. The PRIDE course, Module 4: The Sexual Development of Children, addresses the physical and emotional expectations as youth mature. A new course called Promoting Healthy Sexual Development helps caregivers have discussions with youth in order to prevent or delay pregnancy and reduce the risk of sexually transmitted diseases. The course descriptions and schedules are available on the DCFS Virtual Training Center website at www.DCFSTraining.org or call the DCFS Office of Training at 877-800-3393 during regular business hours.

- **A child's sexual behavior is different than the behaviors of other children in the same age group.** Example: It is not unusual to see a 3-year-old girl rubbing between her legs as she sits on the couch watching television. However, we would not expect this in a 16-year-old girl.
- **A child's sexual activity appears too advanced for his or her age.** Example: We would not expect to discover a 7-year-old engaged in anal intercourse. This behavior would be of concern to us because we would wonder how a child so young would even have knowledge of this kind of activity.
- **A child continues to engage in sexual activities in public.** In this case, the specific activity of a child may be okay, but it is behavior that should occur only in private. Example: It may not be unusual for a 17-year-old boy to masturbate, but we would not expect him to do it publicly in a shopping mall.
- **Sexual behavior occurs with other children who are not the child's friends or peers.** Children and youth usually choose other children who they know and have an on-going relationship with when they explore or engage in sexual activities. It is unusual for children to engage in sexual activities with strangers or those they do not know well.
- **A child is preoccupied with sex to the exclusion of other activities.** If sexual activities seem to be the central part of the child's life or the child appears to be "driven" to engage in sexual acts, this needs attention.

- **A child's sexual activity causes physical or emotional pain to self or others.** Example: We expect a 6-year-old may masturbate, but it is not usual to do this until he or she bleeds.

- **A child engages in sexual activity with children who are younger, smaller, less mature, or somehow more vulnerable.** We expect healthy sexual activity to be among friends or peers of the same age, size, developmental level, etc. If a child is in any position to take advantage of another child for sexual gain, this is a concern. Example: A child who is baby-sitting for another younger child may have power over the younger child because the baby-sitter is "in charge" and the younger child is expected to obey them.

- **A child's sexual behaviors continue after clear and consistent attempts by an adult to intervene or redirect the child to other activities.** If the behavior seems to be out of the child's control, or if they refuse to change their behavior, this may be a sign of a problem.

- **Expressions of anger frequently accompany a child's sexual behavior.** Children with sexual behavioral problems often learn to use sex to express their anger. Patterns of expressing anger through sex are scary and dangerous and need to be stopped.

- **A child uses tricks, games, promises, threats, or force to get another child to be sexual.** Sexually abusive children can be very clever at getting another child to cooperate with them and have sex. They will fool them into going along with them or threaten them if they try to tell anybody.

DCFS Support Program for Sexually Problematic Behavior

Most of the time, the behavior you report to the caseworker will involve children acting out sexually toward other children. When you report this behavior to the caseworker or DCFS Hotline, the caseworker or hotline staff person makes an "unusual incident" report to DCFS. If the sexual acting out constitutes a criminal act, the police will be notified. Legal action can be taken as needed and appropriate.

Criteria for Identifying a Sexual Behavior Problem

Sexual behavior problem is very simply defined: children or youth who exhibit sexual behavior that is unusual or unexpected for their age or who have acted out sexually. The term describes a broad range of behaviors including those that are and those that are not harmful to others.

Children with sexual behavior problems may exhibit "no contact" behaviors, where they have not touched anyone else, or "hands-on" behaviors like fondling another child, rubbing against them, or simulating intercourse. Without treatment, the child may progress to more problematic sexual behaviors like

tricking or bribing other children and, in rare cases, forcing them to engage in sex. Once you have reported the behavior to the child's caseworker, the child will be referred to a treatment provider specializing in children's behavior problems or disorders. The treatment provider will be able to give you detailed information about the nature of the problem, the level of supervision the child needs and the issues that will be addressed in treatment.

DCFS Policy: Safety

Within 24 hours of the report of the sexual misbehavior, the child's caseworker will conduct a review of the incident, the child's need for supervision and whether other younger, smaller, less able children in the home might be at risk. In many cases, the sexual behaviors go away after four to five months of treatment.

In order to protect all children, the department requires the following:

- the child with sexual behavior problems should not share a bedroom with other children who may be vulnerable;
- the caseworker must develop a written plan for supervision describing how the child will be supervised and who is responsible; and
- the caregiver must evaluate his or her ability to provide the child with an appropriate level of supervision.

