



Bridge Resource Family Handbook

Strengthening
Families

Helping Children
Stay Connected



Oklahoma Department of Human Services
Child Welfare Services

Bridge Resource Family Handbook

Strengthening Families

**Helping Children
Stay Connected**

Acknowledgements

Portions adapted with permission from the Oklahoma State
Department of Health Good Health Handbook.

Portions adapted with permission from the Illinois Department of
Children and Family Services Foster Family Handbook.

**If you would like a copy of this guidebook on a CD, contact
the Bridge Family Resource Center at 1-800-376-9729**

Copies are available for download at www.okbridgefamilies.com.

Table of Contents

Section 1.....Welcome

Welcome to the Oklahoma Department of Human Services.....	1-1
Bridge Resource Family	1-1
DHS Practice Standards and Bridge Resource Family Guiding Principles	1-2
DHS Policy	1-5
DHS Organization	1-6
DHS Organizational Chart.....	1-8
DHS Regional Map	1-9
DHS Directory – County Offices.....	1-10

Section 2.....Trauma-Informed System

What is Trauma?.....	2-2
Resilience in Children	2-3
Trauma-Focused Treatment.....	2-4
Medication.....	2-5
Trauma-Informed Resources	2-5
Self-Care – Caregivers Also Need Care.....	2-6

Section 3.....Rights and Responsibilities

Resource Parents’ Rights.....	3-1
Resource Family Inquiries and Requirements	3-3
Resource Parents’ Roles and Responsibilities	3-5
Resource Specialists’ Roles and Responsibilities	3-8
Parental Substitute Authority.....	3-10
Discipline	3-10
Religious and Cultural Observations.....	3-14

Confidentiality.....	3-14
Child Welfare Investigations	3-16
Fair Hearings.....	3-19
Written Plan of Compliance	3-19

Section 4..... Out-of-Home Care – Bridge Resource Parent

Children’s Rights.....	4-1
The Sibling Bond.....	4-2
Visitation	4-5
Frequently Asked Placement Questions	4-8
Considering a Placement.....	4-9
When a Child is Placed.....	4-10
Protecting and Nurturing Children	4-11
Ways to Integrate a Child into the Resource Home	4-12
Building a Relationship with the Child.....	4-12
Travel and Vacations.....	4-13
Life Books	4-13
When a Child Leaves	4-14

Section 5..... Teamwork

Members of the Team	5-1
Family Team Meeting.....	5-4
Initial Meeting	5-5
Reassessment	5-5

Section 6..... Bridge Kinship Resources

Family Assessment.....	6-1
Pre-Service Training	6-1

Contract	6-2
Kinship and Temporary Assistance for Needy Families	6-2
Child Care	6-2
Discipline in Kinship Resources	6-2
Kinship Training Stipend.....	6-2
Kinship Start-Up Stipend.....	6-3
What You Need to Know About Becoming a Bridge Kinship Resource	6-3
Section 7.....	Financial Assistance
Maintenance Payment.....	7-1
Claims.....	7-1
Difficulty of Care	7-2
Social Security Survivors' Benefits and Supplemental Security Income Benefits	7-4
Section 8.....	Resource Family Training
Pre-Service Training	8-1
Expiration of Pre-Service Training	8-1
In-Service Training.....	8-1
Books and Video Training.....	8-1
Online Training	8-1
Foster Parent College	8-1
The Learning Management System.....	8-2
Other Training Opportunities.....	8-3
Section 9.....	Grievance Procedures/Legal
Child's Grievance.....	9-1
Resource Parent's Grievance.....	9-1
Foster Care Mediation	9-2
Bridge Resource Parent Complaints.....	9-2

Reporting Suspected Abuse or Neglect	9-3
Legal Liability of Resource Parents.....	9-3
Civil Law	9-3
Criminal Law	9-3
Child Passenger Restraint Law	9-4
Section 10.....	Support Services
Child Care	10-1
Informal Arrangements or Babysitting.....	10-1
Alternate Caregiver	10-2
Respite	10-2
Resource Parent Liability Insurance.....	10-3
Foster Parent Association and Support Groups	10-3
Section 11.....	Juvenile Court
Abuse and Neglect Referral Process.....	11-1
Juvenile Court Process	11-2
Emergency Custody Hearing.....	11-2
Adjudicatory Hearing	11-2
Dispositional Hearing.....	11-2
Review Hearing.....	11-2
Permanency Hearing.....	11-2
Resource Parent Participation	11-3
Permanency Planning Report.....	11-3
Notice of Removal	11-3
Termination of Parental Rights	11-3
Adoption and Safe Families Act.....	11-4
Multi-Ethnic Placement Act of 1994	11-4

Section 12..... Indian Child Welfare

About IWCA12-1

Section 13.....Education

Enrollment13-1

Confidentiality.....13-1

Special Education Services13-1

Rights of Children with Disabilities13-2

Evaluation.....13-2

Individualized Education Program13-3

Home School.....13-3

SoonerStart.....13-4

Section 14..... Health Care

SoonerCare14-1

Child Health Check-Up14-2

Records.....14-3

Psychotropic Medications.....14-3

Medical Consent14-3

Medical Emergencies14-4

Financial Responsibility14-4

Transportation.....14-5

Health-Related Responsibilities14-6

Universal Precautions.....14-6

Proper Handwashing Procedures.....14-7

HIV14-8

Resources.....14-8

Signs of Illness14-8

Taking a Child’s Temperature.....	14-10
Immunization Requirements	14-11
Vaccine-Preventable Diseases	14-12
First Aid Kit.....	14-14
Medical Library.....	14-15
First Aid for Poisoning.....	14-24
Nutrition – Healthy Eating Tips	14-26
Fitness.....	14-29
Oral Health Care	14-31
Section 15.....	Child Development
Discovering Your Child’s Developmental Needs	15-1
Developmental Checklists Birth to 18.....	15-1
Self-Esteem	15-17
Separation and Loss.....	15-18
Section 16.....	Behavioral Health
Common Reactions to Placement	16-1
Stages of Grief.....	16-2
Tips to Help Decode a Child’s Behavior	16-4
Biting in the Toddler Years.....	16-5
Toilet Learning	16-7
Sexual Behavior of Children.....	16-8
Caring for Children from Chemically Dependent Families	16-11
Talking About Substance Abuse.....	16-12
Runaway or Abducted Children.....	16-16
Section 17.....	Parenting Pregnant Youth
Specialized Services	17-1

Involvement of Legal Parents and Father.....17-1

Counseling17-1

Parenting the Child17-1

Rights of Pregnant and/or Parenting Youth.....17-2

Section 18..... Independent Living Program

DHS Independent Living Program.....18-1

Independent Living: A Brief History.....18-1

Independent Living Philosophy.....18-2

Living Service Matrix.....18-3

Assessment and Service Planning18-5

Educational Opportunities.....18-5

Youth Development Funds18-7

Independent Living Youth Contingency Funds18-7

Incentive Payments.....18-7

“Yes I Can” Alumni Network.....18-8

The University of Oklahoma National Resource Center for Youth Services18-8

Things You Can Do to Help Youth Prepare for Independent Living18-9

Section 19..... Oklahoma Post-Adoption Services Program

Determination of Special Needs.....19-1

Funding Sources19-2

Adoption Assistance Benefits19-3

 Duration of Benefits19-4

 Application and Amount of Adoption Assistance.....19-5

Frequently Asked Questions19-5

Resource Family Information Chart.....19-7

Reuniting Families19-9

Confidential Intermediary Search Program.....19-10

Section 20.....Resources

Foster Parent Resources.....20-1

Oklahoma Tribes20-1

General Resources.....20-1

Health and Development20-2

Child Care 20-2

Education 20-3

Tax Deduction 20-3

Support Services.....20-3



Section 1. Welcome

**Welcome to the Oklahoma Department of
Human Services
Bridge Resource Family
DHS Practice Standards and
Bridge Resource Family Guiding Principles
DHS Policy
DHS Organization
DHS Organizational Chart
DHS Regional Map
DHS Directory – County Offices**



Welcome to the Department of Human Services

Welcome to the Oklahoma Department of Human Services (DHS) Foster Care Program. Thank you so much for committing to making a difference in a child's life. You are vital to our work with families in crisis.

Foster family care means an essential temporary Child Welfare (CW) service for a child and parents, legal guardian, or custodian when the child's safety cannot be ensured in his or her own home due to the risk of child abuse, neglect or special circumstances necessitating out-of-home care on a temporary basis in a home away from the child's parents, legal guardian or custodian.

The feelings of loss and disconnection families experience as a result of being separated can remain with children and parents forever. Foster family care services are aimed at turning the losses into gains and maintaining essential connections for children and families, thereby making the connections stronger than before. When this cannot safely be accomplished, identifying an alternate permanent plan for each child's care is needed.

You need to be prepared for the changes a child placed in your home will make in your daily lives, and we hope this handbook will be a helpful guide in your foster parent journey. Updates will be sent as needed.

DHS Child Welfare Services is taking a close look at how we work with children and families. We know that in order for children to achieve permanency as quickly as possible, we must honor, respect and learn from families. We must also listen to the voices of children and include the people most important to the child in making decisions that affect the child and the family. For children placed in out-of-home care this can sometimes be a challenge. The Bridge practice was developed and is being utilized when placing children in out-of-home care. It is called Bridge because bridges provide a connection from one place to another, and that is what we want to do – connect children and families. For years, families who opened their hearts and homes to children in need of out-of-home care were referred to as foster families and their homes referred to as foster homes. In more recent years, foster families and foster homes have become known as resource families and resource homes. With Bridge, families providing out-of-home care will now be referred to as Bridge resource families. You may see the terms foster family, resource family or Bridge resource family used interchangeably throughout this handbook, but please know the term used is not what is most important. It is the valuable service you are providing the children and their families.

Bridge Resource Family

A Bridge resource family is a family who may be asked to:

- (A) Provide temporary care, love and nurturance to the child and serve as a mentor actively helping the parent improve their ability to safely care for their children while staying connected and assisting in the transition to reunification, legal guardianship or adoption to another family
- (B) Serve as the legal guardian for the child while maintaining a child's connection to kin, culture and community
- (C) Adopt the child while maintaining a child's connection to kin, culture and community

As a Bridge resource parent, you are a vital member of the professional team consisting of the child welfare specialist, the biological family and the child, with a goal of making plans and decisions for children in out-of-home care based upon what is in the best interest of the child.

DHS Practice Standards and Bridge Resource Family Guiding Principles

DHS Child Welfare Practice Standards and Bridge Resource Family Guiding Principles were developed to guide both DHS and you, as a Bridge resource family, in the work we do and the care we provide for families and children.

1. We continually examine our use (misuse) of power, use of self and personal values and biases, ensuring they do not interfere with our ability to partner with families.

DHS

- We must be aware of and recognize how we use the power of the position.
- Our use of team supports the process of examining personal biases and use of self.
- We believe in the importance of hearing all voices – whether we agree or not.
- We continually assess our personal biases and styles, ensuring that they do not interfere with our ability to partner with families; at the same time we will regularly enter into discussions/mentoring with our supervisors (at all levels) about personal biases and the way they are impacting our work.

Bridge

- We allow ourselves to imagine and feel the experiences of families as we work to assist them in accomplishing their goals.
- It is critical that families see and believe that we are genuine and that we care.
- We are aware of and recognize how we use (misuse) the power of the position of being resource parents.
- We regularly enter into discussions and consult with the child welfare team about personal biases, and the way they impact our work with children and families.

2. We respect the children and families we serve.

DHS

- We separate what parents have done from who they are.
- Address the issues instead of judging.
- Behave as if we are a visitor in the family's home – a visitor with a purpose.
- Learn about their life demands and value their time.
- Be humble, understanding that “any given day” it could be us.
- We hold a belief that people can change – with the right tools and resources.

Bridge

- We separate what parents have done from who they are.
- We remain humble, understanding that “any given day” it could be us.
- We hold a belief that people can change – with the right tools and resources.
- We hold a belief that partnering between the child's family and the Bridge family supports children.

3. We listen to the voice of children and youth.

DHS

- We have frequent and meaningful conversations with children about what they need to feel safe, using language and making decisions that respects their love for their family and their need for connection to their culture.
- We ensure that children have accurate information and understand what is happening in their lives.
- We actively find ways for children to contribute and have an influence and a sense of control on the decisions made about their lives; being honest about their options and choices.
- We frequently engage children in conversations about how to improve our system.

Bridge

- We have frequent and meaningful conversations with children and youth about what they need to feel safe.
- We use language and make decisions which respect their love for their family, and their need to connect to their culture.
- We ensure that children and youth have accurate information and understand what is happening in their lives.
- We actively find ways for children and youth to contribute and have influence and a sense of control on the decisions made about their lives; being honest about their options and choices.

4. We continuously seek to learn who families are and what they need.

DHS

- We do not make assumptions about families. They are the expert of their own lives and often have solutions to their own problems. We create an environment where families can teach us about who they are and what they need.
- We communicate with families in their primary language in order to understand their experiences, their culture and how they make parenting decisions.
- We are students of the culture, race and ethnicity of the families we serve – and we actively use this information as we join with families in planning and decision making.
- We have an attitude that we can make a difference – there are the informal supports and resources if we look hard enough and partner effectively with the family and community.

Bridge

- We do not make assumptions about families.
- We communicate with families in their language in order to understand their experiences and culture.
- We have the attitude that we can make a difference.
- We actively learn about the culture, race and ethnicity of the children placed in our homes to support their continued connections.

5. We believe in the value of “nothing about us without us.” We effectively communicate through teamwork, which yields the best results for children and families.

DHS

- When we interact with family, we engage in a conversation that builds relationships, we ask strength-focused questions, we listen and the learning allows us to develop effective service plans.
- The family, the worker and community partners develop common goals that acknowledge the family’s perspectives and the child’s need for safety, permanency and well-being.
- We are transparent with one another to ensure clarity regarding what we are thinking, our concerns and why we are focusing on certain areas of safety and permanency.
- We actively find ways for families to contribute and have control over their own lives.
- We actively engage resource families in the process of teaming, information sharing and decision making.

Bridge

- We are engaged in the process of teamwork, information sharing and decision making.
- We honor the confidentiality of the information about the child’s family.

6. We maintain a child’s permanent connection to kin, culture and community.

DHS

- Young adults need to be informed about their choices, they need to understand what happens to them, and they need to consistently maintain contact with their worker.
- Visitation between a child and their family is a child’s right.
- Families belong together and we maintain optimal connection between a child, their family and their culture.
- We seek to place siblings together; and if we cannot we create frequent opportunities for them to see one another.
- As we make decisions about placement, we consider all of the implications for the child... understanding that every time a child is removed, there is emotional harm.
- We maintain a sense of urgency, knowing that every day a child is in out-of-home care is harmful.

Bridge

- We recognize visitation between a child and their family is a child’s right.
- We understand families belong together and as Bridge Resource parents will help maintain optimal connections between a child and their family, their culture and their community.
- We believe siblings should be placed together; but if they are not, we help create frequent opportunities for them to see one another.

7. We conduct our work with integrity at all levels of the agency and create a standard of excellence and cooperation in the work we do.

DHS

- There is a standard of excellence and cooperation that permeates the work of the agency.
- We are compassionate with one another and we have the difficult conversations about the pain and complexity of this work.
- We formally provide support, an opportunity for debriefing and stress relief for our workers and supervisors so that they can continue to do the work well.
- We communicate honestly and we do what we say we are going to do.
- We actively educate other systems about the needs of children and families and about best practices in child welfare.
- We hold one another accountable to being respectful and courteous, valuing and supporting each other – letting go of territorial issues and working together to accomplish our collective goals.

Bridge

- We promote safety (children are not abused/neglected in out-of-home care).
- We support stability (children do not move unless absolutely necessary).
- We encourage self-sufficiency (empower and teach self protection and life skills).

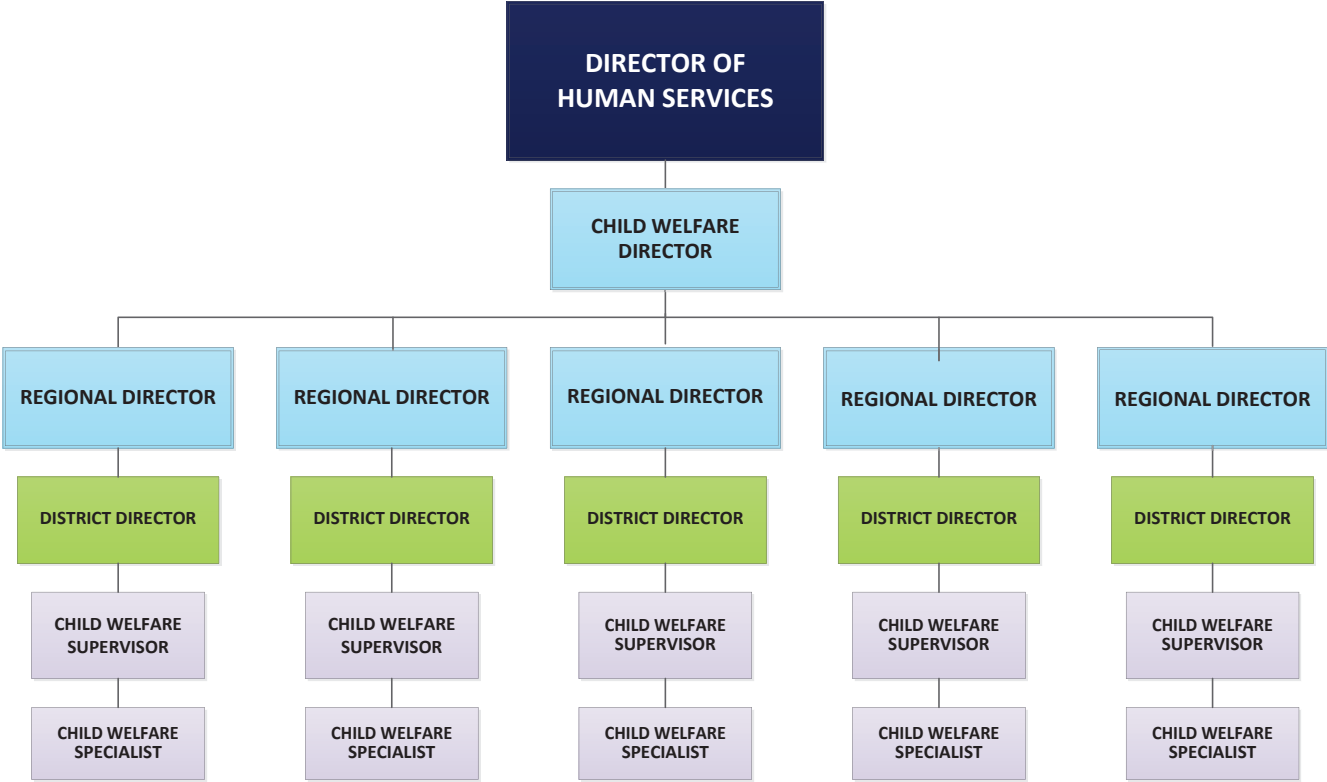
DHS Policy

The most recent proposed DHS policy is available for review and public comment at any time on the DHS website at www.okdhs.org. The current policy and proposed policy sections are located under Quick Links on the right side of the DHS home page. If you would like to make a comment regarding the current policy or proposed policy, please email your comments to STO.OLRP.Policy@okdhs.org.