A written plan for supervision will be completed by the caseworker within 24 hours of receiving the Unusual Incident Report, and will describe:

- how the child will be supervised during contact with other children or possibly vulnerable persons; and
- how others will be informed of the child's behavior problem, on a "need-to-know" basis, and in keeping with confidentiality requirements.

While the caseworker is responsible for developing the plan for supervision, others must also be involved: the child, if age 12 or older; the primary caregiver; the caseworker's supervisor; the DCFS sexual behavior specialist; the counselor, if the child is already receiving treatment; and others responsible for supervision of the child. Every person involved in making the plan for supervision will receive a copy of it.

Staffing: Determining Services

Within three weeks of the report to the DCFS hotline and the completion of the unusual incident report to DCFS, there will be a multidisciplinary staffing to evaluate the child's behavior and treatment needs from a developmental perspective. The department requires the participation of others who know the child, such as the caseworker, the foster caregivers and therapist, if there is one. As appropriate, children over the age of 12 may be asked to participate.

Services and Treatment

If a determination is made at the staffing that a child's behavior needs further evaluation or that the child has treatment needs, the caseworker will make the referral for clinical services as recommended at the staffing such as those provided by a psychologist or a social worker. Usually, the first step is an orientation for evaluation and treatment, which will occur within 15 days of the date of referral. This is an informal meeting, and it should include discussion with the child, the parent/s, caregivers, caseworker and anyone the child considers to be important in his life.

Treatment begins with an evaluation of the child's overall functioning. There will be tests and interviews with the child to determine treatment needed, and a plan will be developed. The goal is for the child to "successfully" complete treatment.

Most people consider treatment of the behavior problem "successful" when the child no longer exhibits the behavior.

If the Child Moves to a New Foster Family

The caseworker will give the new caregivers information about the child's sexual behavior problem. The department requires caseworkers to inform foster parents of all such problems. It also requires the caregiver to sign a new plan for supervision.

Confidentiality

The child's plan for supervision will list the adults responsible for supervising the child. These persons could include school personnel, child care providers, church staff, recreational leaders and others who have a need to know. The caseworker (not the caregiver) is responsible for informing others who need to know about the child's behavior problem and his or her need for supervision. DCFS' Guardian or designee must give signed consent for this information to be shared. Anyone who is informed of the child's behavior problem will also be informed of confidentiality requirements, including not sharing the information with anyone else without the department's consent.

If anyone responsible for the care and supervision of the child does not agree to provide appropriate supervision, other arrangements for the child will be made.

The therapist working with the child, the child's caseworker, caregivers, sexual behavior specialist and members of the multidisciplinary team will determine when the child no longer needs a written plan for supervision. In children under the age of 13, this is usually after six months have passed without an incident of sexual misbehavior. Older children or youth are more likely to have more complex behaviors and treatment needs. Removal of the plan for supervision will occur upon recommendation of the therapist and the multidisciplinary team.

Key Issues in Fostering Children of Chemically Dependent Families

The behavior of children coming into foster care is often rooted in their former environment. This is particularly true of children from chemically involved families. Here's what caregivers may see:

- lack of trust — They often have learned they cannot trust others and may not trust their own feelings and perceptions;
- attachment disorders — Many children come into foster care with no past history of healthy attachments to their caretakers;
- low self-esteem — Children may feel they are unworthy and unlovable. They often feel guilt and shame;
- role confusion — Children often feel responsible for meeting their parents' needs or develop the role of being "the family caretaker" in response to messages they receive from their parents. Many children assume responsibilities for the care of younger brothers and sisters and have responsibilities inappropriate for their age and ability. Example: A nine-year-old who becomes "mom" to her one and three-year-old brothers;
- children may assume dysfunctional roles in response to the demands of their family's system. Example: a child who becomes the "scapegoat" of all family members when they are angry; and
- chemical involvement — Because several generations in their family may be chemically dependent, children, particularly adolescents, may come into foster care involved with alcohol or other drugs.

Implications for the foster family: When a child from a chemically-involved family comes into foster care, his or her behavior may seem inappropriate to you. He or she may be confused about your expectations and may not immediately know how to be a member of your family. Talk to your caseworker immediately about getting your child the help he or she needs. Here's what your family can do to help.

Tips for Parenting Children from Chemically Dependant Families

Below are tips for parenting children from chemically dependent families.

- demonstrate to children how healthy families organize themselves. Create consistent routines. Involve the child in family activities and planning of celebrations;
- help children take more control of their own lives. Encourage them to make choices. Set reasonable limits on their behavior. Help them to develop appropriate expectations of themselves. Remember: they need time to develop these skills;

- lying is often common in chemically dependent families. Children may need help in learning it is OK to tell the truth;
- many children of substance abusers have been verbally abused. It is also highly likely they may have been neglected and physically or sexually abused. Touching of any kind may be threatening;
- children may feel they have no right to their feelings because their parents denied or minimized feelings. They may look for approval by being compulsively helpful and may need help in understanding they have value as a person; and
- expressions of strong feelings such as love may have occurred only during periods of parental substance abuse. Children, especially adolescents, may seek expressions of feelings through the use of chemicals.