DHS policy is designed to ensure compliance with federal and state legal requirements and productive service delivery. DHS policy includes rules that must comply with the Administrative Procedures Act (APA), per Section 250 et seq. of title 75 of the Oklahoma Statutes. In accordance with APA, rules are approved by the DHS Director, Governor and Legislature before they are implemented by DHS. Rules directly affect clients, vendors or the general public. The policy also contains instructions to staff that describe DHS procedures and affect only DHS staff.

DHS Organization

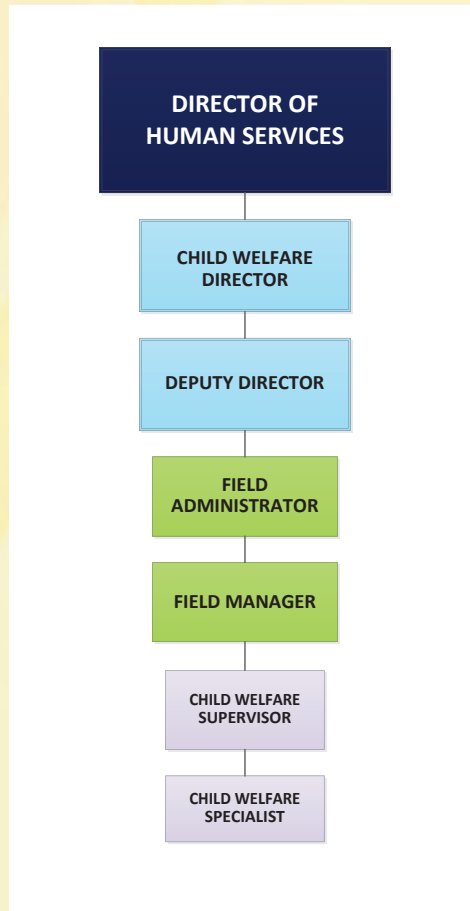
The state is divided into five regions, supervised by a regional director. At the district level, the chain of command is Child Welfare specialist, Child Welfare supervisor, district director, regional director. An organizational chart and map have been included to help you conceptualize this information. Demographic information is also included regarding county offices.



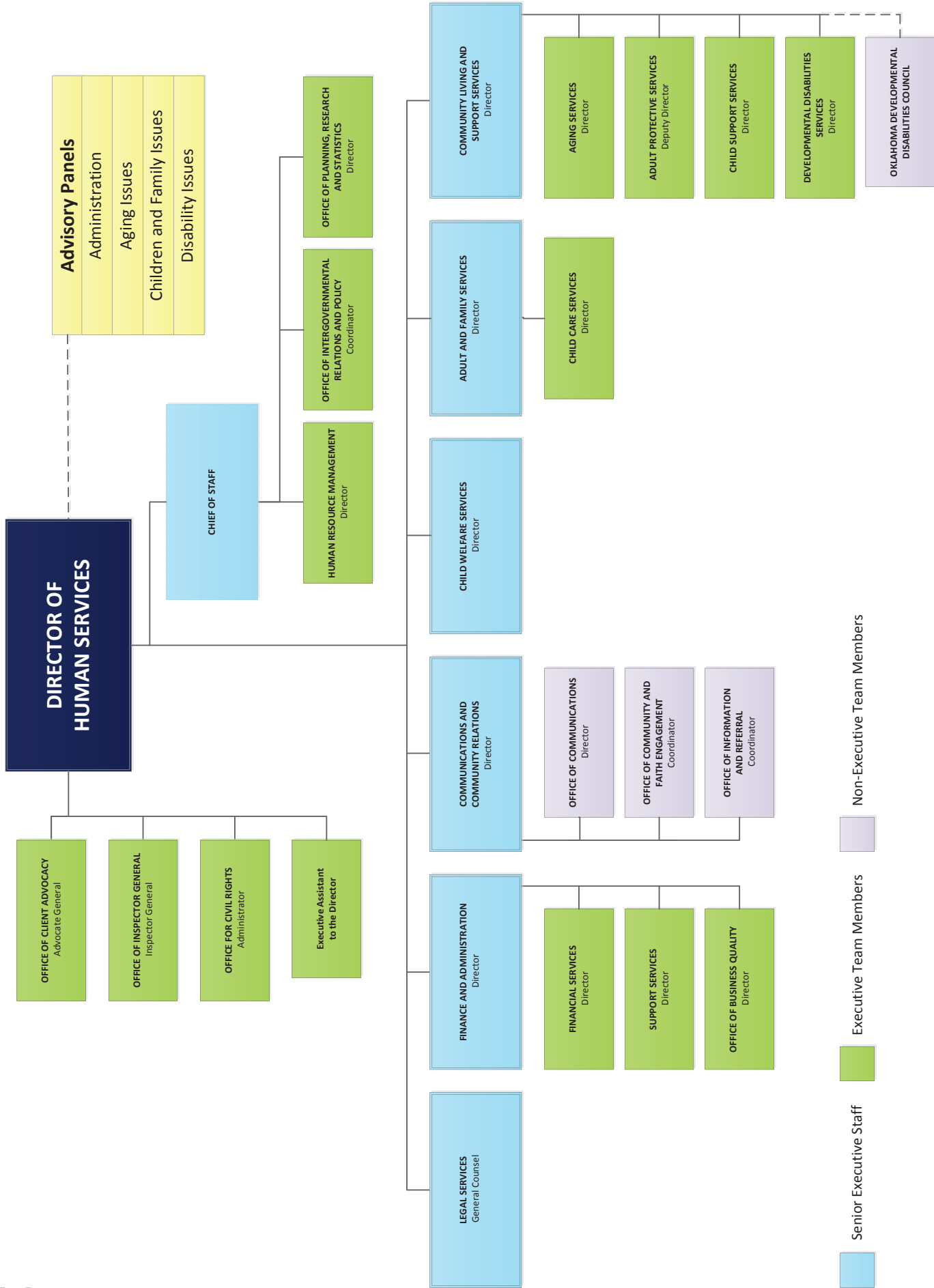
The worker for the child who visits in your home follows this organizational structure.

Bridge staff (adoption and foster care) is supervised by a deputy director. At the regional level, the chain of command is:

- Child Welfare specialist
- Child Welfare supervisor
- Field manager
- Field administrator
- Deputy director



The resource specialist assigned to your home follows this organizational structure. If your home is being supervised by a private agency, please contact your agency for its structure.



Senior Executive Staff

Executive Team Members

Non-Executive Team Members

Directory - County Offices

Adair

Section Line Road
Rt 1, Box 42
Stilwell, OK 74960
(918) 797-2900
1-800-225-0049
Fax: (918) 797-2996

Alfalfa

400 S. Ohio St.
Cherokee, OK 73728
(580) 596-3335
1-866-294-3936
Fax: (580) 596-2414

Atoka

401 N. Greathouse Drive
Atoka, OK 74525
(580) 889-3394
1-800-225-0051
Fax: (580) 889-3451

Beaver

111 W. 2nd St.
Beaver, OK 73932
Mailing address
PO Box 306
Beaver, OK 73932
(580) 625-3441
1-800-225-0092
Fax: (580) 625-4921

Beckham

102 S. 3rd St., Ste. 5
Sayre, OK 73662-3044
(580) 928-4000
1-800-225-0098
Fax: (580) 928-4080

Blaine

410 W. Main St.
Watonga, OK 73772
(580) 623-2000
1-800-808-8961
Fax: (580) 623-2066

Bryan

4302 Hwy. 70 West
Durant, OK 74702
(580) 931-2500
1-800-225-0062
Fax: (580) 931-2599

Caddo

208 Hardees West St.
Anadarko, OK 73005
Mailing address
208 Hardees West
Anadarko, OK 73005
(405) 247-4000
1-800-225-0053

Canadian

El Reno

314 W. Rogers St.
El Reno, OK 73036-2450
(405) 295-2700
1-800-572-6845
Fax: (405) 295-2727

Yukon

7901 E. U.S. Highway 66
El Reno, OK 73036-2450
(405) 295-2000
1-866-806-1056
Fax: (405) 295-2098

Carter

925 W. Broadway St.
Ardmore, OK 73401
(580) 490-6060
1-800-225-9927
Fax: (580) 490-6088

Cherokee

1298 W. 4th St.
Tahlequah, OK 74464
Mailing address
PO Box 1067
Tahlequah, OK 74464
(918) 207-4500
1-800-225-9868
Fax: (918) 207-4632

Choctaw

2565 East 2070 Road
Hugo, OK 74743
(580) 317-2900
1-800-225-0076
Fax: (580) 317-2964

Cimarron

One Courthouse Square
Boise City, OK 73933

Mailing address

PO Box 326
Boise City, OK 73933
(580) 544-2512
1-800-572-6838
Fax: (580) 544-2707

Cleveland**Moore**

2507 N. Shields Blvd.
Moore, OK 73160-3305
(405) 912-2000
1-877-207-7317
Fax: (405) 912-2041

Norman

631 E. Robinson St.
Norman, OK 73071-6616
(405) 573-8300
1-800-572-6823
Fax: (405) 573-8350

Coal

One N. Main St.
Coalgate, OK 74538
(580) 927-2379
1-800-572-6829
Fax: (580) 927-2342

Comanche

2609 S.W. Lee Blvd.
Lawton, OK 73505
(580) 250-3600
1-800-572-6841
Fax: (580) 250-3740

Cotton

1501 South 7th St.
Walters, OK 73572
(580) 875-4000
1-800-572-6830
Fax: (580) 875-4048

Craig

310 N. Wilson St.
Vinita, OK 74301
(918) 713-5000
1-800-572-6844
Fax: (918) 713-5080

Creek

10 N. Mounds St.
Sapulpa, OK 74066
(918) 746-3300
1-800-572-6834
Fax: (918) 746-3397

Custer

190 S. 31st St.
Clinton, OK 73601
(580) 331-1900
1-800-572-6846
Fax: (580) 331-1966

Delaware

438 S. 9th St.
Jay, OK 74346
Mailing address
PO Drawer 750
Jay, OK 74346
(918) 253-4213
1-800-433-6772
Fax: (918) 253-6534

Dewey

502 W. Ruble St.
Taloga, OK 73667
Mailing address
PO Box 128
Taloga, OK 73667
(580) 328-5546
1-800-433-6967
Fax: (580) 328-5524

Ellis

103 N. Washington St.
Arnett, OK 73832
Mailing address
PO Box 215
Arnett, OK 73832
(580) 885-7546
1-800-433-6773
Fax: (580) 885-7490

Garfield

2405 Mercer Drive
Enid, OK 73702
Mailing address:
PO Box 3628
Enid, OK 73702
(580) 548-2100
1-800-433-7074
Fax: (580) 548-2199

Garvin

2304 S. Chickasaw St.
Pauls Valley, OK 73075
(405) 238-6461
1-800-433-6846
Fax: (405) 238-9554

Grady

1707 W. Frisco Ave.
Chickasha, OK 73018
(405) 574-7400
1-800-433-7075
Fax: (405) 574-7545

Grant

112 E. Guthrie St.
Medford, OK 73759
(580) 395-3312
1-800-433-6909
Fax: (580) 395-2815

Greer

130 N. Oklahoma Ave.
Mangum, OK 73554
(580) 782-1000
1-800-433-7076
Fax: (580) 782-1050

Harmon

114 W. Hollis St.
Hollis, OK 73550
(580) 688-3361
1-800-433-6945
Fax: (580) 688-2367

Harper

1001 N. Hoy St.
Buffalo, OK 73834
Mailing address
PO Box 355
Buffalo, OK 73834
(580) 735-2541
1-800-433-7079
Fax: (580) 735-6119

Haskell

#9 Highway E.
Stigler, OK 74462
Mailing address
PO Box 659
Stigler, OK 74462
(918) 967-4658
1-800-638-3641
Fax: (918) 967-8647

Hughes

801 Kingsberry Road
Holdenville, OK 74848
(405) 379-7231
1-800-493-7980
Fax: (405) 379-2376

Jackson

201 S. Main St.
Altus, OK 73521-3129
(580) 480-3400
1-800-493-7974
Fax: (580) 480-3500

Jefferson

400 E. Hwy 70
Waurika, OK 73573
Mailing address:
PO Box 180
Waurika, OK 73573
(580) 228-3581
1-800-493-7981
Fax: (580) 228-3626

Johnston

1003 E. Main, Ste. 4
Tishomingo, OK 73460
(580) 371-4000
1-800-493-7975
Fax: (580) 371-4050

Kay

Newkirk
801 W. South St.
Newkirk, OK 74601
(580) 362-5800
1-800-597-1872
Fax: (580) 362-5880

Ponca City

801 W. Grand Ave., Ste. B
Ponca City, OK 74601
(580) 763-6700
1-800-493-7982
Fax: (580) 763-6770

Kingfisher

102 W. Coronado Drive
Kingfisher, OK 73750
Mailing address
PO Box 118
Kingfisher, OK 73750
(405) 375-3867
1-800-493-7976
Fax: (405) 375-6493

Kiowa

430 S. Main St.
Hobart, OK 73651
(580) 726-6500
1-800-493-7983
Fax: (580) 726-6550

Latimer

1809 Highway 270 East
Wilburton, OK 74578
Mailing address
PO Box 609
Wilburton, OK 74578
(918) 465-5800
1-800-493-7978
Fax: (918) 465-5850

LeFlore

511 S. Harper St.
Poteau, OK 74953
Mailing address
PO Box 370
Poteau, OK 74953
(918) 649-2300
1-800-493-7960
Fax: (918) 649-2481

Lincoln

2020 E. 1st St.
Chandler, OK 74834
(405) 258-6800
1-800-493-7984
Fax: (405) 258-6896

Logan

1414 S. Division St.
Guthrie, OK 73044-4946
(405) 264-2700
Fax: (405) 264-2782

Love

311 S. Highway 77, Ste. A
Marietta, OK 73448
(580) 276-3383
1-800-815-7558
Fax: (580) 276-5413

Major

1425 N. Main St., Ste. 3, 4, 5
Fairview, OK 73737
Mailing address
PO Box 98
Fairview, OK 73737
(580) 227-3759
1-800-815-7571
Fax: (580) 227-2712

Marshall

111 Highway 70 West
Madill, OK 73446-1024
(580) 795-8100
1-800-815-7567
Fax: (580) 795-8141

Mayes

501 S. Elliott St.
Pryor, OK 74361
(918) 824-4900
1-800-815-7572
Fax: (918) 824-4980

McClain

1930 S. Green Ave.
Purcell, OK 73080
Mailing address
PO Box 467
Purcell, OK 73080
(405) 527-6511
1-800-815-7570
Fax: (405) 527-2085

McCurtain

1300 S.E. Adams St.
Idabel, OK 74745
(580) 208-3400
1-800-815-7562
Fax: (580) 208-3500

McIntosh

25 Hospital Road
Eufaula, OK 74432
Mailing address
PO Box 231
Eufaula, OK 74432
(918) 689-1200
1-800-219-3238
Fax: (918) 689-1265

Murray

1019 W. Wyandotte Ave.
Sulphur, OK 73086-4421
(580) 622-2186
1-800-815-7568
Fax: (580) 622-3734

Muskogee

727 S. 32nd St.
Muskogee, OK 74403
Mailing address
PO Box 608
Muskogee, OK 74402
(918) 684-5300
1-800-815-7573
Fax: (918) 684-5363

Noble

205 15th St.
Perry, OK 73077
(580) 336-5581
1-800-815-7569
Fax: (580) 336-4795

Nowata

309 Delaware Ave.
Nowata, OK 74048
(918) 273-2327
1-800-815-7574
Fax: (918) 273-1748

Okfuskee

119 S. 1st St.
Okemah, OK 74859
(918) 623-3100
1-800-884-1528
Fax: (918) 623-3165

Oklahoma**Southwest Oklahoma County (55A)**

401 W. Commerce St.
Oklahoma City, OK 73109
(405) 644-5700
1-800-884-1532
Fax: (405) 644-5772

Midwest City (55B)

9901 S.E. 29th St.
Midwest City, OK 73130
(405) 739-8000
1-800-884-1579
Fax: (405) 739-8120 or (405) 739-8158

Juvenile Justice (55D)

5905 N. Classen Court
Oklahoma City, OK 73118
(405) 767-2600
1-800-884-1581
Fax: (405) 767-2640

Kelley Child Welfare (55F)

2409 N. Kelley Ave.
Oklahoma City, OK 73111
(405) 522-5818
1-800-884-1534
Fax: (405) 522-4835

Rockwell (55H)

7201 N.W. 10th St.
Oklahoma City, OK 73127
(405) 470-6200
1-800-884-1534
Fax: (405) 470-6361

Crossroads (55J)

1115 S.E. 66th St.
Oklahoma City, OK 73149
(405) 604-8800
1-866-231-8394
Fax: (405) 604-8945

Shepherd Mall (55L)

2401 N.W. 23rd St., Ste. 1H
Oklahoma City, OK 73107
(405) 522-4700
Fax: (405) 522-4623

Okmulgee

5005 N. Wood Drive
Okmulgee, OK 74447
(918) 752-2000
1-800-884-1582
Fax: (918) 752-2090

Osage

550 Kihekah Ave.
Pawhuska, OK 74056
(918) 287-5800
1-800-884-1573
Fax: (918) 287-5914

Pawnee

501 5th St.
Pawnee, OK 74058
(918) 762-3606
1-800-270-0786
Fax: (918) 762-3476

Payne

711 E. Krayler Ave.
Stillwater, OK 74075
(405) 707-3700
1-800-270-0797
Fax: (405) 707-3790

Pittsburg

1900 S. Main St.
McAlester, OK 74501
(918) 421-6100
1-800-270-0792
Fax: (918) 421-6218

Pontotoc

2320 Arlington, Ste. B
Ada, OK 74820
(580) 310-7050
1-800-270-0798
Fax: (580) 310-7127

Pottawatomie

1400 N. Kennedy Ave.
Shawnee, OK 74801
(405) 878-4000
1-800-270-0793
Fax: (405) 214-4133

Pushmataha

104 S.E. B St.
Antlers, OK 74523
(580) 298-3361
1-800-270-0803
Fax: (580) 298-2129

Roger Mills

480 E. Broadway Ave.
Cheyenne, OK 73628
Mailing address
PO Box 339
Cheyenne, OK 73628
(580) 497-3393
1-800-270-0794
Fax: (580) 497-2632

Rogers

2020 Holly Road
Claremore, OK 74017
(918) 283-8300
1-800-270-0804
Fax: (918) 283-8445

Seminole

206 E. 2nd St.
Wewoka, OK 74884-2604
(405) 257-7400
1-800-270-0796
Fax: (405) 257-7480

Sequoyah

1611 S. Kerr Blvd.
Sallisaw, OK 74955

Mailing address

HC 61, Box 20
Sallisaw, OK 74955
(918) 776-8000
1-800-270-0805
Fax: (918) 776-8112

Stephens

1805 W. Plato Road
Duncan, OK 73534

Mailing address

PO Box 1367
Duncan, OK 73533
(580) 251-8300
1-800-734-7506
Fax: (580) 251-8396

Texas

1000 N.E. 4th St.
Guymon, OK 73942
(580) 338-8592
1-800-734-7514
Fax: (580) 338-2988

Tillman

125 N. 9th St.
Frederick, OK 73542-5416
(580) 335-6800
1-800-734-7507
Fax: (580) 335-6850

Tulsa**McLain (72B)**

3666 N. Peoria Ave.
Tulsa, OK 74106
(918) 430-2300
1-800-734-7509
Fax: (918) 428-5613

Downtown (72C)

444 S. Houston Ave.
Tulsa, OK 74127
(918) 581-2401
1-800-734-7516
Fax: (918) 581-2114

Child Welfare (72D)

444 S. Houston Ave.
Tulsa, OK 74127
(918) 581-2033
Fax: (918) 581-2074

Tulsa County (72G)

6128 E. 38th St., Ste 315
Tulsa, OK 74135
(918) 933-4500
1-800-909-7491
Fax: (918) 933-4662

Wagoner

102 N.E. 7th St.
Wagoner, OK 74467
(918) 614-5000
1-800-734-7518
Fax: (918) 614-5128

Washington

5205 Jacquelyn Lane
Bartlesville, OK 74006
Mailing address
PO Box 1099
Bartlesville, OK 74006
(918) 338-5700
1-800-734-7512
Fax: (918) 338-5777

Washita

106 Lowber Lane
Cordell, OK 73632
(580) 832-3391
1-800-734-7519
Fax: (580) 832-3516

Woods

509 Barnes Ave.
Alva, OK 73717
Mailing address
PO Box 724
Alva, OK 73717
(580) 430-3100
1-800-734-7513
Fax: (580) 430-3164

Woodward

2119 W. Main St.
Woodward, OK 73801
(580) 254-6000
1-800-734-7520
Fax: (580) 254-6080

Section 2. Trauma-Informed Care

What is Trauma?
Resilience in Children
Trauma-Focused Treatment
Medication
Trauma-Informed Resources
Self-Care—Caregivers Also Need Care



Trauma-Informed
Care

Section 2: Trauma-Informed System

A trauma-informed child welfare system is one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness and skills into their organizational cultures, policies and practices. They act in collaboration, using the best available science to facilitate and support resiliency and recovery.

DHS has made the commitment to become a trauma-informed child welfare system. Each child deserves a family that understands the impact of the trauma experienced by most children entering out-of-home care, helps the child heal from this trauma, and keeps the child even in tough times so the child does not have to change placements. A five-year Oklahoma Trauma-Informed System Implementation plan has been developed based on the recommendations from the Chadwick Trauma-Informed Systems Project's Trauma-Informed Community Assessment of Oklahoma's Child Welfare System and the ongoing work of the National Child Traumatic Stress Network (NCTSN) Breakthrough Series Collaborative to Utilize Trauma-Informed Practices to Improve Foster Care Placement Stability-Tulsa site.

The Trauma-Informed Systems plan will enable DHS to add clinical treatment and "trauma-informed" service approaches/interventions designed to reduce the impact of exposure to maltreatment, exposure to violence, and/or trauma on children and adolescents to include:

- 1) Psycho-educational programs on the impact of child maltreatment, exposure to violence, and trauma
- 2) Outreach/screening of children/adolescents for trauma/violence exposure
- 3) Referral/triaging of identified trauma-exposed children to the appropriate intensity of behavioral and clinical services
- 4) Acute interventions and supportive services during or in the immediate aftermath of exposure to child maltreatment, violence and/or traumatic events
- 5) Training providers to improve their responses
- 6) Reducing the potential for traumatic stress in service delivery
- 7) Service systems changes to improve the delivery of treatment

The Pinnacle Plan establishes a comprehensive and systematic transformation of DHS's Child Welfare system to a trauma-informed system. It is important to recognize that exposure to trauma is the rule, not the exception, among children in the child welfare system. Resource families have some of the most challenging roles in the child welfare system. Resource families must be nurtured and supported so they, in turn, can foster safety and well-being. Relatives serving as resource families may themselves be dealing with trauma related to the crisis that precipitated child welfare involvement and placement. DHS will enhance practice with trauma-informed initiatives, additional screening tools, and a Systems of Care focus. This effort will enhance all aspects of the child welfare system so that it is trauma-informed and will provide screenings, assessments and supportive services to help children achieve permanency.

What is trauma?

Child traumatic stress refers to the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling). Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness and out-of-control physiological arousal. A child's response to a traumatic event may have a profound effect on his or her perception of self, the world and the future.

- Acute trauma is a single traumatic event that is limited in time.
- Chronic trauma refers to the experience of multiple traumatic events.
- Complex trauma describes both exposure to chronic trauma — usually caused by adults entrusted with the child's care — and the impact of such exposure on the child.

Traumatic events may affect a child's:

- Ability to trust others
- Sense of personal safety
- Effectiveness in navigating life changes

Traumatic stress can adversely impact a child's ability to protect himself/herself from abuse and the child's altered world view may lead to behaviors that are self-destructive or dangerous, including premature sexual activities. Repeated traumatic experiences, particularly in very young children, and especially those at the hands of caregivers, can actually alter crucial pathways in the developing brain. Over time, a child who has felt overwhelmed over and over again may not react normally to even minor everyday stresses.

The impact of a potentially traumatic event depends on several factors, including:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces following the trauma
- The presence/availability of adults who can offer help and protection

Children who have been through trauma may show a range of symptoms that are called "traumatic stress reactions." These reactions are grouped into three categories.

- Hyperarousal — means the child is jumpy, nervous or quick to startle
- Re-experiencing — means images, sensations or memories of the traumatic event keep coming uncontrollably into the child's mind
- Avoidance and withdrawal — means the child feels numb, frozen, shut-down or separated from normal life, and may pull away from friends and activities, even those he or she used to enjoy. Sometimes children withdraw to avoid any reminders of the traumatic event.

Children may be non-symptomatic during the initial removal process, but may begin to display trauma reactions and symptoms after they have been placed in a safe home. The child's reaction to traumatic stress can adversely impact the placement stability due to the child's inability to regulate his or her moods leading to behaviors that threaten stable placements and reunification. Additionally, the child may lack trust in caregivers, which may lead to rejection of possible caring adults or to superficial attachments. Early experiences and attachment problems may reduce a child's natural empathy for others, including foster or adoptive family members. New resource parents, unaware of the child's trauma history or of what memories are linked to strong emotional reactions, may inadvertently trigger strong reminders of trauma.

Traumatic stress reactions can lead to a range of troubling, confusing and sometimes alarming behaviors and emotional responses in children. For example, they:

- May have trouble learning. They may not be able to focus, concentrate or take in new information
- May have trouble going to sleep or staying asleep, or experience nightmares when they do sleep
- May feel moody, being tearful one minute and cheerful the next, or suddenly becoming angry or aggressive
- May not "act their age," instead reacting like a much younger child

Although these emotional reactions and behaviors can be frustrating and challenging, they are not calculated or conscious. Children who have been through trauma may act out for a variety of unconscious reasons.

Resilience in Children

Although nothing can entirely wipe out the effect of trauma, research has shown that there are many factors in a child's life that can promote resilience. Children can be more likely to "bounce back" from trauma if they:

- Have a strong, supportive relationship with a competent and caring adult
- Feel a connection with a positive role model or mentor
- Feel that their talents and abilities are being recognized and nurtured
- Feel some sense of control over their lives; being empowered can help in their recovery from trauma
- Feel invested in and part of a larger community, be it their neighborhood, faith-based groups, scout troop or extended family

As a resource parent, you can play a big role in helping the children in your care develop resilience. To help children overcome trauma it is important to:

- Provide a secure base of love and protection
- Be emotionally and physically available
- Recognize and respond to the child's needs
- Provide guidance
- Provide opportunities for children to safely explore the world around them

There will be times you will need to impose consequences for inappropriate and problematic behavior. When correcting behaviors and establishing consequences, keep in mind how trauma affects children's sense of self and their ability to control their emotions and behavior. When correcting children who have experienced trauma, remember to:

- Be clear, calm and consistent
- Target one behavior at a time

- Avoid shaming or threatening, especially threatening children with removal from the home for bad behavior
- Keep the child’s “emotional age” in mind when you give consequences
- Pick your battles

Trauma-Focused Treatment

As a resource parent, you should seek help when the child in your home:

- Displays reactions that interfere with the ability to function in school and at home
- Talks about or commits acts of self-harm
- Has trouble falling asleep, wakes up often during the night, or frequently has nightmares
- Complains of frequent physical problems but checks out OK medically

Treatment may be needed when the child in your home:

- Asks to talk to someone about a traumatic experience
- Talks over and over again about the trauma, or seems “stuck” on a particular part of it
- Seems plagued by guilt or self-blame
- Expresses feelings of helplessness and hopelessness

The first step in securing help for the child placed in your home is getting a trauma assessment. A trauma screening can be completed to help determine if a child needs a trauma-focused mental health assessment or treatment. A screening is a brief set of questions aimed at measuring a child’s exposure to trauma and his/her symptoms. It may be requested by you as a caregiver to the children placed in your home to complete a trauma screening. A trauma assessment is completed by a mental health provider that drives treatment planning for a child. Included in the assessment is a clinical interview, objective measures, behavioral observations of the child, and collateral contacts with family, child welfare specialist, etc.

There is a no “one size fits all” when it comes to treatments for children who have experienced trauma. However, research has shown that most effective trauma-informed treatments include common elements:

- They are based on scientific evidence; meaning the treatments have been systematically studied, and data demonstrating their effectiveness have been published
- They include a comprehensive trauma assessment to determine the child’s trauma history and needs
- After the assessment, the provider proposes a treatment plan, which includes involvement of parents, family or resource parents in the child’s therapy
- Trauma-focused therapy actively addresses the child’s traumatic experiences and traumatic stress symptoms

It is important for resource parents to advocate for the children placed in your home as the effects of trauma may be misunderstood or even misdiagnosed by mental health providers who are not trauma trained. Children in foster care are sometimes given many different diagnoses or misdiagnosed. For example, the nervousness and inability to pay attention that comes with trauma may be misdiagnosed as attention deficit hyperactivity disorder (ADHD). At any time during the treatment process, if you have concerns or questions regarding the treatment the child is receiving, share those concerns or questions with the child’s therapist and/or caseworker.

The symptoms of traumatic stress should be treated by someone who has the specific training to do so. There are many routes to finding a qualified mental health professional. A map of all the trained therapists in Trauma-Focused Cognitive Behavioral Therapy in Oklahoma as well as additional information and resources can be found through the Oklahoma TF-CBT website at <http://oklahomatfcbt.org/> You can also ask a pediatrician, family physician or your CW Specialist for a referral to a professional with expertise in traumatic stress.

Medication

Children in foster care are more likely to be prescribed psychiatric medication than other Medicaid-eligible children. Some psychiatric/psychotropic medication can be safe and effective for reducing specific symptoms such as nightmares, sleep problems and anxiety, but no medication can “cure” children’s traumatic stress. It is appropriate to ask questions or raise concerns if: the child placed in your home is prescribed medications alone, and is not receiving any therapy; medications have been prescribed for a child younger than age 4; the child placed in your home is taking more than one psychotropic medication; or you observe any side effects that concern you, or the child reports discomfort with side effects.

Trauma-Informed Resources

There are multiple resources on trauma. Simply doing an Internet search will provide extensive information. The two most well-known resources on trauma are:

- National Child Traumatic Stress Network — www.nctsn.org. NCTSN provides resource parents Caring for Children Who Have Experienced Trauma: A Guide for Resource Parents — www.nctsn.org/rpc. Resource parents can also find Trauma-Informed Care: An Introduction for Bridge Resource parents, which is based on the NCTSN’s Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents through the Learning Management System available at <http://bridgelms.oucpm.org>.
- Chadwick Center for Children and Families — www.ChadwickCenter.org.

Please consult with your Bridge Resource Worker or the child’s Child Welfare Specialist for additional resources.

Self-Care — Caregivers Also Need Care

Learning how to take care of ourselves is one of the most important skills we can develop as caregivers. By modeling how we take care of ourselves, we can help the children learn how to take good care of themselves as well. For many resource parents, the day-to-day grind of caring for a child who has experienced trauma takes an emotional and physical toll. When the stress of parenting affects your own mental and physical health, and impairs your ability to parent effectively, you are suffering from compassion fatigue (also called vicarious trauma). In addition to compassion fatigue, there are other ways that parenting a child who has experienced trauma can affect you. As a resource parent, you may be exposed to the child's trauma through many ways and can actually cause you to experience the same symptoms associated with traumatic stress, which is called Secondary Traumatic Stress (STS). You can take these steps when you start to feel overwhelmed by STS:

- Remind yourself that the children are now safe and the traumatic events happened in the past
- It can be helpful to distinguish our interpretation of what the children experienced from their more immediate concerns
- It is important to remember that all children have strengths that you can encourage and build upon

Many resource parents are drawn to this work because you want to save other children from going through what you went through. It is possible a child's trauma and reaction to trauma can serve as a trauma reminder for a resource parent and can actually threaten a placement. Coping when a child's trauma is a reminder can be challenging, but it can also be an opportunity for healing and growth. If a child in your care is triggering unexpected or intense feelings, reactions or memories of past trauma, it is important to:

- Recognize the connection between your reactions and your own trauma history
- Distinguish which feelings are about what is happening at the moment and which are related to your past experience
- Be honest with yourself, the child and your caseworker about what is happening
- Research out for support
- Accept that no matter what choice you make in dealing with your own trauma, what works for you may not work for the child placed in your home

It is important to commit to self-care and make a plan for reducing stress, maintaining a balance between work and relaxation, and between your commitments to others and to yourself. Your self-care plan should include activities that you do purely for fun and include a regular stress management approach, such as a physical activity you enjoy.



Section 3. Rights and Responsibilities

- Resource Parents' Rights**
- Resource Family Inquiries and Requirements**
- Resource Parents' Roles and Responsibilities**
- Resource Specialists' Roles and Responsibilities**
- Parental Substitute Authority**
- Discipline**
- Religious and Cultural Observations**
- Confidentiality**
- Child Welfare Investigations**
- Fair Hearings**
- Written Plan of Compliance**



**Rights and
Responsibilities**

**Rights and
Responsibilities**

Section 3: Rights and Responsibilities

Resource Parents' Rights

From: Oklahoma Statutes Citationized
Title 10A. Children and Juvenile Code
Article 1 - Oklahoma Children's Code
Chapter 9 - Programs, Contracts and Administrative Provisions
Section 1-9-119 - Statement of Foster Parents' Rights.

A statement of resource parent's rights shall include, but not be limited to, the right to:

1. Be treated with dignity, respect and consideration as a professional member of the child welfare team
2. Be notified of and be given appropriate, ongoing education and continuing education and training to develop and enhance foster parenting skills
3. Be informed about ways to contact the state agency or the child-placing agency in order to receive information and assistance to access supportive services for any child in the foster parent's care
4. Receive timely financial reimbursement for providing foster care services
5. Be notified of any costs or expenses for which the foster parent may be eligible for reimbursement
6. Be provided a clear, written explanation of the individual treatment and service plan concerning the child in the foster parent's home, listing components of the plan pursuant to the provisions of the Oklahoma Children's Code
7. Receive, at any time during which a child is placed with the foster parent, additional or necessary information that is relevant to the care of the child
8. Be notified of scheduled review meetings, permanency planning meetings, and special staffing concerning the foster child in order to actively participate in the case planning and decision-making process regarding the child
9. Provide input concerning the plan of services for the child and to have that input be given full consideration in the same manner as information presented by any other professional on the team
10. Communicate with other foster parents in order to share information regarding the foster child; in particular, receive any information concerning the number of times a foster child has been moved and the reasons why, and the names and telephone numbers of the previous foster parent if the previous foster parent has authorized such release
11. Communicate with other professionals who work with the foster child within the context of the team including, but not limited to, therapists, physicians and teachers

12. Be given, in a timely and consistent manner, any information regarding the child and the child's family that is pertinent to the care and needs of the child and to the making of a permanency plan for the child; disclosure of information shall be limited to that information which is authorized by the provisions of Chapter VI of the Oklahoma Children's Code for foster parents
13. Be given reasonable notice of any change in or addition to the services provided to the child pursuant to the child's individual treatment and service plan
14. Be given written notice of:
 - (a.) Plans to terminate the placement of the child with the foster parent pursuant to Section 1-4-805 of this title
 - (b.) The reasons for the changes or termination in placementThe notice shall be waived only in emergency cases pursuant to Section 1-4-805 of this title
15. Be notified by the applicable state agency in a timely and complete manner of all court hearings, including notice of the date and time of any court hearing, the name of the judge or hearing officer hearing the case, the location of the hearing, and the court docket number of the case
16. Be informed of decisions made by the court, the state agency or the child-placing agency concerning the child
17. Be considered as a preferred placement option when a foster child who was formerly placed with the foster parent is to reenter foster care at the same level and type of care, if that placement is consistent with the best interest of the child and other children in the home of the foster parent
18. Be provided a fair, timely, and impartial investigation of complaints concerning the certification of the foster parent
19. Be provided the opportunity to request and receive a fair and impartial hearing regarding decisions that affect certification retention or placement of children in the home
20. Be allowed the right to exercise parental substitute authority
21. Have timely access to the appeals process of the state agency and child placement agency and the right to be free from acts of harassment and retaliation by any other party when exercising the right to appeal
22. Be given the number of the statewide toll-free Foster Parent Hotline
23. File a grievance and be informed of the process for filing a grievance

B. The Oklahoma Department of Human Services and a child-placing agency under contract with the department shall be responsible for implementing this section.

C. Nothing in this section shall be construed to create a private right of action or claim on the part of any individual, the department, the Office of Juvenile Affairs, or any child-placing agency.

Resource Family Inquiries and Requirements

Inquiries

Any person, who is at least 21 years of age, may apply to become a foster parent by contacting the Bridge Family Resource Center at 1-800-376-9729.