Source: PRIDE Training

Caregivers should immediately notify and seek help from the caseworker if a child is suspected of being a substance abuser or if drug paraphernalia is found. Consultation and help is available at all levels for children and families. Most local school districts have access to or provide substance abuse prevention services. The caregiver should work in concert with the caseworker to access these services.

Talking With Your Children About Substance Abuse

Many youth think using drugs, alcohol and inhalants will make them happy or popular, or help them learn the skills they need when they grow up. All children need to know abusing substances can cause them to fail at all of those things and may even cause their death. If children think "everybody's doing it", they need to know they're wrong, and there is no one better to tell them than YOU.

Talking Can be Hard, But it is Important

Surveys show drug use is less among kids whose parents "warn" against it, than whose parents never discussed it. "Warning" is not yelling. Talking with youth at a level they can understand shows them you care, as well as where you stand on the issue. Many parents don't know how to bring up the subject or feel like youth know more than they do. Adolescents or teens may resist efforts to talk. Some parents think their child is too young to know about drugs. Don't hesitate— start talking!

Be Realistic

A child cannot get through childhood, adolescence, or their teen years without running into drugs. To many children in care, family drug use is "normal." Don't try to compare today's world with the one you lived in at the same age. Farm, city, or suburbs — drugs are everywhere. Children will assume that if they've tried a drug once and nothing bad happened, they will be OK the next time. Today, over half the students in high school have experimented with drugs before they finish high school. Since the drug culture of the 1960's, drug use has not only increased, but drug variety and potency has increased too.

Set a Good Example
Examine your own use of drugs and alcohol. Do you tell children not to drink and then celebrate important occasions by getting a "buzz"? Do you need prescription drugs to "relax"? Children know what's going on. It is important to practice what you preach.

Know the Facts
Educate yourself about drugs. PRIDE Training Module 10, available to all caregivers, covers substance abuse and fostering children from chemically dependent families. Information about drugs and alcohol is available at your local library or health department and through the Internet.

Plan What to Say and Where to Say It
Look for a calm time, like riding in the car, where you can both talk without being interrupted. Know exactly how you feel. Make sure other adults living in your home feel the same way, so children won't receive "mixed" messages. Review ahead what you want to say. Don't wait for the crisis — start talking NOW!

When the Talking Time Comes
Don't lecture. Let your child talk, too. Listen. Be respectful of her right to talk and have an opinion**.**

Clarify family rules about substance abuse. If you don't know the answer to a question, say so. Suggest that you both find the answer together. Discuss situations in which your child may be pressured to use drugs or alcohol and how to say "No"! Keep the conversation going from childhood to adulthood. Keeping communication lines open and taking time to talk whenever possible will help your child in making choices when you aren't there.

Warning Signs of Substance Abuse

- changes in mood or behavior — depression, anxiety, being irritable, withdrawing from family, school or social activities, spending increased time alone, impulsiveness;
- changes in friends — no longer associates with friends and is reluctant to bring friends home, or to have you meet them;
- changes in school behavior — cuts classes, gets lower grades, loses interest in school or extracurricular activities; and
- injuries — falls, bruises, accidents. Any unexplained injury (unlike a sports related injury) is a serious warning.

Drug Paraphernalia
Products designed for use with controlled substances, "paraphernalia," are legally sold in various types of stores that youth may frequent. A few examples are: rolling papers, roach clips, stash cans, bongs, frisbees with attached pot pipes and cocaine spoons.

Every day items may also be associated with drug use. The following items are used with the corresponding drugs and may be found in closets, under beds, in the hem of curtains and in various hiding places:

- marijuana: rolling papers, plastic baggies, stash cans, pipes, bongs, roach clips;
- PCP: tin foil;
- inhalants: cleaning rags, empty spray cans, tubes of glue, soft drink cans, ping pong balls;
- Codeine: Cough syrup bottles, needles, syringes;
- heroin and morphine: needles, syringes, cotton balls, teaspoons, medicine droppers;
- cocaine: glassy surfaces, mirrors, single-edged razor blades, rolled-up paper tubes, straws, nasal sprays; and
- crack: pipes, small glass vials, colored stoppers, pyrex tubes, small screens.