Requirements

All applicants must:

- Be at least 21 years of age and preferably no more than 55 years older than the child considered for placement
- Have healthy relationships whether married, single, separated or divorced
- Have the ability to manage personal and household financial needs without relying on the foster care reimbursement
- Provide appropriate sleeping arrangements for each child placed
- Provide verification that all members of the household are in sufficiently good physical and mental health to provide for the individual needs of each child placed
- Consent to a search of all DHS records, including Child Welfare records
- Ensure that each member of the household, 18 years of age or older, submits fingerprints for a state and national criminal history records search
- Consent to a search of Juvenile Justice Information System (JOLTS) records for any child older than 13 years of age in the household
- Ensure that no member of the household has a prior conviction of any sexual offense
- Not smoke in the home when a child is placed in the home
- Not smoke in the automobile when transporting a child placed
- Provide references
- Complete DHS-approved pre-service training
- Complete 12 hours of in-service training each calendar year
- Demonstrate the basic competencies that are to:
 - (A) Protect and nurture children who have been abused, emotionally maltreated, or neglected
 - (B) Meet the medical and developmental needs of these children

(C) support relationships between children and their parents, siblings and kin as specified by DHS

(D) connect the child to a safe, nurturing relationship

(E) collaborate with DHS as a team member

- Provide a home that is clean and safe
- Have a house assessment completed
- Have extended family or friends to provide support and child care other than, or, in addition to, licensed child care paid by DHS
- Submit verification of employment when requesting paid child care services for a child in foster care
- Acknowledge and agree to abide by applicable state statutes and DHS rules regarding children in their care that include, but are not limited to:
 - (A) DHS, as the legal custodian of the child, has the right to move any child from any foster home at any time when in the child's best interests and in accordance with statutes governing movement of children
 - (B) The necessity of maintaining and respecting the confidential nature of all information regarding a child placed in the foster home, and that a breach of confidentiality may be grounds for closure of the foster home and termination of the foster care contract
 - (C) The requirement that DHS investigate or assess allegations of abuse, neglect, or maltreatment of any child in DHS custody placed in an approved foster home in the same manner as any other abuse or neglect investigation or assessment conducted by DHS
- Notify DHS whenever any member of the foster family is seriously ill or hospitalized
- Provide a physician's statement, once approved as a foster parent:
 - (A) For any hospital stay
 - (B) For ongoing outpatient medical or mental health care, including psychological counseling
 - (C) Upon DHS request
- Agree to provide foster care as a planned, temporary placement for children with the goal of family reunification or other permanency plan
- Work as a member of a professional multidisciplinary team with DHS staff to develop an individualized service plan for each child placed
- Share parenting of the child in care with the parents, who may have different values and lifestyles
- Agree to actively mentor the parent in helping them improve their ability to safely care for their child

- Treat all information regarding the child and family as confidential, only sharing such information necessary to obtain services for the child or with persons who are directly involved with the case
- Participate in the development of an effective parent and child visitation plan that may include contact with the parents and siblings, if siblings are separated
- Comply with DHS rules on discipline
- Maintain requirements necessary for continued approval as a foster home
- Participate in the re-assessment of the foster home and the evaluation of the DHS Foster Care program and services
- Utilize the foster care reimbursement for the care and maintenance of the child's basic needs, such as food, clothing, shelter, incidentals, non-prescription medications, including special activity fees, allowances and recreational opportunities
- Utilize the clothing allowance included in the foster care reimbursement to provide adequate clothing for the child placed
- Comply with all state statutes relating to the care and support of minors including those that prohibit the use of tobacco, alcohol or non-prescribed medications

Resource Parents' Roles and Responsibilities

As members of a professional team with DHS staff, resource parents assume responsibility both to DHS and to the children and families served. A clear understanding of the roles, abilities and requirements of the resource parents is necessary for effective coordination with DHS staff and the children and families served.

Responsibilities of the resource parent to the child in DHS custody and the child's family

Responsibilities of the resource parent include:

- (A) Integrating the child into the foster family setting and caring for the child as the foster parent would for the foster parent's own child
- (B) Providing mentoring services to the child's parents and coordinating visitation and contact to facilitate timely reunification, including phone and mail contact when appropriate
- (C) Working as a multidisciplinary team member with the Child Welfare worker and the child's parents toward family reunification or other permanency plan
- (D) Helping the child understand why he or she is in foster care and to deal with the grief caused by the separation

- (E) Cooperating and assisting in sibling contact or visitation, including phone and mail contact, when siblings are separated
- (F) Helping the child maintain a connection to the child's kin, culture and community
- (G) Cooperating and assisting the CW worker in the placement of siblings together
- (H) Helping the child develop a positive identity and self-esteem by feeling lovable, capable, worthwhile and competent
- (I) Helping the child learn appropriate behavior without using physical punishment
- (J) Utilizing appropriate behavior management, parent-child conflict resolution, and stress management techniques in a manner appropriate to the age and development of the child in foster care
- (K) Enrolling the child in an accredited school, if applicable, and ensuring that the child attends
- (L) Advocating for the child to obtain appropriate educational testing and placement in a timely manner
- (M) Attending school conferences and Individualized Education Plan (IEP) meetings
- (N) Ensuring the child participates in extracurricular and other recreational activities as appropriate
- (O) Ensuring the child's necessary medical, dental, and counseling needs are met by:
 - (i) Making appointments and participating in trauma-focused services as recommended
 - (ii) Providing transportation to appointments and sibling and parent visits
 - (iii) Obtaining prescription medications or over-the-counter medications as necessary and administering the medication as directed
- (P) Maintaining records of all medical, dental, and counseling appointments and notifying the CW worker of the time and place of the appointments, all medications prescribed for the child, and over-the-counter medications given to the child
- (Q) Notifying the CW worker of all medical and educational problems and progress
- (R) Ensuring the child's opportunity to participate in the religious practices of the child's family's choice, including the provision of transportation to worship services other than those of the foster parent, if necessary, and ensuring a child in foster care is not made to attend religious services against the child's wishes
- (S) Providing transportation for the child to meet with legal counsel upon reasonable request, attending court hearings as desired or required, submitting to the court written reports or presenting testimony concerning the strengths, needs, behavior, important experiences, and relationships of the child, in addition to other information the court requests

(T) Providing from the foster care reimbursement:

- (i) Essentials such as food, shelter, non-prescription medical needs, clothing, shoes and toiletries
- (ii) Clothing and fees for special activities
- (iii) School pictures
- (iv) Athletic and band instrument fees
- (v) Cap and gown rental and prom clothing
- (vi) Birthday and holiday gifts

(U) Providing federally mandated independent living services to youth who are at least 16 years of age and assisting other children in learning basic life skills that allow the opportunity to improve self-concept and strengthen identity in preparation for life after foster care

(V) Allowing the child access to mail from family members and the child's attorney

(W) Allowing the child overnight stays with friends of the child whom the foster parent knows and approves while ensuring the safety of the child

Responsibilities of the resource parent in the development and support of an appropriate permanency plan for each child

Responsibilities of the resource parent include:

- (A) Informing the CW worker and other team members of each child's strengths, needs, progress and development
- (B) Participating in the development of an effective parent and child visitation plan that defines contact with the parents and siblings, if siblings are separated
- (C) Collaborating with the child's CW worker prior to visits with the birth parents unless part of a specific plan
- (D) Advising the CW worker of all pertinent information about the child and family
- (E) Participating in meetings and case staffings when appropriate
- (F) Completing all required training hours annually, including annual policy training when offered
- (G) Maintaining current medical and education records for each child in foster care. A Life Book is maintained for each child placed in the home to support the child's sense of family continuity. These records accompany the child when he or she leaves the foster home.

Resource Specialists' Roles and Responsibilities

A clear understanding of the roles, responsibilities and requirements of the resource specialist is necessary for effective coordination with resource parents and the children and families served.

- (1) Recruitment.** The resource specialist engages in activities designed to recruit resource families who reflect the diversity of the children in out-of-home care and who are willing and able to parent children with special needs. Every effort is made to place a child in a kinship placement.
- (2) Inquiries.** The resource specialist discusses with each potential applicant the basic responsibilities and requirements expected of a resource parent, the types of children requiring out-of-home placement, and the elements of the approval process.
- (3) Assessment process.** A DHS contractor completes the resource family assessment. The initial consultation with the family is completed in the family's home. The resource specialist:
 - (A) Conducts at least two home visits with the family, excluding the final review of the assessment
 - (B) Evaluates the prospective foster or kinship home to assess the location, condition, and ability to accommodate children in foster care
 - (C) Contacts three personal references by phone or in person
- (4) Training.** The resource specialist:
 - (A) Assists the applicant in pre-service training
 - (B) Documents all other training the resource family completes, including 12 hours of required in-service training
 - (C) Engages the family in completing the required 12 hours of in-service training each calendar year
 - (D) Provides the resource family with materials to obtain the 12 hours of in-service training
 - (E) Assists the family in completing requirements, if applicable
- (5) Disposition of the assessment.** The resource specialist:
 - (A) Confirms in writing all decisions made regarding the assessment and application process
 - (B) Shares with the applicant the resource family assessment for the applicant's input prior to deciding to select in or out of the foster care program
 - (C) Provides the applicant with an explanation of the reasons the assessment is denied, if applicable
 - (D) Provides the applicant with a copy of the resource family assessment, if the assessment is approved

(6) Reimbursement. The resource specialist:

- (A) Refers relative kinship providers to the local DHS office for the application of Temporary Assistance for Needy Families benefits pending completion of the assessment process
- (B) Enters an initial training stipend of \$375 when the kinship providers are enrolled in training
- (C) Enters a final training stipend of \$375 when the kinship providers complete training no later than seven days after the documentation of completion has been entered into KIDS
- (D) Coordinates with the local DHS office when TANF benefits should end and foster care payments will begin
- (E) Assists families in applying for Supplemental Security Income or Social Security for a parent who is deceased or disabled, per OAC 340:75-7-52.1
- (F) Responds to reimbursement issues timely

(7) Retention. The resource specialist engages in activities that value and support the foster parent's role and assists the resource family in navigating the Child Welfare system.

(8) Re-assessments. The resource specialist timely completes the yearly re-assessments.

(9) Visitation. The resource specialist visits the resource family in their home at least quarterly to provide ongoing support and address any concerns or issues that the resource family may have.

(10) Placements. The resource specialist:

- (A) Carefully considers the child's physical and emotional health and safety in identifying placements, including potential kinship providers
- (B) Works with the resource family to place siblings together

(11) Investigations and policy violations. The resource specialist works in conjunction with the resource family to address any identified issues, concerns, or policy violations through a written plan of compliance, per OAC 340:75-7-94, to ensure the placement is safe and stable for children.

(12) Team member. The resource specialist:

- (A) Works as a professional team member with Permanency Planning, Child Protective Services, Adoption Services, and the resource family to ensure the child's safety, well-being, and permanency
- (B) Treats the resource family with respect and assists the resource family with any issues arising with the children placed in the home and any concerns they have as a resource family

(13) Closure. The resource specialist assesses the need for closure of a resource home and timely completes all necessary documentation regarding closure of the home

(14) Fair hearing. The resource specialist prepares documentation for a fair hearing, per OAC 340:75-1-12.6

Parental Substitute Authority

Parental substitute authority is defined as the ability of the resource parent to integrate the child requiring out-of-home placement into the family setting and to care for the child as the resource parent would his or her child, by:

- (A) Meeting the child's physical and emotional needs
- (B) Teaching the child problem-solving, self-control and responsibility
- (C) Building the foster parent – child relationship. This does not include the authority to use corporal punishment on any child in DHS custody

The ability to exercise parental substitute authority does not allow a resource parent to:

- Use physical discipline on a foster child even if the resource parent utilizes this method of disciplining their own children
- Share confidential information about the foster child with family and friends
- Force a foster child to attend worship services against the child's family beliefs
- Resource parents must work within the guidelines set out in DHS policy

Discipline for Children in Out-of-Home Care

For your information, the DHS policy regarding discipline and punishment has been included.

(a) Primary responsibility. A primary responsibility of foster families is to help children learn behaviors that promote their self-regard, personal ability, and socialization skills. The rules governing these efforts are outlined in OAC 340:75-7-38(b) through (d).

(b) Positive interactions. Foster family interactions with a child:

- (1) Protect and nurture the child's physical and psychological well-being
- (2) Advance the child's development
- (3) Meet the child's needs
- (4) Teach the child ways to prevent and solve problems
- (5) Maintain and build the parent and child relationship
- (6) Build the child's self-control and responsibility
- (7) Comply with DHS rules on discipline to provide a safe, nurturing environment that allows the child to experience security and positive self-esteem

(c) Teaching techniques.

(1) Positive behavior management. Positive behavior management techniques include, but are not limited to:

(A) Rewards. Rewards may be small gestures of approval, such as treats, toys, and symbols of recognition such as stickers, stars, happy faces, or money. Rewards are for the interest, desire, and effort the child displays, not for performance, talent, or ability. This technique must not be used all the time

(B) Privileges. Privileges allow the child to experience greater freedom or opportunity and an increased responsibility. Privileges are used to encourage the child's interest and talents by supporting the child's efforts in pursuing interests

(C) Praise. Praise may be communicated with a smile or nod of approval, expressing to the child how pleased the person is with him or her

(2) Self-control. To promote the child's self-control, foster parents clearly communicate expectations and provide structured, safe environments. The foster parent's use of planning and preparation prevents confrontation, acting-out, and negative behaviors by:

(A) Establishing expectations. Children in out-of-home care experience varied expectations of foster parents in every placement setting. Since each placement setting is different, the foster parent must communicate expectations to the child. Expectations are communicated through setting rules, telling the child what to expect, and modeling. Clearly communicated expectations provide structure for the child and a structure for building and maintaining self-control

(B) Modifying the environment. Structured, safe environments allow children to succeed at identified tasks. Foster parents structure environments by removing sources of stimulation for the child and establishing routines and consistency in day-to-day schedules.

(3) Direct intervention. When the child does not have sufficient self-control to ensure acceptable behavior, the foster parent uses direct intervention and techniques. Techniques used are dependent upon the child's developmental needs and anticipated outcomes. Techniques appropriate for responding to lack of self-control include:

(A) Rules. Rules are established guidelines that:

(i) Allow the child to know what can and cannot be done

(ii) Help the child know right from wrong

(iii) Communicate to the child how something is done and help prevent problems

(iv) Provide a way to respond to a problem

(B) Time out. Time out provides space between the child and a situation where the child exhibits behavior that is not acceptable or where the situation is dangerous. Recommended time out is one minute per age of the child. Time out is typically used for the younger child.

(C) Restricting privileges. Privileges are restricted when a child is not allowed to do something for a specified period of time, such as not playing with a particular toy, watching television, playing the stereo, playing computer games, having phone privileges, or engaging in some other pleasant activity. Talking to parents or siblings is not included in restricting phone privileges.

(D) Grounding. Grounding involves imposing restriction on a child's interaction and involvement with friends or activities outside of the placement setting, such as restriction to the house or leaving the premises to attend parties, movies, or visit friends. Grounding is typically used for the older child.

(E) Logical consequences. Logical consequences require the family to impose a response to the child's behavior consistent with and connected to the unacceptable behavior exhibited.

(F) Natural consequences. Natural consequences occur in response to the behavior. This technique is most appropriately used with adolescents and for those who tend to get in power struggles. Natural consequences are never allowed when a child's safety or well-being is in question.

(4) Physical discipline. DHS prohibits the use of any form of physical discipline for any child in DHS custody in an out-of-home placement or any act or omission that would emotionally, physically, or psychologically harm the child.

(A) The foster parent contacts the child's Child Welfare (CW) worker or the resource specialist if he or she cannot discipline the child through appropriate non-physical means.

(B) DHS does not authorize any school personnel to administer corporal punishment to any child in DHS custody. The foster parent does not sign such authorizations, but refers school personnel to the child's CW worker to establish alternative discipline methods.

(C) The developmental needs of a child and the desired outcomes define the discipline techniques used to modify the behaviors of the child. Some of the circumstances that may affect the technique used include:

- (i) The behavior the child is exhibiting
- (ii) The foster parent's feelings about the behavior
- (iii) The purpose assigned to the behavior
- (iv) Where the behavior occurs
- (v) Who is present at the time of the behavior

(5) Punishment. Unacceptable behavior management methods and techniques promote negative behavior, are punitive, and do not promote self-control. Unacceptable behavior management techniques for a child include, but are not limited to:

- (A) The use of the hand or any object, such as a board, fly swatter, paddle, belt, switch, electrical cord, hair brush or wooden spoon, to hit, strike, swat or physically discipline
- (B) Deprivation of food or sleep
- (C) Deprivation of family visits
- (D) Slapping, pinching, shaking, biting, pushing, shoving, thumping or rough jerking
- (E) Cursing or other verbal abuse
- (F) Private or public humiliation or any act that degrades
- (G) Derogatory remarks about the child, the child's biological family, race, religion or cultural background
- (H) Solitary confinement in areas such as closets, cellars, and rooms with locked doors
- (I) Threatening to move the child from the foster home
- (J) Use of any chemical agent, such as mace, sleeping pills or alcohol
- (K) Physical force or threat of physical force
- (L) Assuming and maintaining an unnatural position, that may include holding arms out-stretched from the body, placing the nose against a wall, or forced squatting
- (M) Tying with a rope, cord, or other object
- (N) Ordering, allowing, or encouraging physical discipline or hitting by other children or anyone else in the home
- (O) Washing the mouth out with soap, eating certain foods, that may include peppers or hot sauce for punishment
- (P) Forced physical exertion, such as running laps and push-ups

Physical restraint. The use of physical restraint is only justified as an emergency safety measure in response to imminent danger to the child or others and when no alternative means are sufficient to accomplish the purpose. Physical restraint may only be used when the resource parent has been properly trained and practiced in the DHS-approved restraint technique. The resource parent contacts the child's Child Welfare Specialist or Resource Specialist immediately when physical restraint has been utilized and completes the necessary paperwork as provided by Child Welfare.

DHS rules. The resource family must abide by DHS rules for discipline of a child in DHS custody even if there is a difference between DHS discipline rules and the methods used to discipline the family's own children.

Religious and Cultural Observation

The removal of a child from the parents' home does not sever the parental rights. It is the right of both the parents and the child to maintain their own religious and cultural beliefs.

A resource parent has the authority to determine whether the child will attend religious functions as a part of their family unit as long as they do not conflict with the religious preferences of the child or parents. A resource parent may integrate the child into their religious practices, but resource parents may not impose their own religious preferences over those the child has already established. The child's personal religious beliefs must be respected.

Resource parents may include children up to the age of 12 in their religious practices, unless the child is in temporary custody and the child's parents object. In this situation, the resource parents and the child's parents should work together to afford the child an opportunity to attend the church of the parents' preference or to arrange supervision appropriate to the needs of the child while the resource parents attend church.

A youth 12 years of age or older may declare his or her informed preference not to participate in a formalized religion. If a youth 12 years or older has not expressed an informed preference not to participate, but, as an act of rebelling, declines to participate in attending church, the resource parent may act as any prudent parent in encouraging the youth's participation.

If requested, reasonable efforts will be made to allow the child to attend the religious services of the child's or parents' choice. This may include providing or arranging for transportation to services different from the resource parents' own, if those services are available within the same town or community.

Formal admission to a religious faith, such as confirmation or baptism, cannot be made by the child without parental consent when parental rights have not been terminated. If rights have been terminated, the consent of DHS is required. A resource parent must discuss with the child's Child Welfare Specialist any desire to have a child baptized, confirmed or otherwise made a part of a religious community prior to taking any action in this area.

Confidentiality

All information concerning children in out-of-home placements, the child's family, the circumstances of placement, or future planning for the child must be kept confidential and must not be shared outside of the resource family. This includes not talking about these things with relatives, friends or neighbors. If the child is recognized or questions are asked when the resource family is out in public or at a gathering of friends or acquaintances, it is appropriate for resource parents, to indicate they are not free to discuss the child's situation.

Photographs identifying the child as a child in foster care must not be used for any newspapers, magazines, or other print or TV media without the express written permission of the child's Child Welfare Specialist.