For parents who suspect a child is using drugs, finding any of these items may be cause for alarm. If found, it is time to frankly discuss drug use with the youth and also to seek professional help.

Substance Abuse Support Organizations

Federal Substance Abuse and Mental Health Services Administration
P.O. Box 2345
Rockville, MD 20847-2345
301-468-2600 or 800-729-6686
www.health.org

Alanon/Alateen
Family Group Headquarters, Inc.
800-356-9996 (literature)
800-344-2666 (meeting referral)
www.al-anon.alateen.org

National Council on Alcoholism and Drug Dependence
800-NCA-CALL (referral to local treatment)

National Inhalant Prevention Coalition
800-269-4237
www.inhalants.org

Inhalant Abuse: "Huffing"

Inhalent abuse or "huffing" can kill suddenly, and it can kill those who sniff for the first time. Every year, young people in this country die of inhalant abuse. Hundreds also suffer severe consequences, including permanent brain damage, loss of muscle control and destruction of the heart, blood, kidney, liver and bone marrow. Today, more than 1,000 different products are commonly abused. One in five American teenagers have used inhalants to get high, according to a 1996 report from the National Institute on Drug Abuse. Many youngsters say they began sniffing when they were in grade school. They start because they feel these substances can't hurt them, because of peer pressure, or because of low self-esteem. Once hooked, these victims find it a tough habit to break. These questions and answers will help you identify inhalant abuse and understand what you can do to prevent or stop this problem.

"Huffing" is the deliberate inhalation or sniffing of common products found in homes and schools to obtain a "high", such as:

- glues/adhesives;
- nail polish remover;
- marking pens;
- paint thinner;
- spray paint;
- butane lighter fluid;
- gasoline;
- propane gas;
- typewriter correction fluid;
- household cleaners;
- cooking sprays;
- deodorants;
- fabric protectors;
- whipping cream aerosols; and
- air conditioning coolants.

How can you tell if a young person is an inhalant abuser?

- unusual breath odor or chemical odor on clothing;
- slurred or disoriented speech;
- drunk, dazed, or dizzy appearance;
- signs of paint or other products where they wouldn't normally be, such as on the face or fingers;
- red or runny eyes or nose;
- spots and/or sores around the mouth;
- nausea and/or loss of appetite; and
- chronic inhalant abusers may exhibit such symptoms as anxiety, excitability, irritability, or restlessness.

What could be other tell-tale behaviors of inhalant abuse?

- sitting with a pen or marker near nose;
- constantly smelling clothing sleeves;
- showing paint or stain marks on the face, fingers, or clothing; and
- hiding rags, clothes, or empty containers of the potentially abused products in closets and other places.

Caring for Youth With HIV/AIDS

AIDS stands for "acquired immune deficiency syndrome." It is caused by a virus called the "human immunodeficiency virus" (HIV). HIV is a communicable infectious disease, but it *is not* easily transmitted. Transmission requires the exchange of infectious bodily fluids during some intimate or invasive activity. Only certain body fluids and activities have been identified as modes of transmission for HIV.

Youth with HIV may present caregivers with new challenges in following treatment recommendations and reducing the behavioral risks of transmitting the disease to others. The DCFS AIDS Project and treatment providers may provide assistance in managing these issues.

Most children with HIV disease can survive in reasonably good health for many years. Unpredictable and serious problems can occur in the course of daily living, but foster families need not feel alone in addressing these issues. The DCFS AIDS Project and other community programs offer support to families fostering children with HIV.

DCFS AIDS Project: 312-328-2150

The AIDS Project is a statewide specialty service in the DCFS Division of Clinical Practice and Development. Their services include:

- providing consultation about HIV testing, risk reduction, treatment, resources, and policies;
- assisting with placement of HIV-exposed and infected children;
- providing training and on-going consultation about HIV medical, psychosocial, and policy issues; and
- facilitating support services to birth and foster families affected by HIV.

HIV Transmission Sources

Infectious

- blood and blood products
- semen
- vaginal fluids
- breast milk
- pericardial fluid

Possibly Infectious

- cerebrospinal fluid
- synovial fluid
- pleural fluid
- peritoneal fluid
- amniotic fluid

Non-Infectious

- saliva
- tears
- perspiration
- urine
- feces
- sputum
- nasal secretions
- vomitus

Routes of HIV Transmission

- sexual intercourse;
- anal, vaginal, or oral (fellatio and cunnilingus) sex;
- exposure to blood;
- transfusion of blood or blood products;
- sharing intravenous needles, syringes or "works;"
- occupational needle stick or mucous membrane exposure;
- perinatal; and
- from mother to child during pregnancy, intrapartum, and postpartum (via breastfeeding).

HIV is <u>Not</u> Transmitted Through

- casual contact;
- coughing or sneezing;
- eating or sharing food;
- touching or shaking hands;
- hugging or kissing;
- insect bites;
- donating blood;
- swimming or bathing;
- sharing clothing or towels; or
- sharing bathroom facilities.

Make sure you and your children understand that HIV cannot be spread through casual contact with someone who has AIDS or is HIV infected. Fear and wrong information about HIV and AIDS have caused much suffering to those who have been infected with HIV, especially children.

What to Teach Children About HIV/AIDS

Children need to learn about HIV and AIDS at a very early age. By the time your children are 3 or 4 years old, make sure you have clearly explained the following:

- cover cuts and sores with bandages or gauze pads to avoid contact with any kind of germs.
- never touch needles or syringes. If they see someone who is bleeding or if they find a needle or syringe, they should tell an adult. Remind your children never to touch a needle or syringe if they find one in the garbage or on the ground; and
- AIDS cannot be caught by playing with HIV-infected children.

By grade-school age, your child should begin to have a better understanding of illness and body parts. He or she should begin to learn more about how HIV can and cannot be spread.

Sex

Adolescents and teens need to know that the best way to protect themselves against HIV and AIDS is not to have any type of sexual intercourse. Reassure the

child that it is all right to postpone sexual intercourse until he or she is married or in a long-term, mature relationship. If adolescents or teens do not postpone having sexual intercourse, then regular and proper use of *latex* condoms and limiting the relationship to one partner will help them avoid HIV infection. This will also lower the risk of getting other sexually transmitted diseases (STDs) such as syphilis, gonorrhea, chlamydia infection and genital warts. Adolescents should also know about other types of birth control. However, it should be emphasized that other forms of birth control do NOT prevent HIV infection or other STDs.

Drugs

Adolescents need to know about the extreme risk of being infected with HIV if they use drugs, especially intravenous (IV) drugs that are injected with needles. Sharing a needle or syringe spreads blood from one person to another. A non-drug user who has sexual intercourse with an HIV-infected drug user can be infected with HIV. Sharing needles for non-drug use, such as for tattoos, ear piercing, purposely scarring or cutting oneself with needles or razors, or injecting drugs including steroids, can also spread HIV.

Talk to your adolescent about drugs to make sure he or she understands that using any drugs, including alcohol, is not healthy. The risk of getting HIV increases even when non-IV drugs, like alcohol or cocaine, are used because these drugs affect a person's judgment and may lead to risky behaviors — such as having sexual intercourse without a latex condom or having sex with multiple partners.

Testing for HIV: These factors apply to all children and youth

DCFS Policy

Testing a child in foster care requires the consent of a parent or the DCFS Guardian. The Guardian's consent may be obtained through DCFS' authorized agents. DCFS must have temporary custody or guardianship to authorize testing.

The DCFS AIDS Project should be informed if any child/youth tests HIV positive in order to be linked with a qualified specialist and to provide training, consultation and resources for the family.

HIV testing should be encouraged as a matter of routine health care when any of the following risk factors are present:

- a child with HIV-related symptoms;
- a child born to a parent with HIV;
- a child born to a parent with a history of drug use, transfusions, or multiple sexual partners;
- a child who is sexually abused;
- a child born with positive drug toxicology;

- a child with hemophilia or a history of blood transfusions;
- a youth with a history of drug use;
- a youth who is sexually active; and
- a child for whom a complete medical history cannot be obtained.

Child's Right to Consent
Any child over age 12 may consent to testing. Pre- and post-test counseling should be provided. Treatment requires the consent of the guardian or authorized agent.

Physician's Right to Test
A physician may test a patient *without consent* in order to provide appropriate diagnosis and treatment. The physician should, however, provide counseling and inform the guardian.

Symptoms Suggesting Testing May Be Needed
Talk to the child's HealthWorks primary care physician and the caseworker if your preteen or teen is or may be using drugs or alcohol, or is or may be involved in risky sexual behaviors. He or she may be at higher risk of HIV infection.

Symptoms suggesting a need for HIV testing include:

- persistent fevers;
- poor weight gain or rapid weight loss;
- frequent diarrhea;
- recurring or unusual infections;
- chronic lymph node swelling;
- persistent or recurring extreme tiredness or lethargy;
- white spots in the mouth; and
- loss of appetite.

Caregivers may also get confidential information and advice from the DCFS AIDS Project (See page 34) about working with any child/youth who may be at risk of HIV and AIDS.