Confidential information about the child and the child's family will be given to resource parents to assist in:

- Making an informed decision whether to accept the child into the resource home for the planned duration of care
- Anticipating the child's initial behavior when entering the resource home
- Understanding and meeting the individual needs of the child after the child enters the resource home

- Dealing effectively with problems that may arise from relationships between the child and the child's parents, between the child and the resource parents and between the child and the resource parents' own children
- Working effectively as a team member with Child Welfare, biological parents and the child toward family reunification or an alternate permanent plan

The resource parent will treat all information regarding the child and family as confidential, sharing only the information necessary to obtain services for the child or sharing information only with persons who are directly involved with the case. Information in the Individual Service Plan includes the child's strengths and needs, as well as general behavior and the circumstances that made placement necessary; plus important life experiences the child may discuss in the resource home. Resource parents are required to keep all this information confidential and are bound by the same confidentiality restrictions that apply to DHS by state and federal law. Misuse of confidential information may result in closure of the resource home.

Pertinent information about a child in out-of-home care may be shared with:

- Properly identified law enforcement officers performing an investigation
- The child's attorney
- Doctors providing authorized medical care for children
- Members of the District Attorney's staff
- The Court and Post Adjudicatory Review Boards
- Court Appointed Special Advocate (CASA)
- Properly identified employees of DHS
- Counselors, therapists, school personnel and other agencies or individuals professionally involved with the child

Maintaining Confidentiality of Client Information

All Child Welfare records and information are confidential pursuant to State and Federal statutes and regulations. [Oklahoma State Statutes, Title 10A, Sections 1-6-102, 1-6-107 and 45 CFR Part 1340] These statutes mandate that agency records with regard to a child who is or has been under its care, custody, or supervision or to a family member or other person living in the home of such child are confidential. Any record made in the course of an investigation or inquiry by the agency to determine whether a child is or may be deprived is confidential and not open to public inspection. Agency records include any study, plan, recommendation, assessment, report or other information describing history, diagnosis, condition, care, treatment or custody. Agency records would also include any record either obtained or maintained by the resource parent, such as school records, information regarding the child's health, Life Books or journaling by the resource parent regarding the child in out-of-home care. The contents of the agency's record cannot be disclosed without an order of the court except to certain persons or entities. Child Welfare case-specific information is not subject to the Oklahoma Open Records Act. Child Welfare's policy is neither to confirm nor to deny that any specific child abuse or neglect investigation is in process or that any Child Welfare services are being provided to a specific child or family member unless the criteria specified in DHS rule is met regarding death or near death of a child.

Child Welfare Investigations

Resource parents who may have an abuse or neglect allegation made about them and an investigation completed should consider that:

- YOU ARE NOT ALONE!
- Resource parent pre-service training covers the likelihood of abuse allegations being made against a resource parent, but most families think it won't happen to them.
- Just because an allegation has been made, DHS DOES NOT assume that abuse/neglect occurred; a thorough assessment of child safety and investigation is completed before any decision is made about the allegations.
- This may be a difficult time for you and may cause disruption within your family.
- You may experience feelings of fear, embarrassment, shock or anger.
- You will definitely want to know what you should do.

Abuse and neglect occurs in foster care. Foster parents are at high risk for abuse allegations because:

1. Resource families are more closely monitored than families in the general public.
2. Resource families may have more children placed in the home than they can handle, or they may accept children who are a poor match with members of the resource family.
3. Children in placement are more likely to exhibit difficult behavior that can increase stress levels in the resource family home.
4. The foster parent's ability to adequately supervise children may be questioned when a foster child is physically abusive or acts out sexually while placed in the resource home.
5. Biological parents of children in placement MAY make false reports. The parents' fears, past trauma or emotional stress could contribute to these reports.
6. Foster children MAY make false reports. Some foster children have attachment issues and become uncomfortable in a family setting. Most have had trauma experiences that affect the way they view the world and people around them. Some foster children may never feel safe due to trauma they have experienced. Their past experiences play a tremendous role for those that make a false report.

Purpose of investigations of resource homes:

Children in the care or custody of the Oklahoma Department of Human Services require ongoing protection from subsequent abuse or neglect while in therapeutic, specialized community home, emergency, Developmental Disabilities Services, tribal, kinship, and foster family care or trial adoptive placements.

State law requires all people who believe that a child has been abused or neglected to make a report to the DHS Statewide Abuse and Neglect Hotline at 1-800-522-3511. The law requires DHS to investigate the reports of child abuse or neglect for the primary purpose of protecting children.

Reporting and Assignment:

When a call is received at the DHS Abuse and Neglect Hotline, the information is documented in a Referral Information Report. The report is carefully evaluated to determine if the referral meets criteria to be accepted for assessment or investigation. All decision-making is fully documented by the Child Welfare supervisor. All accepted abuse/neglect referrals involving children in resource homes approved by DHS will be investigated.

1. When information is received from any source that an accidental injury has occurred to a child in a resource home, a preliminary inquiry is conducted.
 - a. The child's CW worker immediately interviews and observes the child, caregiver and any witnesses.
 - b. If it is determined that the injury was a result of an accident, a summary of the CW worker's inquiry is entered in the narrative and the report may be screened out.
2. An accepted report will be fully investigated and a report of the investigation will be submitted to the appropriate district attorney along with the findings of the investigation that can be substantiated, unsubstantiated or ruled out.
3. A screened-out report may then be referred to CW foster care or adoption staff to address any concerns regarding policy or rules violations.

What information will be collected from me in an investigation?

It is a CW worker's responsibility to find out all she or he can about the situation. Law enforcement may conduct a joint investigation with the CW worker. The CW worker will collect the following types of information:

1. A description of the alleged incident
2. Identification of all residents/caregivers in the home
3. A complete description of any injuries to the child, which may include asking a physician to help determine the severity of the injuries
4. A description of the child and other children in the household
5. Interview and observation of the child and other children outside of your presence in the household as appropriate
6. A description of the home environment
7. A description of the social climate and environment
8. A description of the family's strengths and needs

Some of the information-gathering, especially the descriptions, can be very in-depth. Be prepared for a lot of questions! Detailed information that is collected is used to ascertain the capacity of the care provider. This information is used to assist in substantiating or refuting the allegation and may include:

1. Disciplinary techniques and strategies
2. Ability and understanding of the supervision needs of the child
3. Interest in protecting child from danger
4. Physical and behavioral health
5. Criminal history
6. Motivation for caring for children
7. Knowledge of social, emotional and behavioral development
8. Intellectual functioning
9. Recognition of strengths and needs
10. Financial status and work history

What are my rights?

1. You have the right to be informed of the allegation made against you. DHS is not authorized to disclose who made the allegation.

2. You have the right to provide your information about the incident being investigated.
3. You DO NOT have the right to deny the CW worker access to the custody child.
4. Since foster children are in the custody of DHS, the department has the right to make the determination whether or not to keep foster children in your care during the investigation.
5. You have a right to have an attorney represent you at your cost.
6. You have the right to appeal any allegation that is substantiated.

How to Protect Yourself Against Allegations:

- A. Prior to placement of a custody child in your home:
 1. Get as much information about the child as possible before you accept a placement.
 2. Understand normal child development.
 3. Don't be afraid to say no to a placement if you feel that you may not be able to meet the child's needs.
 4. Communicate with the child's worker often and honestly. If your worker knows there are problems, the worker can assist you before things get out of control.
 5. Seek outside resources and assistance immediately if behaviors or issues arise that are becoming out of control.
- B. DOCUMENT! Don't trust your memory. Keep a journal of situations, reactions and behaviors.
 1. Keep logs/notebooks on each child to document visitation, medical appointments, school progress/problems, medical needs, behavioral patterns, or changes and efforts to teach acceptable behavior.
 2. Document any changes in behavior in children including type, severity and duration of these changes, especially after parental visitation. Include any action taken to deal with inappropriate behavior. Also document any unusual behavior the child has regarding social workers, police or medical personnel.
 3. Report accidental injuries promptly.
 4. Always document any serious conflicts with parents, children, social workers, counselors, teachers, etc.
 5. If your concerns are not being addressed by the CW specialist, contact the supervisor.
- C. If you accept a high-risk child who has had numerous placements:
 1. Talk with the CW worker about the child's abuse/neglect history and whether the child has a history of making false allegations.
 2. Allow the child to discuss his or her history of abuse/neglect at the child's pace and when the child wants to discuss it.
 3. Tell the child that you plan to protect him or her and yourself.
 4. Enlist the help of a competent professional who is experienced in working with trauma survivors and providing resource family therapy. You and the child will need ongoing therapeutic support from a person who knows you well. Your CW worker can assist you in getting therapy initiated.
 5. Pay careful attention to supervision and safety issues, especially for younger children. Custody children often have fewer boundaries than other children.
 6. Closely supervise children at all times.
 7. Be aware of places in your residence or grounds where children might hide and monitor them frequently.
 8. Leave nap room doors open and periodically check on children during these times.
 9. Conduct daily safety checks often and routinely and make sure all hazardous materials are put away. Safety guidelines cannot be compromised.
 10. Never use, or threaten to use, corporal punishment as a means of discipline. This form of discipline cannot be delegated to resource parents, and is a policy violation.
 11. Carefully screen relatives and friends who come into your home; make sure they understand licensing regulations, house rules and any specific restrictions about individual children because of previous abuse, court orders, etc.

12. Do not be alone with a child who is sexually reactive, acts out sexually, or has provocative behavior. Advise adults and older children in the household to have another adult nearby or in the same room for the protection of both the adult and the child.
13. Sexually abused children are sometimes more likely to become repeat victims of sexual abuse. Even if a child has a history of making false allegations, always take new allegations seriously and report them. It is the duty of the resource parent, working together with professionals, to protect the child and give the child functional boundaries and self-protective strategies.

Fair Hearings for Resource Parents

The primary purpose of the fair hearing is to safeguard the rights of resource parents and provide recourse to address infractions of individual rights and interests. A fair hearing may be granted to the resource parent when DHS:

1. Denies the resource parent's claim for foster care reimbursement
2. Pays foster care reimbursement to the resource parent in a sum lower than the amount claimed
3. Does not pay foster care reimbursement to the resource parent in a timely manner
4. Closes the resource parent's home as indicated on the Notice of Closure to DHS Foster Parents
5. Does not return a child in DHS custody removed from the resource parent's home due to a child abuse or neglect investigation as indicated on the Notice of Decision Not to Return Child After Investigation

When a resource home is closed, written notification explaining the reasons for the closure is hand-delivered or mailed to the resource parent. Should resource parents have questions concerning the closure of their home, they may discuss them with the Resource Specialist or supervisor.

If resource parents believe that the action is not consistent with DHS rules, they may appeal by completing the form, Resource Family Request for a Fair Hearing, within 30 days of the date of notice of closure. DHS staff will assist resource parents in completing the Fair Hearing Request if needed.

An administrative law judge will preside over the hearing. Resource parents may present written information. Hearing decisions may be appealed to the DHS Director and ultimately may be challenged in a civil court.

Written Plan of Compliance

A Written Plan of Compliance (WPC) could be necessary following an investigative finding or after a policy violation or concern has been identified and needs to be corrected in order for the resource home to continue to be used.

The WPC is a joint effort between the resource parent and the resource specialist responsible for the resource home. It is a plan that identifies and addresses needs in the resource home, ensures the provision of needed services to the resource home and the children placed there and identifies steps that need to be taken by the resource family, as well as DHS, to assist the resource family in resolving the situation. The WPC is time limited, with a time frame, in most instances, that does not exceed 90 days. Within the specified time frame, the WPC is reviewed, at agreed upon intervals, regarding the progress being made and the continued use of the home. The WPC must be signed by the resource parents, the resource specialist that developed the plan and the resource specialist's supervisor.

If resource parents are unwilling or unable to acknowledge the issue which requires resolution or to participate in a WPC, the home may be closed. The WPC is reviewed by the field manager.

Section 4. Out-of-Home Care – Bridge Resource Parent

Children’s Rights

The Sibling Bond

Visitation

Frequently Asked Placement Questions

Considering a Placement

When a Child is Placed

Protecting and Nurturing Children

**Ways to Integrate a Child into the Resource
Home**

Building a Relationship with the Child

Travel and Vacations

Life Books

When a Child Leaves



Section 4: Out-of-Home Care

On any given day, there are thousands of children in out-of-home care, which includes foster care. Resource families take on one of the greatest challenges our society generates, in that they are providing care for children who have been placed in out-of-home care.

As you learned in the Welcome Section of this handbook, becoming a Bridge resource parent for the State of Oklahoma means you are not only caring for children placed in your home, but also you are actively helping their parents as well in improving their ability to safely care for their children. Equally important is the fact you are maintaining a child's connection to his or her kin, culture and community.

There are some basic differences between Bridge traditional resources and Bridge kinship resources. Traditional resource parents provide care and nurturing to children by taking them into their homes for a limited or a more long-term period of time, without knowing the children or their families beforehand. Kinship resources are defined by a relationship with the child and/or the child's family that precedes the child's need for out-of-home care. In both instances, traditional or kinship, individuals apply to DHS or a Bridge Resource partner agency to become resource parents. If you are providing kinship care for the children placed in your home, the Bridge Kinship Resources Section of this handbook contains information pertinent to just kinship care.

As a Bridge resource parent, traditional or kinship, the following four things must occur before your home is fully approved:

- An approved family assessment (home study)
- Fingerprint results for all individuals 18 years or older
- Completion of DHS-approved pre-service training
- Signed contract

Children's Rights

The rights of children listed below were taken from the DHS publication Licensing Requirements for Child Placing Agencies, and these rights ensure children in out-of-home care are:

- Not forced to participate in publicity or promotional activities
- Not publicly identified to their embarrassment as wards of the agency
- Provided an opportunity to participate in religious services
- Supplied with facilities and supplies for personal care, hygiene and grooming
- Supplied with clothing and shoes appropriate to the season, age, activities and individual needs and are comparable to that of other children in the community

- Provided space in the resource home for the child's personal possessions and for a reasonable degree of privacy
- The right to bring, possess, and acquire personal belongings subject only to reasonable household rules and the child's service plan
- Given their personal belongings when the child leaves the home
- Expected to perform only household tasks within the child's abilities, reasonable for the child's age and similar to those expected of other household members of comparable age and ability
- Given guidance in managing their own money
 - (A) Money earned by the child or received as a gift or allowance is the child's personal property
 - (B) The child is not required to use earned money to pay for room and board, unless it is a part of the service plan and approved by the parent or custodian and DHS
- Allowed privacy in writing, sending or receiving correspondence unless restricted by the service plan
- Not denied meals as punishment
- Not subjected to remarks that belittle or ridicule the child or the child's family
- Allowed to visit with the child's family, in accordance with the service plan
- Not forced to acknowledge dependency or gratitude to DHS or resource home
- Given the opportunity, at the child's request or DHS' request, for private conversation with DHS staff members who are responsible for the child's supervision
- Provided educational opportunities in accordance with the child's plan of care

The Sibling Bond

The bond between siblings is unique. It is the longest lasting relationship most people have, in many instances longer than the parent/child or husband/wife relationship. While the strength of the bond may wax or wane, a person's lifetime quest for personal identity is undeniably interwoven with his or her siblings.

In early childhood, siblings are constant companions and playmates. Through games and conversations with each other, they learn to interact with the larger community. During adolescence, the ties between once-close siblings may temporarily weaken as the siblings establish their individuality and independence. In adulthood, the needs of immediate families usually take precedence over the relationships with siblings, but the sibling ties often emerge stronger from this period. Siblings generally share their adult struggles and triumphs with each other.

The cycle of the sibling bond comes full circle when the siblings become much older. After their parents and spouses may be gone and their children are raising children of their own, the bond between siblings often intensifies, as they once again become each other's closest companions, sometimes living together for the remainder of their lives.

The sibling bond develops in children raised in well-adjusted families, but it may be even stronger for brothers and sisters from dysfunctional families who must learn very early to depend on and cooperate with each other to cope with their common problems.

Sometimes, it is only through their siblings that children gain positive self-esteem. When they see good qualities in a brother or sister they are less likely to see themselves as "a bad kid from a bad family." Siblings are often able to reveal to each other parts of themselves they are reluctant to share with anyone else, thus strengthening the bond between them.

These early ties remain even when siblings are separated in out-of-home care or through adoption. Claudia Jewett wrote:

Children separated from brothers and sisters may never resolve their feelings of loss, even if there are new brothers and sisters whom they grow to love. There may be more drive in adopted adults to track down their remembered biological siblings than there is to locate their birth parents, so great a hole does the loss of a sibling leave in one's personal history. Many adopted adults desperately want to meet a person who they think might look like them. Seeing similarities between themselves and their biological siblings helps to provide the elusive answers to questions they may have about their heritage (Adopting the Older Child, 1979).

The media often reports stories about brothers and sisters who have been separated through adoption, and as adults, begin a tireless search for each other. One such story involved Eleanor, 39, who searched for her older brother Jim, 41. They had been separated from each other when they were young children. These two children had been extremely close. It was Jim who, when they were first adopted, showed their new parents how to get his sister to eat her vegetables and brush her teeth. It was Jim who had made the transition into their new family easier for Eleanor. But when Jim showed signs of emotional problems, the adoptive parents returned him to the adoption agency. It was believed to be in everyone's best interest. Thirty-six years later, the only information Eleanor has been able to learn in regards to Jim is that he had been in a shelter for the homeless. It was believed he had also been in and out of mental institutions. Unfortunately, the decision to separate the children proved damaging to both of them. Jim's emotional problems worsened, following him through his life, and Eleanor was traumatized by the loss of her brother.

Research Findings

Although reasons for separating siblings may have merit, numerous studies invalidate them. They indicate that separating siblings often delivers inappropriate messages and results in greater problems for children over time. Research on siblings reveals the following five points:

1. When children are separated because of sibling rivalry, it teaches them the way to deal with conflict is to walk away from it, not to work it out. Siblings who remain together learn how to resolve their differences and develop stronger relationships.

2. The responsibilities felt by an older child for a younger sibling is not necessarily a negative. It can be used constructively by adoptive parents to help both children develop appropriate roles with each other. The care-giving child can be helped to become a child again and the younger child can learn that adults can be trusted.

3. Even a needy child does not necessarily benefit from being the only child in the family. According to Margaret Ward's study, *Sibling Ties in Foster Care and Adoption Planning*, an only child may receive a great deal of attention, but the child may also become the embodiment of all the parents' hopes and aspirations. The child may be expected to change troublesome behavior sooner than he or she is able and to accomplish or achieve far beyond his or her actual potential.

4. When a sibling is removed from a home because of behavior problems, remaining children get the message that the same thing can happen to them. It reduces their sense of trust in adults.

5. Removing a sibling from an out-of-home placement or adoptive home because he or she has abused his or her brother or sister does not guarantee that the abuse will not continue in another environment with another victim. Therapy may be a more appropriate intervention.

Issues of Sibling Relationships

Despite the growing recognition that it is healthier for brothers and sisters to remain together, child welfare specialists charged with the responsibility of placing sibling groups still struggle with the difficult reality of finding families willing to accept sibling pairs or groups. If the purpose of the child welfare system is to protect and help children, everyone involved should be intent on carrying out that mission whether dealing with one child or siblings.