Caregivers Have a Need to Know About HIV Test Results
If DCFS knows of a child's exposure to HIV or HIV infection, the DCFS AIDS Project should be notified immediately. Additionally, the caseworker should tell the caregiver about the child's status *prior to placement* in order to prepare the family to make an informed decision about taking care of the child.

The realities of foster care are that sometimes, initially, the history is unknown until after the child is placed into the foster home. In this case, foster families may be notified of the child's HIV status after the fact. In either case, the AIDS Project would provide training and on-going support services about HIV issues.

Babies Under 18 Months Old

Caregivers taking a baby under 18 months old should ask the caseworker if the baby has been tested for HIV. Children under 18 months who are known to have been exposed to HIV are followed by a qualified HIV clinic for further diagnosis and treatment. The AIDS Project will help make this linkage.

Studies have shown that the majority of children exposed to HIV in their mother's womb, or at the time of birth, have not contracted the HIV virus. New protocols for delivering and treating the baby and the mother have reduced the national perinatal infection rate from 25 percent to just 2 percent. Many babies who initially test positive in infancy lose their mother's antibodies and will test negative by 18 months because they are not infected.

Adolescents

More of the infected children in foster care will be of adolescent age. Youth 12 and older should be included in the decision to test for HIV according to the risk factors. Youth 12 and older should also be consulted about any disclosure of their HIV status and consent should be sought for the release of information.

Confidentiality of HIV Status

The Illinois Human Rights Act protects persons infected with HIV as "handicapped" individuals who have the right to equal access and opportunity without discrimination. Confidentiality of information surrounding an adult or child's status is written in the AIDS Confidentiality Act and in DCFS rules and procedures.

When HIV status is released to caregivers, or others who "need to know", these individuals are expected to **keep this information confidential**. *They may not redisclose this information to others without permission of the parent or the DCFS Guardian. For youth 12 years of age and older, they must be asked to give consent.*

Who "needs to know" about HIV status?

Release of information about the HIV status of a child in foster care is based on the person's "need to know." Those with a need to know include: birth parents, guardian, **caregivers**, relative caretakers, directors of child care facilities, staff who provide direct personal care, medical providers of direct personal care, other persons who need to know in order to provide services.

DCFS Policy: Disclosing HIV Status

DCFS is not authorized to release the HIV status of persons for whom DCFS is not legally responsible, including parents. Parents are responsible for informing service providers of their family's HIV status, or they may sign consents for DCFS to release this information.

If a child is known to have been exposed to the HIV virus or tested HIV positive, the caseworker or agency must inform the child's caregivers.

If a teacher, caretaker, or someone else may need to know about the child's HIV status, consult with the caseworker or DCFS AIDS Project. Caregivers should NOT communicate this information themselves, but should ask the caseworker to communicate what needs to be known. The Illinois Department of Healthcare and Family Services informs the school superintendent, who may inform the principal, teacher and school nurse, if necessary. If the court needs to be informed, the information should be shared by attorneys or caseworkers privately with a judge, in chambers.

HIV status should not be written where it can be seen by people who do not have a need to know. The dates of HIV testing may be written on the child's Health Passport. However, the results of HIV testing must be kept in a separate and confidential section of any case record. Disclosure of positive HIV information requires the consent of the DCFS Guardian and youth 12 years of age and older.

Special Health Considerations

In a foster home setting, the only potential mode of HIV transmission is infected blood or semen penetrating beneath the skin into the body tissues.

Three universal precautions to be used by the whole family are:

1) use a cloth barrier or wear gloves when caring for bleeding wounds, nosebleeds, bloody diarrhea and diaper changes;
2) clean surfaces exposed to blood with a bleach solution (ratio of 1 cup of bleach to 1 gallon of water); and
3) consistently wash hands (and teach children to wash hands) with soap and warm water.

Children in the home should not share teething toys, feeding bottles or toothbrushes, as some bleeding may occur from the gums at the time the child is teething or losing baby teeth.

Adults and youth should not share razors or syringes.

Biting and other aggressive behavior on the part of all children should be discouraged, but it has not been known to lead to HIV infection.

All foster families should use these universal precautions as a matter of good hygiene. Please see the following section for more information on disease prevention.

Other Communicable and Infectious Diseases

How Do Germs Spread?

Everyone can be exposed to germs that can make them ill. Each of us can also spread germs that have the potential to make others ill. This exposure can occur anywhere, for example, in the home, school and public places.

We don't see germs. Germs can be spread from the skin of one person directly to another, usually through touching. Germs can also be spread to you by touching an object with germs already on it (example: a bathroom faucet, doorknob, tabletop) and then touching your eyes, nose, or mouth. Other examples include but are not limited to:

- hands of one person touch a germ-infected area on another person or a germ-infected object, and then touch other people without washing their hands; and
- shared items in the home, such as telephones or toys, are germ-infected then touched by other people who then touch their own eyes, nose or mouth.