Child welfare specialists who are dedicated to keeping siblings together and who are willing to be flexible about prospective adoptive families can be successful. For example, large families are often willing to adopt a sibling group of three or four, but these families make some specialists uneasy. They worry that parents may be overburdened and will not be able to give each child enough attention. They wonder whether the household will be too chaotic and at what point the family will be strained beyond its capacity to give quality care. On the other hand, research shows that living in a large family has many benefits. Large families teach everybody how to work together; the older children help the younger children and they learn to share.

Parents in large families are less likely to overreact to minor problems. Large families also tend to operate with more structure – set guidelines and consequences that are known to everyone. For many children who experienced inconsistency and even abuse and neglect, this will be a welcome change from the chaos they faced in their earlier lives.

Children in large families learn to cooperate with people of different personalities and temperments which helps them become more flexible about changes in their world and prepares them for interaction with the wider community.

An agency's determination to keep siblings together must be reflected in its recruitment messages. When recruitment highlights sibling groups in a positive manner, families willing to adopt them respond.

Most people are distressed when they hear there is a chance siblings will have to be separated. It seems against the natural order of things. Even a family considering the adoption of only one child will almost always want to adopt his or her siblings once they are made aware of them. Sibling relationships are sometimes the only semblance of normalcy these children have. Taking away someone's siblings, strips him or her of important relationships that make him or her feel okay about himself or herself.

Why Siblings are Separated

Although it is generally accepted that separating siblings should be the exception, many brothers and sisters are living apart. Unfortunately the decision to split the family is often left to the discretion of the child's child welfare specialist and may be determined largely by resources available for placement.

Today, with more children entering the child welfare system, it is becoming increasingly difficult to find families willing to accept a sibling group.

Often these sibling groups have come from troubled backgrounds, having suffered abuse and neglect by their biological parents. It is thought that, placed separately, the children will each receive the undivided attention of their new parents, and this will help each develop to his or her highest potential.

Child welfare specialists may decide to separate siblings if one of them is victimizing the other.

Separation is also common when one child has difficulty giving up his or her role as caregiver to the other children. Removing the care-giving child may appear to be in his or her best interests, so he or she can learn to become a child again without the constant reminder of past responsibilities. As a resource parent, you can advocate for the siblings being placed together and assist in ensuring frequent visitation when they are not.

Visitation

The single greatest factor affecting family reunification is the frequency of contact between parents and children. Planning and making successful family visits happen are difficult teamwork tasks for resource parents and child welfare specialists, but research has repeatedly confirmed that family visitation is the key. Although complicated arrangements and emotions do not make visits easy, the results speak for the value of family visiting.

Why Visits Work

When a child is removed from home, both the parents and the child may feel like failures. Parents frequently feel inadequate and children may feel that somehow the breakup of the family is their fault. When someone from outside the family removes the child, there is trauma and a feeling of loss of control. Visits help to heal the feelings of failure and inadequacy and lay the groundwork for building a better parent/child relationship.

Dealing with Expectations and Emotions

Even though everyone wants to visit, all parties involved in the visit have different expectations. Balancing feelings and expectations involved in visitation is difficult for everyone, including child welfare specialists and resource parents.

Children want to visit family to:

- Be reassured they are still loved and lovable
- Be reassured that the parents, siblings, and extended family are OK
- Receive permission from the parents to be happy where he or she is living until returning home is possible

- Ease the pain of separation, loss, and grief

Parents want to visit children to:

- Be reassured that the child is being cared for
- Reassert their commitment to the child
- Be reassured that the child has not forgotten them
- Be informed about the child's growth and development
- Become better at parenting

Resource parents attending visits expect to:

- Keep in touch with changes in the family that may impact the permanency plan
- Learn more about the child's relationship with his or her parents
- Understand the child better
- Provide support to the child in his or her effort to cope and understand the situation

Child Welfare Specialists take primary responsibility for the visits by:

- Actively engaging the parents in setting up a visitation plan
- Consulting the resource parents, and sometimes the child, in accordance with DHS rules and the individualized service plan
- Developing goals for the visits to enhance their impact on progress toward permanency plans
- Supervising the visit or making arrangements for other supervision if necessary
- Recording clinical observations during the visit of parent/child interaction or other significant factors
- Reporting the nature/successfulness of the visits to the juvenile court

If the visitation plan or the actual visit doesn't satisfy everyone's hopes and expectations, they are likely to respond negatively. The child welfare specialist will need to deal with everyone's emotions, and the resource parent may be left with a very disappointed, sad or angry child acting out his or her feelings. Although this may be stressful, remember that even if the results of a visit do not seem positive at the moment, every visit is a positive step toward the child reaching a permanent family.

Frequency, Length, Supervision and Location of Visits

Visitation begins no later than one week following the child's removal from home and a visitation schedule that considers the child's needs is developed and includes more than one time per month visitation thereafter until the child is returned or the permanency plan is no longer reunification. Visits become more frequent and longer and have less supervision as the child's parents correct the conditions of intervention. Exceptions are made when the parents fail to cooperate with visitation arrangements, when the court orders no visitation, if the whereabouts of the parents are unknown, or visitation, even supervised, endangers or subjects the child to damaging psychological/emotional stress.

Early in a case, visits may require supervision by the child welfare specialist, and when necessary, may be held in a neutral environment such as the DHS office. Supervised visits give the specialist an opportunity to make clinical observations which may prove useful to making decisions about services and permanency recommendations.

As soon as safety/progress permits, visits may be moved to locations more conducive to parent-child interaction, such as parks, restaurants and shopping malls. As the parents progress in eliminating risk factors, the frequency and length of visits increases and the location moves to the resource parents' or parents' home, as appropriate.

Visitation Plan

A visitation plan is designed jointly by the family, the resource parent and the child welfare specialist. The plan and schedule provide security for the parent-child interaction and allow parents a reliable routine for practicing new parenting and relationship skills. The schedule should address frequency, length, location and any other relevant circumstances specific to the case. The visitation plan is signed by the family, the resource parent, the child welfare specialist, and, if appropriate, the child.

Sibling Visits

All efforts are made to place sibling groups together in both temporary and permanent placements. When this is not possible, siblings need to have frequent contact with each other. Resource parents should expect to work with the Specialist and other resource parents where siblings are placed to develop a sibling visitation plan, with input from the children if age-appropriate.

Other Relatives and Important Persons

In addition to parents and siblings, grandparents, teachers, ministers, extended family members, and others all play crucial roles in a child's development. When relatives or other people important in the child's life request visitation, the child welfare specialist facilitates this kind of contact with the resource parent's assistance. In planning such contact the specialist considers the wishes of the parents, the wishes of the child, the permanency plan and the directives from the court.

Mail and Phone Contact

DHS encourages contact by children in out-of-home placements with their parents, extended family, and friends through phone calls and letters. Mail, including email, and phone calls are not monitored or restricted unless necessary for the child's protection.

Overnight Visitation with Friends

Children in out-of-home placements may have overnight stays with friends whom the resource parents know and approve. Resource parents use the same discretion about such arrangements as with their own children, balancing the normal social experiences of childhood with care to assure that informal social occasions or overnight visitation with friends do not jeopardize the safety and well-being of the child.

Frequently Asked Placement Questions

Will I get to choose the children placed in my home?

DHS does its best to place children with a resource family who can best meet the behaviors and needs of the child. Some resource parents prefer to work with teens, while others do better with young children. Resource parents are able to specify the age, gender and number of children placed in the home. However, they are not allowed to request a particular child be placed in their home unless the home has been determined, by definition, to be a kinship resource.

How long will a child remain in my home?

The length of time a child remains in a resource home varies according to the plans for reunification and how quickly reunification with the child's family might occur. Children may remain in out-of-home care for a few days, a few months or longer. If the child cannot be reunited with their family, a permanent placement for the child will be sought. Permanent placements could include placement in the current resource home, a kinship placement, a placement with siblings, or an Indian Child Welfare compliant placement. Permanent placements are accomplished through legal guardianship or adoption while continuing to maintain the child's connection to kin, culture and community.

Will I have to work with the child's parent?

As a Bridge resource home, you will be expected to serve as a mentor actively helping the child's parents to improve their ability to safely care for their children. The DHS Bridge Resource Parent Program is comprised of a team of persons working together to do what is in the best interest of children. Resource parents are critical members of that team. The goal for a child placed in DHS custody is to achieve safety and permanency as soon as possible, which includes working with the child's parents towards reunification.

Can we adopt a child who is placed in our home?

Many families are interested in both fostering and adopting. They agree with DHS that the needs of the child come first. In most cases, this means they help prepare children for reunification with their family or toward a relative or kinship placement. When termination of parental rights is in the child's best interest and adoption is the child's plan, then resource parents who have cared for the child will be given the opportunity to apply for adoption.

If I accept a child from another culture or belief system, how could I best deal with the child's needs?

The children who are placed in a resource home will be from different types of situations, communities, families and cultures. What specific things could be done to welcome a child from a different culture? Remember that for all of these children – regardless of community or culture – life with a different family will not be what they are used to. Here are suggestions that will hopefully help a child feel comfortable in a resource home:

- Find out as much as possible about the child's heritage, culture and language
- Identify and prepare one of the child's favorite foods
- Have books, toys and/or magazines in the resource home that reflect the child's culture
- Find out if the child attends a particular religious service and be prepared to take the child to the services or to other culturally related activities
- Be prepared to take proper physical care of the child (for example, have hair care products in the home that are appropriate for an African-American child)

Considering a Placement

When considering placement of a child, the following questions should be asked:

- How old is Johnny?
- Why is Johnny in foster care?
- What has happened to Johnny?
- Please describe Johnny's personality and current behaviors.
- How is Johnny feeling emotionally at this time?
- How does Johnny feel about being in foster care?
- How do Johnny's parents feel about him being in foster care?
- What is the plan for Johnny's visits with his parents?
- How have his parents been handling the visits?
- Does Johnny have any siblings? If so, what are their names and ages and where are they placed?
- When is Johnny's next visit with siblings?
- What is the plan to place the siblings together?

- Does Johnny have any medical problems or allergies? Is he on any medication, and if so, for what reason?
- Does he sleep well? If not, please explain.
- Does he eat well? If not, please explain.
- Does he have any food or other types of allergies?
- How long will Johnny need to be in care?
- Is this a change of placement for Johnny, and if so, why is he being moved?
- How is the legal case progressing? Are there any problems?
- What is the permanency plan for Johnny?

When a Child Is Placed

Here are further questions to ask when the decision has been made to accept a child into the home:

- When does Johnny need to see the doctor?
- When did he have his last physical and dental exam?
- What are the names of Johnny's doctors and dentist and where are they located?
- Does Johnny have any medical, dental or behavioral health appointments already scheduled?
- What, if any, violent, traumatic or upsetting events have happened to Johnny or has witnessed?
- Does Johnny have a supply of his medication? How much longer should he continue on his medication? Where/ how can the prescription be refilled?
- Does Johnny need clothing?
- When is Johnny's family's next court date?
- What are some of Johnny's favorite and least favorite foods?
- What is Johnny's usual daily schedule?
- Where has Johnny been attending school (if school age)? Where will Johnny go to school? Will Johnny go to school tomorrow?
- What are the transportation arrangements for Johnny to get to and from school?

- What is the correct spelling of Johnny's full name? Does he have a nickname? What does he like to be called?
- Who does Johnny talk to on the telephone? What are their numbers?
- What is the office and after-hours telephone number of the child welfare specialist? What is the name and telephone number of the supervisor?
- Who are some of the individuals closest to Johnny, and what is their relationship to him?
- Has Johnny ever run away?
- Are there individuals we should be concerned about when out in public?

Protecting and Nurturing Children

Normally, the bonding between mother and child and the child's attachment, love and commitment to the entire family provides a nurturing environment for healthy development. Attachment is defined as an affectionate and emotional tie between two people that continues indefinitely over time, even if distances separate people. Children's identities are forged in their families. Each learns the family's language and vocabulary, preferences in food, feelings about other people and ways of handling problems. Feeling protected and nurtured within their families allows children to push forward and explore new things, while still secure and connected to their family foundations. Children lose the personal foundation for growth and development, however shaky, when the bond with mother and the attachment to family is broken by entering out-of-home care. A misconception is that children placed in out-of-home care feel relieved and, perhaps, grateful to be leaving an abusive or neglectful family situation, when in reality most children remain very attached to siblings, extended family and parents, even those who have abused or neglected them. Children often see their family's behavior as normal.

Even children who are aware that their own family may live differently from other families often find their family's behavior reassuring because it is predictable. Leaving a predictable situation and the only family you have ever known and being given the message that your family is bad may seem worse to a child than enduring abuse or neglect at home. Being part of a family identified as having problems that result in his or her removal from the home may lead the child to question his or her own adequacy and worth.

The impact on a child's life of being separated from the family depends on:

- Age when they entered out-of-home care
- Types and number of losses and separations they have experienced
- Their personal capacity to cope with the situation
- Help and support they receive at the time

Getting all available information about the child is very important to understanding his or her feelings and helping the child adjust to their new resource family and obtain the services needed.

Ways to Integrate a Child into the Resource Home

If the resource family chooses to have a celebration to welcome the child into the home, it is a good idea to have a small and quiet celebration so as not to overwhelm the child. Some ideas for making the arrival more comfortable are:

- Prepare a welcome sign and personalize the child's space with a sign such as "Johnny's Room."
- Place age-appropriate items in the area.
- Give the child a tour of the home to show him that his space is ready, whether that is an entire room or a bed, some drawers and closet space in someone else's room. If another child is in the home, have that child be the tour guide.
- Point out the evacuation exits in the event they are needed.
- Have a stuffed animal the child may keep waiting on the child's bed.
- Have a care package available with toothbrush, toothpaste, comb, story books or coloring books and crayons.
- Have an oversized white T-shirt ready to serve as pajamas for the first night and make decorating it with fabric markers part of the welcome ritual, and other children in the family could wear similar T-shirts that first night to help the child feel more at home.
- Consider taking a picture of the event for the child to keep and add this to a collection of other pictures you take throughout the child's stay.

Building a Relationship with the Child

Being placed in a resource family home usually involves the pain of being separated from family. Even when told they are not the cause of the placement, children still may feel they are being punished or their parents are rejecting them. Regardless of the family problems, most children still have tremendous loyalty to their parents. A child will probably be self-conscious and will feel more comfortable if the resource family settles down to a routine as quickly as possible. Help the child understand and accept the rules of the home and the lifestyle gradually. He or she is not only adjusting to a new family, but to other children and possibly a new school and community as well. Even though the child may act confident, he or she may be hiding insecure feelings. Let the child know there is someone available to listen when he or she wants to talk. A receptive attitude will let the child know that his or her feelings can be shared, and he or she won't be judged. You may find the child testing the limits. Many children, for example, respond to their insecurity and anger by refusing to eat, overeating, clinging, wetting the bed, withdrawing, becoming defiant or venting anger at their new resource family. This is something that many resource parents experience. With patience, the resource family can help the child learn that this placement is not punishment, but in this new home, people care.

Travel and Vacations

Resource parents are encouraged to include children placed in their homes in the family travel and vacation plans. When travel plans do include a child placed in your home, inform the child's child welfare specialist as soon as possible regarding the destination and duration of the trip. Advance planning is necessary since parental or court approval is needed for the child to travel out of the state or country. These travel plans should not conflict with the child's scheduled parental visits, court appearances, etc. When traveling out-of-state or out of the country, the resource parent will need to take the completed Travel and Medical Authorization form which may be obtained from the child's child welfare specialist.

You will also need to take the child's medical card in case a medical emergency occurs. If the child will not or cannot travel with the resource parent, the child's child welfare specialist must be notified as soon as possible in order that temporary (alternate) care plans can be arranged.

Using the approved alternate caregiver designated by the resource family and approved by DHS is encouraged. Often a person familiar to the child is willing to provide temporary care during the time the resource parent will be gone – emergency travel, family crisis, etc. — thus preventing another change or disruption in the continuity of care for the child.

Life Books

A Life Book chronicles a child's life in care and connects that part of his or her life to the rest of the child's history and family traditions. This critical tool helps the child understand his or her stay in out-of-home care and provides a record of important events and documents. Many significant people may come and go throughout the child's life and acknowledging these individuals and memories through the process of creating a life book affords the child the opportunity to explore and understand the past.

Imagine not knowing even basic pieces of information about your own history. What if we didn't know much about our own parents? What if we were not sure how or why we came to live in the home we are in? What if we had been in more schools than we could remember? What if we had no pictures of ourselves or of family members taken before we were in high school? Sadly, many adults who grew up in out-of-home care cannot answer these questions.

When creating a life book, you are limited only by your imagination. DHS has a format for life books available to all resource parents, and scrap-booking supplies can be found at any number of retail stores. Here are some suggestions for topics to include in a typical life book:

- Introduction (i.e., the purpose of the book)
- Birth announcement
- Important documents (i.e., birth certificate, Social Security card, etc.)
- Baby pictures
- Birth family pictures
- Explanation of how the child came to be in out-of-home care
- Pictures of resource families and written information about where they have lived and when the child was there
- Pictures and names of child welfare specialists who were important in the child's life
- Journal entries
- School pictures, records and awards
- Cultural and religious information
- Pictures and mementos of favorite friends
- Pictures and notes about pets
- Pictures and notes about trips, vacations and special events

When a Child Leaves

It may be difficult for the resource family when a child leaves the home. Personal sacrifices have been made to help this child, and understanding, time and energy have been expended by the resource family. Because of this attachment to the child, the resource parent will play an important role in helping the child prepare to return home or to another appropriate placement. Talk to the child's child welfare specialist or the resource specialist in regards to telling the child about the move and how best to handle questions or concerns.

Try to make the move easy for the child. Send a letter about the child to the new resource family or birth parents for easier transition. Point out changes in routine, behavior and personality that have occurred. Make sure that the child's life book, personal property, health records and medical cards are transferred with the child.

If possible, it is very important and strongly encouraged that resource parents maintain a relationship with the child after he or she leaves.



Section 5. Teamwork

Members of the Team
Family Group Conference
Initial Meeting
Reassessment



Teamwork

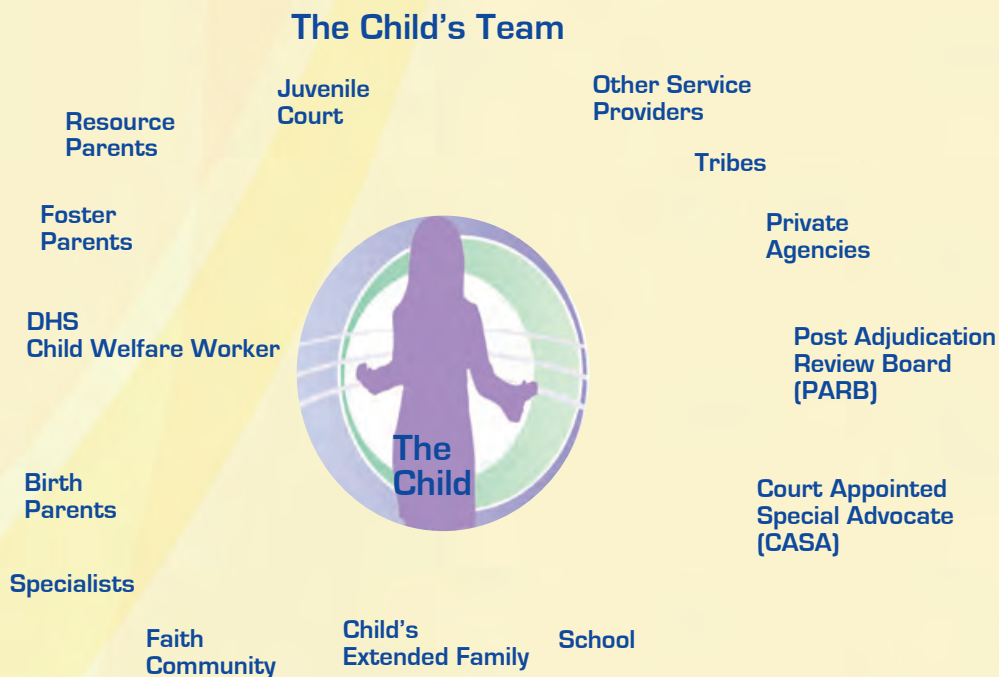
Teamwork

Section 5: Teamwork

Members of the Child Welfare Team

Children are placed in DHS custody by the juvenile court as a result of abuse or neglect. Many individuals are involved in a team effort to reunite children with their families, or when this is determined not to be in the best interest of children, to establish another permanent home for them. As a resource parent, you are a vital member of the team, and the information you have regarding the children placed in your home is very important to a successful outcome.