Some germs can be spread through the air and may be breathed in. These germs can survive in the air for some time and travel far from the infected person. Tuberculosis, measles and chicken pox are spread this way.

When someone coughs or sneezes, for example, germs are sent into the air in droplets. Colds, flu, pertussis (whooping cough), and most forms of bacterial meningitis are diseases spread by droplets. Germs for hepatitis B, hepatitis C, and HIV/AIDS are spread through contact with human blood, body fluids (example: urine), or body substances (example: feces and saliva). Germs for West Nile virus and Lyme Disease are spread by insect bites.

The Illinois Department of Public Health has prepared a series of short informational documents, called ***Health Beat Fact Sheets***, that explain more about the diseases mentioned in this section. The ***Health Beat Fact Sheets*** are available on the Internet at http://www.idph.state.il.us/public/hbhome1.htm.

Reducing the Spread of Germs

There is no perfect way of preventing the spread of germs. However, universal precautions, cleaning/disinfecting and frequent hand washing are effective in stopping the spread of most germs. Universal Precautions is an approach to infection control that involves the use of disposable gloves or other items to block the spread of germs when cleaning up or touching blood, body fluids or body substances. HIV/AIDS, hepatitis B, hepatitis C and other blood-borne illnesses can be spread through blood, body fluids or body substances.

Caregivers should know about Universal Precautions and other ways to reduce the spread of germs so that they can protect their family's health. If precautions such as the ones listed below are regularly followed, caregivers and their families can reduce the chance of being infected or spreading germs.

1) The Illinois Department of Public Health recommends frequent hand washing with soap and water for at least 20 seconds. Hand washing should always occur before and after food preparation and eating, and after toileting. The scrubbing action will remove most germs from your hands. Liquid soap is considered more hygienic than bar soap. Liquid hand sanitizers (e.g., those containing alcohol) and disinfecting wipes kill most germs and can be handy when soap and water are not available.

2) Children need to be taught to wash their hands. When supervising a child, help or encourage the child to wash his or her hands. Adults caring for very young children should also wash hands before and after diaper changing, and after helping young children who are potty training.

3) After thorough cleaning with soap and water, cover open cuts and injuries with bandages.

4) In the home, shared items such as a phone or keyboard should be disinfected.

5) Wash toys, stuffed animals, blankets and things children put in their mouths with soap and water. Toys that children (particularly infants and toddlers) put in their mouths should be washed and sanitized between uses by individual children. Toys for infants and children should be chosen with this in mind. If you can't wash a toy, it probably is not appropriate for an infant or toddler. When an infant or toddler finishes playing with a toy that has been placed in their mouth, the toy should be removed from the play area and put aside for washing and sanitizing before reuse by other children.

   To prepare a bleach sanitizing solution, mix one tablespoon of bleach with one gallon of water (or ½ tablespoon of bleach with ½ gallon of water). Use within 24 hours.

   To wash and sanitize a hard plastic toy:

   - scrub toy in warm, soapy water;
   - rinse toy in clean water;
   - immerse toy in bleach sanitizing solution and allow it to soak for ten minutes. If the toy cannot be immersed, spray with bleach sanitizing solution ensuring that all surfaces are dampened for ten minutes contact time;

- remove toy from bleach sanitizing solution and rinse well with cool water. Use cool water to rinse non-immersed, sanitized toys; and
- air dry on a clean surface.

6) Items such as teething toys, feeding bottles, toothbrushes, razors or syringes should not be shared.

7) Eating, drinking, applying cosmetics, and handling contact lenses should only be done with clean hands and in clean places.

8) Clean surface areas and clothing that have been exposed to blood or body fluid with a mild bleach solution (1 part bleach to 9 parts water). This solution should be freshly prepared, as it will lose its germ-killing power if stored. (See instructions below) Wash hands after the clean-up.

9) All contaminated sharps (e.g., needles) should be placed in a "sharps container" or a heavy plastic bottle or jar for disposal.

10) Use disposable gloves when it is necessary to have direct contact with any blood, body fluids, or body substances. Place the used gloves in tightly sealed bags and dispose of properly. Always wash hands after removing gloves.

11) When disposable gloves are not available, other items can serve as a protective barrier between hands and unknown or questionable blood, body fluids and body substances (examples: plastic grocery, garbage or storage bags, disposable diapers, etc.) Double bag all objects used to touch or clean-up and tightly seal the bags. Wash hands after the clean-up.

12) Mouth-to-mouth resuscitation without current, appropriate training and a CPR Micro Shield (mouth shield used for mouth-to-mouth resuscitation) is discouraged.