The image below indicates the members of the team with the child being the central focus.



Teamwork

Bridge is based on a teamwork concept. The child welfare specialist, biological parents, resource parents and other professionals involved with the family work together in planning for the child. As a Bridge resource parent, you will be providing care, love and nurturance to the children placed in your home and serving as a mentor actively helping the child's family improve their ability to safely care for their children, thus assisting in the transition to reunification. Whether permanency for a child is that of reunification, legal guardianship or adoption, you will be asked to maintain the child's connection to his or her kin, culture or community.

Members of the Team

Child Protective Services

Child Protective Services workers are responsible for assessing the safety of children who are reported to be alleged victims of child abuse and neglect. CPS workers are involved with children and their families through either the CPS Investigation track or the CPS Assessment track. The purpose of the CPS Investigation track is to determine

whether abuse and neglect is occurring that places the child's safety in jeopardy. The purpose of the CPS Assessment track is to determine, through family engagement, what services could assist the family in preventing future child abuse and neglect. Regardless of the track, the CPS worker is always alert to assessing the safety of all children in the home. In those instances when a child cannot safely remain in their own home, the CPS worker is involved in securing an alternate safe placement. The CPS worker is often the first point of contact in the Bridge process by acquiring names of relatives and friends who could be resources for the child. The CPS worker is also responsible for explaining Bridge to the child, if he/she is old enough, and to the child's family. The CPS worker facilitates the child's transition from the home to the Bridge family and is often involved in the initial contact and visitation arrangements. The CPS worker is also involved in preparing and introducing the child, the child's family, and the resource family to the Permanency Planning process, which may also include a new worker.

Permanency Planning

The child welfare specialist engages a child and family in the process of assessment and service planning. The Specialist assists the family with accessing services and supports which will assist them in correcting the conditions which led to removal of the child from their home. If the child cannot be safely returned to his or her own home, the Specialist is responsible for helping the child achieve permanency through adoption, guardianship, or for older youth who plan to emancipate from care, an effective transition plan. The specialist also supports the child in out-of-home care through referral for needed services and working together with placement providers as part of the professional team to effectively meet the child's needs while in care.

The child welfare specialist, as a member of the Bridge team, provides a link for interaction and teamwork among DHS, birth parents, resource parents, the child and all involved parties. The specialist facilitates information sharing, direct contact and meaningful dialogue among all the team members with the goal of meeting the child's needs for safety, permanency and well being.

Resource Specialist

The resource specialist recruits resource families, assists in obtaining or completes the resource family assessment, coordinates training and engages in activities that value and support the resource parent's role and assists the resource family in navigating the CW system. They work as a professional team member with Permanency Planning, Child Protective Services, Adoption Services, and the resource family to ensure the child's safety, well-being, and permanency. They treat the resource family with respect and assist the family with any issues arising with the children placed in the home and any concerns the resource family may have.

SWIFT Adoptions

Swift adoption services include processes completed by contracted agencies or DHS staff to gather history regarding a child in DHS custody, including the child's biological family background, medical, educational, and social history for purposes of full disclosure to a prospective adoptive family. The mission of the Swift Adoption Services is to secure an adoptive family for every waiting child for whom adoption is the permanency plan. Children can be assured a permanent adoptive family through early identification, assessment and child preparation; aggressive recruitment and preparation of prospective adoptive parents; elimination of legal and other barriers to adoption; and adequate provision of supportive services.

Child Welfare Tribal Liaison

A Child Welfare tribal liaison is assigned for each tribe with a Tribal/State Agreement for Foster Care. The liaison facilitates contacts with the tribes and has specific duties and responsibilities for children in tribal custody and for children in DHS custody placed in tribal resources.

Resource Parent

A resource parent is an individual approved by DHS to provide out-of-home care to a child in a nurturing, stable, safe environment. This term includes relatives or other kinship caregivers.

Juvenile Court

The focus of the Juvenile Court in cases of child abuse and neglect is on the welfare of the child in the context of the family. This requires social service professionals and the Court to work closely with one another to assess the family situation and protect the child. The child is made a ward of the Juvenile Court if adjudicated deprived because of abuse or neglect. The family's progress toward reunification is reviewed by the Court until reunification occurs or is determined not to be in the child's best interests.

Judge

A judge is an official who presides over a court of law. The judge is like an umpire in a game and conducts the trial impartially and in an open court. The judge hears all the witnesses and any other evidence presented by the prosecution and the defense. In deprived matters, the judge may, upon application by the district attorney, issue a court order to place the child in emergency custody when the child is in need of immediate protection. The judge hears the evidence presented during the hearing and decides whether the child is adjudicated. The judge decides whether the child is placed in the custody of the people responsible for the child (PRFCs, a relative, DHS, or another agency), and may order the PRFCs and child to participate in a court-ordered treatment plan.

District Attorney

The district attorney has the responsibility to determine whether filing a petition is warranted based on information obtained during the Child Protective Services investigation. DHS has the responsibility to make a written recommendation, regardless of whether the district attorney verbally indicates he or she may not file a deprived petition. Consultation, coordination, and a good working relationship between the child welfare specialist and the district attorney is essential to ensure court protection of the child.

Assistant District Attorney

An assistant district attorney works for and with the district attorney and has the same responsibilities as the district attorney as it relates to DHS and Child Welfare.

Attorneys

In deprived actions, a separate attorney is appointed for the child. The child's attorney represents the child and any expressed interests of the child. The roles and responsibilities of the child's attorney are:

- (1) Represent the child and any of the child's expressed interests

- (2) Arrange to meet with the child as soon as possible after receiving notification of the appointment
- (3) Except for good cause, meet with the child prior to any court proceedings
- (4) Speak with the child by telephone if a personal visit is not possible due to exigent circumstances
- (5) Contact the custodian or caretaker of the child prior to the hearing when a meaningful attorney-client relationship between the child and attorney is not possible due to the child's age or disability

DHS provides the child's attorney access to all reports, records, information relevant to the case, and any reports of examination of the child's parents, legal guardian or custodian. The attorney is advised of the child's location and how best to contact the child. The child welfare specialist, as an advocate for the child, coordinates and consults with the child's attorney to ensure the protection and well-being of the child.

Private Agencies

The child welfare specialist engages the services of private agencies to help implement the Individualized Service Plans for children and families. Examples are counseling agencies, faith-based service agencies, mental health facilities, county health departments, youth services agencies and other providers that DHS might contract with for medical care or therapy.

Post Adjudication Review Boards

Post Adjudication Review Boards have been established for each judicial district to review the case of every child alleged and adjudicated deprived that are in out-of-home placements. The court appoints the individuals who serve on the boards. Resource parents have the right to provide information to the boards and to attend those meetings relating to a child placed in their home. Resource parents should contact their child welfare specialist to learn when their child's case is scheduled for review. Individual cases are reviewed at least every six months.

Court Appointed Special Advocate

A Court Appointed Special Advocate is a volunteer appointed by the court to serve as an officer of the court and as a guardian ad litem to advocate for the best interests of a deprived child in the court's jurisdiction. While the child is placed in a resource home, the CASA will make regular visits with the child and may plan activities with the child away from the home. CASA and resource parents work together in planning activities and visits with the children. The CASA program is not available in all 77 counties, nor are CASA volunteers available for every child in those counties which have a CASA program.

Family Team Meeting

A Family Team meeting is a way to engage and partner with a family and all the people who surround a family. It's a way to facilitate communication between child welfare, children/youth, their families and the community partners about the responsibility we share in protecting the child(ren)/youth. The purpose is to support the family in building a support network that will eventually sustain them in keeping their children safe after their child welfare case is closed. A family team meeting can be used as an avenue of discussion to resolve any issue that comes up within the course of a case. Some ways that family team meetings support families include:

- Reaching agreement on which identified safety issues will be resolved and how they will be addressed throughout the life of the case
- Developing a service agreement that is created using the best ideas of the family, informal and formal supports that the family believes in, the agency approves of, and also lessens risk and heightens safety for the child/youth and family
- Planning for how all participants will take part in, support and implement the Service Agreement developed by the team
- Resolving any need for placements that arise if the child/youth is removed from the home

Initial Meeting

The initial meeting is a meeting that involves the resource parents, the child's parents and the child welfare specialist in order for the resource parents and child's parents to meet face-to-face to exchange information regarding the child and begin to establish an open relationship with each other. Children are not involved in the initial meeting, and ideally the meeting should occur within seven days of the child being placed in out-of-home care.

Reassessment

Resource homes are reassessed on a continual basis. A formal written reassessment of each approved home is completed annually as long as the resource is open. The areas covered during this reassessment include:

- Review of children placed in the home
- The adjustment of children to the home
- Resource parents' handling of problems
- Reason for resource parents' requesting the removal of any child
- Any significant changes in the resource parents' circumstances
- Safety issues in the home such as current pet vaccinations, storage of weapons, location and condition of smoke detectors and fire extinguishers
- Safety issues concerning transportation such as insurance, car seats and seat belts
- Number of children for which the resource home is approved
- A review of policy including changes and updates
- Background checks on all household members 18 years and older, every three years
- Financial and medical information updated every three years, or as necessary

Resource parents are encouraged to keep a log or journal, noting any significant changes in the child's behavior or adjustment, as well as all medical, dental and mental health appointments. Resource parents and child welfare specialists are encouraged to communicate on a continual basis regarding the adjustment, development, behavior and accomplishments of each child in a resource home.



Section 6. Bridge Kinship Resources

Family Assessment
Pre-Service Training
Contract
Kinship and TANF
Child Care
Discipline in Kinship Resources
Kinship Training Stipend
Kinship Start-Up Stipend
What You Need to Know About
Becoming a Bridge Kinship Resource



Section 6: Bridge Kinship Resources

There are some basic differences between Bridge traditional resources and Bridge kinship resources. Traditional resource parents provide care and nurturing to children by taking them into their homes for a limited or a more long-term period of time, without knowing the children or their families beforehand. Kinship resource parents provide care for children they are related to who require out-of-home placement. Non-relative kinship resource parents provide care for children with whom they have a bond or emotional connection that existed prior to the children being taken into DHS custody. In both instances, traditional or kinship, individuals apply to DHS to become resource parents.

The following points help to distinguish kinship resources from traditional resources:

- Are you related to the child placed in your home by blood, marriage, or adoption? Did you know the child and parents before he or she was placed in DHS custody? If so, you are providing kinship care.
- Because you are providing kinship care, the child was able to be placed in your home before you were fully approved as a resource home. Placement of the child in your home was allowed to prevent the child from staying in a shelter or being placed with individuals he or she did not know.
- Even though the child was placed in your kinship home before full approval, you are not eligible to receive a monthly maintenance payment for the child until:
 - The full integrated assessment has been approved and signed by the supervisor
 - Fingerprint results for all individuals 18 years or older residing in the home have been received and reviewed
 - DHS-approved of pre-service training has been completed
 - A contract has been signed by the resource parents

Family Assessment

A family assessment (home study) will be completed by an individual DHS has contracted with to complete the family assessment. A minimum of two home visits will be conducted in order to gather information regarding all individuals that reside in your home and to assess your family's strengths and abilities to provide care for the children placed in your home. The family assessment must be reviewed and signed by a child welfare resource supervisor before approval is given.

Pre-Service Training

All resource applicants, traditional or kinship, must complete DHS-approved pre-service training prior to final approval of the resource. Completion of the training is also a prerequisite for receiving the monthly maintenance payment. The training helps prepare you to understand and deal with the impact that abuse and neglect may have on a child's behavior, how to view the child's behavior through a trauma-informed lens, and with other issues that you may experience as a resource parent. The training also helps you to understand the child welfare system and your unique role as a kinship resource parent. Resource Family Training sessions are held in many formats. Your resource specialist discussed with you the best format for your family.

Contract

Your DHS Resource Specialist is responsible for ensuring you read, understand and sign a contract. You will be provided with a copy of the contract. The issuance of a contract number through DHS is what enables you to receive the monthly foster care reimbursement.

Kinship and Temporary Assistance for Needy Families

Relatives of the children placed in their care, may apply for Temporary Assistance for Needy Families. Contact the local OKDHS office to speak with a TANF worker in regards to the requirements that must be met in order to qualify for this payment. Once your home is approved as a kinship resource, you must notify TANF immediately. Resource parents are not eligible to receive a TANF benefit and the maintenance payment at the same time. Should that occur, an overpayment will be created, and all overpayments must be repaid in full.

Child Care

When traditional or kinship resource parents work 20 hours or more per week, DHS can pay child care expenses. Verification of employment must be provided, including the days of the week and hours of the day that are worked, when application for child care is made. Child care is paid for employment purposes only, not for educational or training reasons. If your family has a special need, please discuss it with your resource specialist and an exception can be made to approve child care not within current requirements.

Discipline in Kinship Resources

This is an important subject. There is no difference in regards to discipline techniques, whether a kinship or traditional resource. Physical discipline such as spanking, swatting, slapping on the hands, etc. are neither appropriate nor approved forms of discipline. DHS prohibits the use of any form of physical discipline on a child in DHS custody, even if a kin relationship exists. Resource parents are encouraged to practice reinforcement of the child's appropriate behavior and to use the child's own strengths to help find effective ways for him or her to develop self-control. Resource parents may consult with the child's child welfare specialist or resource specialist to learn of resources to help with discipline issues.

Kinship Training Stipend

The kinship training stipend is a payment available to kinship resources to assist in meeting some of the needs during the time in which training is being completed. An initial training stipend of \$375 is available when the applicants are enrolled in training, and a final training stipend of \$375 is available when the applicants complete the training. In order to receive the training stipends, children must be placed in your home and remain in your home during the duration of the training. The training stipend is available only for kinship resources.

Kinship Start-Up Stipend

Kinship resource parents receive a one-time start-up stipend to help meet the additional financial needs as a result of having children placed in their homes. The stipend amount is available for each child placed in the home, and is equivalent to the current monthly maintenance payment per the age of the child. Please check with your resource specialist to obtain the current amount.

Kinship resource parents are eligible to receive the one-time stipend after the child has been in the home at least two weeks and a contract has been signed.

What You Need to Know About Becoming a Bridge Kinship Resource

Before you are approved:

- A child welfare specialist will visit you in your home to complete an initial assessment
- Children may be placed in your home, but you will not receive a monthly maintenance payment until you are approved as a Bridge Kinship Resource with the following requirements being met:
 - A contract has been signed by the resource parents
 - DHS-approved training has been completed
 - Fingerprint results have been received and reviewed
 - The Family Assessment has been approved and signed by the supervisor
- If you are related by blood to the children placed in your home, you may apply for financial assistance at your local DHS office.
 - Temporary Assistance for Needy Families — Child Only
 - Food benefits (based on household income)
 - Please apply immediately if you so choose.
- Paid child care is available if all adults are employed outside the home at least 20 hours per week
- Children placed in your home may be eligible for a start-up clothing voucher
- Once children are placed in the custody of the State of Oklahoma, they are eligible to receive Medicaid benefits
- The child welfare specialist will provide the Medicaid information to you at the time of placement or as soon as possible. The medical number for the child can also be found in the Child's Passport.

During the approval process:

- A contractor will complete an in-depth assessment with you and your family that will include at least two (possibly more) home visits
- You are encouraged to become the child's payee if the child placed in your home is receiving Social Security benefits, but you are not eligible to receive the Social Security benefits and the monthly maintenance payment at the same time
- State and federal laws, as well as DHS, require that all adult household members providing care for children must complete pre-service training
- A \$375 training stipend is available when you are enrolled in training
- A \$375 training stipend is available when you complete training
- Children must be placed in your home to be eligible to receive the training stipends
- A one-time start-up stipend will be available that is equivalent to the monthly maintenance payment per the age of the child
- Paid child care continues to be available if all adults are employed outside the home at least 20 hours per week
- A child welfare specialist will visit with you and the children placed in your home at least once a month
- It is the right of the children placed in your home to visit their parents and other family members

After you are approved:

- A monthly maintenance payment, based upon the age of the child, will begin when your home as been approved which means the following has occurred:
 - A contract has been signed by the resource parents
 - Pre-service training has been completed
 - Fingerprint results have been received and reviewed
 - The Family Assessment has been approved and signed by the supervisor
- If you are receiving Child Only TANF benefits, you must notify your TANF worker immediately when you become an approved Bridge Kinship Resource in order that the benefits can be canceled
- You are not eligible to receive TANF and the monthly maintenance payment at the same time
- Your monthly maintenance payment should be received around the 15th of each month and no later than the 20th, and is for the prior month's care of the child

- You may choose not to accept the monthly maintenance payment, but all requirements necessary to approve your home must still be met
- Paid child care continues to be available
- All health care (medical, dental and vision) and counseling services for children in DHS custody continues to be available
- Over-the-counter and non-prescription items are your responsibility
- Bridge Kinship Resource families must complete twelve hours of in-service training each calendar year and provide verification of the training received to their resource specialist
- Contact your resource specialist if you have questions regarding your resource home or have additional questions and cannot reach the children's child welfare specialist
- Contact your children's child welfare specialist if you have questions regarding the children placed in your home



Section 7. Financial Assistance

Maintenance Payment

Claims

Difficulty of Care

**Social Security Survivors' Benefits and
Supplemental Security Income Benefits**



Section 7: Financial Assistance

Maintenance Payment

Resource parents are eligible to receive a monthly maintenance payment once the final approval of their home has taken place. Final approval of a resource home occurs when:

- The full integrated assessment has been approved and signed by the supervisor
- Fingerprint results for all individuals 18 years or older residing in the home have been received and reviewed
- DHS-approved pre-service training has been completed
- A contract has been signed by the resource parents

Once the final approval of the resource home has occurred, resource parents receive a monthly maintenance payment for the care of the children placed in their home. The rates depend on the age of the children. Please contact your resource specialist for current monthly maintenance rate.