In addition to the precautions listed above, caregivers should follow the advice of health care professionals when extra precautions are needed.

Practical tips for germ protection:

- Mosquitoes can spread West Nile virus. Use insect repellant to prevent mosquito bites.

- Ticks can spread Lyme disease. Use insect repellant to reduce tick bites. Check children for ticks after spending time outdoors.

- Remember to reapply insect repellent as needed. Swimming and perspiration can cause repellant to wear off.

- Always use tissues when coughing and sneezing, and dispose of properly. Wash hands afterwards.

- One way to help children wash their hands thoroughly is to have them sing "Happy Birthday" while hand washing.

- Germs easily collect under long fingernails and in long hair. To avoid this:
  - keep fingernails trimmed short or use a nailbrush to clean under them; and
  - wear long hair in a ponytail or bun when cleaning or working with blood or body fluids.

- Avoid touching eyes, nose, mouth, other items, or surfaces with contaminated hands (gloved or ungloved).

Procedure for making and using bleach disinfecting solution:

1. Assemble necessary supplies: water, bleach, spray bottle, disposable protective gloves, paper towels, and two plastic garbage bags.

2. Prepare a bleach disinfecting solution by mixing one-part bleach with nine-parts water in spray bottle. Be careful not to spill solution on your skin.

3. Put on gloves before using the bleach disinfecting solution.

4. Wipe up the spill using paper towels. Use sufficient paper towels to soak up the spill and to ensure gloves do not become visibly soiled. Discard the paper towels in a plastic garbage bag. If gloves become visibly soiled, carefully remove and discard them in a plastic bag (see instructions below) taking care that hands do not become visibly soiled. After removing gloves, immediately wash hands with soap and water for 20 seconds, dry hands and put on a clean pair of gloves. Gloves that are not visibly dirty or bloody do not need to be changed.

5. Clean the surface by spraying it with bleach disinfecting solution and wiping it with paper towels. Repeat until the surface is free of dirt or blood. Place paper towels in a plastic garbage bag.

6. Disinfect the surface by re-spraying it with bleach disinfecting solution. The surface should be sufficiently moist to allow 10 minutes of contact time. Allow the surface to air dry.

7. While the surface is drying, safely remove gloves and place them in a plastic bag (see instructions below). Double bag and then secure the second bag before placing it in a trash container.

8. Immediately wash hands with soap and water for 20 seconds.

Procedure for safe removal of protective gloves:

1. Always consider the outside surface of gloves to have germs.
2. Grasp the outside of glove with opposite gloved hand; peel off.
3. Hold removed glove in the gloved hand.
4. Slide fingers of the ungloved hand under remaining glove at wrist.
5. Peel the glove off over first glove.
6. Discard both gloves in a plastic bag. Double bag and then secure the second bag before placing it in a trash container.
7. Immediately wash hands with soap and water for 20 seconds.

Role of Illinois Department of Public Health

IDPH has authority to require quarantine or isolation of persons who have been exposed to or diagnosed with certain dangerously communicable diseases (e.g., tuberculosis, Severe Acute Respiratory Syndrome (SARS), pandemic influenza) when those persons pose a serious public health risk. IDPH does not have rules governing head lice, scabies, ringworm or impetigo. There are Health Beat Fact Sheets about these conditions available at http://www.idph.state.il.us/public/hbhome1.htm.

To find a local health department recognized by IDPH in your county/vicinity, go to this website: http://www.idph.state.il.us/local/alpha.htm. For counties that do not have a health department recognized by IDPH, contact IDPH Division of Infectious Diseases at 217-782-2016.The local Public Health office may be contacted for additional information if needed.

Resources:

- **For all medical emergencies, call 9-1-1**
- **Health Beat Fact Sheets** (IDPH): http://www.idph.state.il.us/public/hbhome1.htm
- **Communicable Disease Guide** (2002), Illinois Department of Public Health http://www.idph.state.il.us/health/infect/comm_disease_guide.pdf
- **Management of Chronic / Infectious Diseases in School Children** (2003), Illinois State Board of Education and Illinois Department of Public Health http://www.idph.state.il.us/health/infect/chronicinfectiousdiseases2003.pdf
- **Reportable Infectious Diseases and Conditions in Illinois** (IDPH) http://www.idph.state.il.us/health/infect/reportdis.htm
- **Local Health Department Alphabetical Listing (these are the local health departments recognized by IDPH)**: http://www.idph.state.il.us/local/alpha.htm. In areas without a health department recognized by IDPH, contact IDPH Division of Infectious Diseases at 217-782-2016.