Resource parents receive a monthly maintenance payment for the first day children are placed in the home if final approval of the resource home has occurred. Resource parents do not receive a maintenance payment for the last day children are in the home.

Claims

Payment begins the month following the final approval of the resource home. For example, if children are placed in your home in January, and you are an approved resource, you would not receive the maintenance payment for those children until February. Resource parents receive maintenance payments only for the days children are in the home. The last day of placement is the exception.

Child Welfare staff approves the foster care claims every month. The claims are then generated via the KIDS automated financial management system. Claims are processed and every effort is made for the maintenance payments to be direct deposited or loaded on the EBT card by the 15th of the month, but are not considered to be late until the 20th of the month. If the monthly maintenance payment has not been received by the 20th of the month, please notify your child welfare resource specialist.

When a child's age places him or her in the next age group within the foster care maintenance payment rates, the higher rate becomes effective the month following the child's birthday and is automatically generated by the computer. For example, if a child turned six in January, the increased maintenance payment amount would be indicated on the February payment that is received in March. The increased amount is automatically generated by the computer. Resource parents are not responsible for advising the child welfare specialist of the child's birthday.

If you close the account associated with your direct deposit, it is very important to advise your child welfare resource specialist immediately. If you have any questions concerning the claims, or notice an error in payments received, please contact your child welfare resource specialist immediately.

Underpayments will be corrected through a supplemental claim that is generated by the computer. Overpayments must be repaid in full by the resource parent. Overpayments not repaid in full result in the delay of reimbursement being received by the new resource parents where the children are placed. A repayment schedule may be established if necessary. If an EBT card has been lost or stolen, notify your child welfare resource specialist.

Difficulty of Care

Difficulty of care rates are available to assist resource parents in the additional care and supervision required due to a child's physical, mental or emotional disability. Resource parents contact the child's child welfare specialist regarding the qualifications and to request difficulty of care. If difficulty of care is approved, the resource parent receives the difficulty of care rate in addition to the monthly maintenance payment amount. Please contact your resource specialist to obtain the current difficulty of care rates.

The criteria for each level of difficulty of care is as follows:

DOC Level I

A child approved for DOC Level I has one or more of the needs, conditions, or behaviors. The child:

- Requires ongoing scheduled medical or psychological appointments that routinely occur more than twice weekly
- Displays emotional difficulties that result in destruction of property
- Requires medical supplies, special equipment, or educational supplies on a routine basis that are not compensable through Medicaid
- Requires daily physical therapy performed by the foster or adoptive family

DOC Level II

A child approved for DOC Level II has one or more of the needs, conditions, or behaviors described in DOC Level I and, in addition:

- Requires 24-hour awake intensive supervision due to severe medical or emotional needs
- Requires special food preparation and feeding due to a condition that restricts normal eating
- Requires special equipment for transportation that results in restricted mobility for the child and foster or adoptive family
- Displays incontinence of the bladder or bowel that is not age appropriate
- Displays multiple disabilities, birth defects, or brain damage that prevents normal intellectual or physical functioning
- Requires strict monitoring of medication
- Requires assistance in movement that is very difficult due to the child's size

- Requires post-hospitalization care, such as frequent changing of bandages and tubes and special hygiene techniques
- Displays emotional disturbances, developmental delay, or mental retardation that results in behavior, such as constant difficulties in school, aggressive and delinquent activities, destructiveness, resistance to authority, and sexual disturbances

DOC Level III

A child approved for Level III has one or more of the needs, conditions, or behaviors described in DOC Levels I and II and, in addition, requires:

- Specialized substitute care

DOC Level IV

A child approved for DOC Level IV has one or more of the needs, conditions, or behaviors described in DOC Levels I, II, and III and requires such specialized care that normally the child would be in institutional or inpatient psychiatric care. The child:

- Requires special equipment such as: apnea monitor, suction machine, gastrostomy tube, oxygen, tracheotomy tube or shunt
- Requires special feeding or nursing care around-the-clock
- Requires frequent nighttime supervision and care that is not age appropriate
- Displays frequent seizures or other abnormal physical reactions that require 24-hour monitoring
- Displays bizarre, socially unacceptable behavior, violent tendencies, potentially harmful behavior to self or others, or sexually predatory behavior to others or animals
- Required previous inpatient mental health treatment or was recently discharged from an inpatient facility
- Requires such intensive care that the foster or adoptive family is severely restricted in normal daily activities and is frequently homebound
- Requires frequent 24-hour awake supervision
- Requires post-hospitalization care for severe burns

DOC Level V

A child approved for DOC Level V has one or more of the needs, conditions, or behaviors described in DOC Levels I, II, III, and IV and has a significant number of intense needs. The child's level of need is likely to become more severe over time and is likely at some time to require personal attendant care or specialized care outside of the home, when prescribed by a professional. A current medical or psychological report within the last six months is required from a qualified physician.

This report must include a diagnosis, prognosis, and recommended treatment. Conditions considered in the determination of DOC Level V include a child who has:

- Been diagnosed by a qualified physician as having severe mental illness, such as child schizophrenia, severe developmental disabilities, brain damage or autism
- Severe physical disabilities or medical conditions that are not expected to improve over time and adversely impact life expectancy when compared with others who have similar physical disabilities or medical conditions
- Severely inhibiting mental health conditions, defined by the Diagnostic and Statistical Manual of Mental Disorders, diagnosed within the past year, that severely limit normal social and emotional development and require ongoing outpatient behavioral health services
- Severe mental retardation as determined by the Social Security Administration and defined by the DSM
- Been waiting for organ transplant or is up to one year post transplant
- A physical condition uncontrolled by medication or treatment, such as Tourette's syndrome or epilepsy
- Levels I through IV are approved at the County level. Level V is approved by the Foster Care field administrator

Social Security Survivors' Benefits and Supplemental Security Income Benefits

Social Security survivors' benefits are available for children whose parents are deceased or disabled. Supplemental Security Income is a program administered by the Social Security Administration that provides financial benefits to disabled individuals who do not qualify for Social Security Disability benefits. When children in DHS custody are placed in a kinship resource, the kinship parent should apply through the Social Security Administration to become the payee to receive the benefits. If children are placed in a traditional resource, the resource parent with whom the children have been placed at least nine months may apply to be the payee to receive these benefits. The resource parent must contact the Resource Specialist to discuss the plan to become the child's payee, as care should be taken to prevent an overpayment due to a resource parent receiving both the monthly maintenance payment and the Social Security benefits.

A resource parent is not eligible to receive the Social Security benefits in addition to the monthly maintenance payment. If the Social Security benefits are greater than the monthly maintenance payment, the resource parent is eligible to receive the full Social Security benefit amount. If the Social Security benefits are less than the monthly maintenance payment, the resource parent is eligible to receive the Social Security benefits and the remainder of the monthly maintenance payment that would be equal to the full monthly amount.

When a child receiving Social Security benefits no longer resides in the resource home, the resource parent is responsible for notifying the Social Security Administration immediately to advise that the child no longer resides in the home.

Section 8. Resource Family Training

Pre-Service Training
Expiration of Pre-Service Training
In-Service Training
Books and Video Training
Online Training
Foster Parent College
The Learning Management System
Other Training Opportunities



Resource Family
Training

Health Management
Training

Section 8: Resource Family Training

Pre-Service Training

Resource applicants are required to complete 27 hours of pre-service training. Contact your local county office for dates, times and enrollment information.

Expiration of Pre-Service Training

If there has been a break in service of five years or more, applicants will be required to complete the DHS-approved pre-service training again.

In-Service Training

Resource parents are required to complete 12 hours of in-service training each calendar year.

Books and Video Training

The DHS Training Section has provided each county with a small library of books, videos and DVDs that resource parents may use in completing their mandatory in-service training hours.

Resource parents may receive from one to four hours of in-service training by viewing a particular video/DVD and completing an accompanying quiz or reading one of the available books and completing a book review.

Online Training

Online training is available through Foster Care and Adoptive Community and Foster Parent College via the National Resource Center for Youth Services, the DHS Learning Management System and the AGOS Group. Access this training at <http://www.okbridgefamilies.com/training/online/>.

Foster Care and Adoptive Home Community and Foster Parent College

In order to make it easier for DHS Bridge resource parents to complete their annual training requirement, DHS has provided 12 prepaid in-service credits through the Foster Care and Adoptive Home Community and Foster Parent College online training sites. Each of these resources offers a variety of courses developed by professionals with expertise in foster and kinship care and adoption. In order to access Foster Parent College, a resource parent must first register through the National Resource Center for Youth Services. The Web address is <http://www.nrcys.ou.edu/programs/rft.shtml>. After entering the website, resource parents should follow the directions given.

The units paid for by DHS through Foster Care and Adoptive Community and Foster Parent College are not available to resource parents providing Therapeutic Foster Care, Emergency Foster Care, or Contract Foster Care for children and youths in the custody of DHS. These families receive in-service training through their contract agencies and may take, free of charge, courses available on the Bridge Families website, www.okbridgefamilies.com. If agreeable to their agencies, the families may take courses from Foster Parent College and the Foster Care and Adoptive Community at their own expense.

Note: Each Bridge resource parent must have his or her own email address to enroll and earn training credits. You must enroll through the links provided below to receive your training at no cost. You cannot be reimbursed if you inadvertently pay for your courses.

Separate registrations are required for Foster Parent College and the Foster Care and Adoptive Community. If you have already registered for either and your email address, Resource Specialist, or other information has changed, please update your registration before selecting another course.

The DHS Learning Management System

Another option available to complete in-service training requirements involves the DHS Learning Management System (LMS). A copy of the letter that was mailed to resource parents is included below for clarification and instructional purposes. LMS training is available in addition to online training through Foster Parent College. This option involves viewing Child Welfare videos and completing an online assessment. The videos may be viewed at <http://www.okbridgefamilies.com/video/>.

After viewing the video, in order to receive training hours, you must complete the online assessment in the LMS with a passing score of 70 percent or better. You may complete the assessment as often as necessary to obtain a passing score. Foster parent training credits for the videos will be reset every year, so you will only be able to receive credit for a single video once each year. Each video is worth 1 hour of training credit.

Instructions for using the LMS:

- Access this URL on your computer: <http://bridgelms.oucpm.org>
- Click the “Create Account” button.
- Select “Head of household” if you receive Foster Care checks in your name. Select “Not head of household” if you are an additional adult in the household.
- Type your first initial and last name in the “Username” field. You will need to remember this username in order to log-on to the LMS in the future.
- Type the password you wish to use in the “Password” field. You will need to remember this password to log-on to the LMS in the future.
- Type the password you have selected again, in the “Confirm Password” field.
- Type your first name in the “First Name” field.
- Type your last name in the “Last Name” field.
- Type your email address in the “Email Address” field.
- Type your phone number in the “Phone Number” field without using hyphens or parenthesis.

- Type your foster care contract number in the “Contract Number” field. Your foster care contract number may be found on the front page of your contract. If you do not have a copy of your contract please contact your resource specialist.

- Click the “Register” button

You will automatically be logged into the LMS. If you return to <http://bridgelms.oucpm.org> in the future you can log in using the username and password you entered earlier. The video assessments are located on the Bridge Resource Parent page. In addition, several additional instructional courses are available for credit on the Online Courses page.

- Click on the name of an assessment or course to launch it.

- Change your personal information by clicking on the “Profile Information” button.

- Track your training hours by clicking the “Transcript” button on the Profile Information page.

- Exit the LMS by clicking the “Logout” button.

Note: Your training hours will accrue instantly in the LMS. However these hours will not transfer to the KIDS system for approximately one week. You may need to work with your foster care specialist if this presents a problem.

If you have any questions about accessing the LMS contact the LMS help desk at help@oucpm.org or call in the Oklahoma City area 405-366-6023 or 866-237-2127 outside the Oklahoma City area.

Each assessment completed on-line through the LMS is equivalent to three training hours.

Other Training Opportunities

Other acceptable in-service training includes workshops such as Red Cross CPR and First Aid, scheduled speakers at Foster Parent Association meetings, workshops for mental health professionals or parenting classes offered by local mental health agencies or school districts.



Section 9. Grievance Procedures/Legal

- Child's Grievance
- Resource Parent's Grievance
- Foster Care Mediation
- Bridge Resource Parent Complaint
- Reporting Suspected Abuse or Neglect
- Legal Liability of Resource Parents
- Civil Law
- Criminal Law
- Child Passenger Restraint Law



Section 9: Grievance Procedures

The Office of Client Advocacy administers and monitors a grievance system on behalf of minors in DHS custody and resource parents. The child and resource parent grievance processes begin in the county office, and every attempt is made to resolve them locally. If not resolved locally, the grievant may request the county forward the grievance to OCA for contested grievance processing. Grievances appealed above the local level are reviewed by the Child Welfare Services director, the Grievance and Abuse Review Committee or ultimately the DHS director.

Child's Grievance

Grievances can be filed by, or on behalf of, minors in the custody of DHS.

Who may file a grievance:

Any minor in DHS custody and any youth in the voluntary care of DHS may file a grievance. Grievances may also be filed by anyone interested in their welfare, for example parents, staff, resource parents or court-appointed special advocate.

What complaints are considered:

Complaints may be about any policy, rule, decision, behavior, action or condition made or permitted by DHS, its employees or other persons authorized to provide care.

How to file a grievance:

To file a grievance, obtain the Grievance form from the local grievance coordinator, your child welfare specialist, or any staff member. Complete the form and include what you want to solve the problem. Return the form to the local grievance coordinator. You have only 15 business days from the date of the problem to file the grievance.

At the time of placement, the child's child welfare specialist will explain the grievance procedure to you and your foster child. You or your foster child will be asked to sign the Notice of Grievance Rights – Minors in DHS Custody form verifying that this procedure has been explained to you. The form gives you the name and telephone number of the local grievance coordinator if you want more information.

Resource Parent's Grievance

Grievances can be filed by resource parents approved by DHS.

Who may file a grievance

Any resource parent approved by DHS may file a grievance without fear of reprisal or discrimination.

What complaints are considered

The complaint may be about any policy, rule, decision, behavior, action or condition made or permitted by DHS or its employees. Grievances against DHS or its staff are handled by the local grievance coordinator in your local DHS county office.

How to file a grievance

To file a grievance, obtain the Grievance form from your local grievance coordinator, your child welfare specialist or OCA. Complete the form and include what you want to solve the problem. Return the form to the local grievance coordinator or any staff member. You have 45 calendar days from the date of the problem to file the grievance. The form gives you the name and telephone number of the local grievance coordinator if you want more information.

When your home is approved and at annual re-assessments, you will be asked to sign the Notice of Grievance Rights – Foster Parents form verifying the procedure has been explained to you.

Foster Care Mediation

The foster care mediation program is a voluntary program for foster parents and child-placing agencies to mediate complaints, per Section 601.6(B)(3) of Title 10 of the Oklahoma Statutes. The mediation program is confidential, fair, speedy, and free. Participants retain any rights they may have to request a hearing or file a court action or complaint. Mediation is:

- (1) An effective way to help disagreeing parties discuss their problem and come to a mutually acceptable resolution
- (2) Not a substitute for legal help. No legal assistance is given by the mediator

For more information regarding foster care mediation, contact 1-800-822-0899 or in Oklahoma City, 405-606-4925.

Bridge Resource Parent Complaints

The Office of Client Advocacy investigates complaints by resource parents alleging that an employee of the department or of a child-placing agency has threatened you (resource parent) with removal of a child from your home, harassed you, refused to place a child in your licensed or certified resource home, or disrupted a child's placement as retaliation against you because you:

- Filed a grievance
- Provided information about an employee to any state official or DHS employee
- Testified, assisted or otherwise participated in an investigation, proceeding or hearing against DHS or child-placing agency

This does not include investigating any complaint resulting from an administrative, civil or criminal action taken by the department or child-placing agency for violations of law or rules or contract provisions by the resource parent.

The Office of Client Advocacy will be granted access to any resource home certified, authorized or funded by the department or a child-placing agency.

Not all disputes and problems are considered appropriate to be addressed through this grievance process.

Reporting Suspected Abuse or Neglect

Oklahoma Statutes mandate that reports of suspected abuse or neglect are made to the Oklahoma Department of Human Services. Reports are made by telephone, in writing or in person. Child Welfare is responsible for investigating or assessing reports of abuse and neglect by the person responsible for the child. An investigation or assessment may also be initiated on the basis of media reporting, personal observations or other situations where there is reason to believe a child is at risk. Reports may be made to Child Welfare at the local county office or to 1-800-522-3511, the statewide toll-free Child Abuse Hot Line.

Legal Liability of Resource Parents

What liability might resource parents have as a result of keeping a child in their home on a foster care basis?

The U.S. Supreme Court has stated resource parents are responsible for day-to-day supervision of the child and provision of the child's needs. Regardless of their rights and duties as resource parents, they could be charged with the same general legal responsibilities any person has under the law:

- To exercise reasonable, aware and prudent behavior in actions and in the supervision and support of the child
- To refrain from criminal activities

A resource parent may be liable for the wrongful death of a child in the resource parent's care. Resource parents may also be liable for injuries to the child caused by the resource parent's lack of care.

Civil Law

A resource parent would not ordinarily be liable for injury to others or property damage caused by a foster child. There are several exceptions when negligence, knowledge, permission or participation of a resource parent would be considered.

Criminal Law

All persons who commit a crime or aid, assist, abet, advise, counsel or encourage its commission may be liable for the crime.

If the child has committed a felony act, regardless of whether or not the minor is charged with a felony, anyone who conceals or aids the child, knowing the child has committed a felony act, may be liable in Oklahoma for the separate crime of accessory after the fact.

Child Passenger Restraint Law

Oklahoma Statutes Title 47, Sections 11-1112

A. Every driver, when transporting a child under 6 years of age in a motor vehicle operated on the roadways, streets or highways of this state, shall provide for the protection of said child by properly using a child passenger restraint system. For purposes of this section and Section 11-1113 of this title, "child passenger restraint system" means an infant or child passenger restraint system which meets the federal standards as set by 49 C.F.R., Section 571.213.

B. Every child age 6 through 12 years who is transported in an automobile must be protected by a passenger restraint system or seat belt.

C. The above provisions do not apply to the:

1. Driver of a school bus, taxicab, moped, motorcycle or other vehicle not required by law to be equipped with safety belts
2. The driver of an ambulance or emergency vehicle
3. The driver of a vehicle in which all seat belts are in use
4. The transportation of children who for medical reasons are unable to be placed in such devices, provided there is written documentation from a physician of such medical reason
5. The transportation of a child who weighs more than 40 pounds and who is being transported in the back seat of a vehicle while wearing only a lap safety belt when the back seat of the vehicle is not equipped with combination lap and shoulder safety belts, or when the combination lap and shoulder safety belts in the back seat are being used by other children who weigh more than 40 pounds. Provided, however, for purposes of this paragraph, back seat shall include all seats located behind the front seat of a vehicle operated by a licensed child care facility or church. Provided further, there shall be a rebuttable presumption that a child has met the weight requirements of this paragraph if at the request of any law enforcement officer, the licensed child care facility or church provides the officer with a written statement verified by the parent or legal guardian that the child weighs more than 40 pounds.

More information regarding child passenger restraints is available through the National Highway Traffic Safety Administration at www.nhtsa.dot.gov. For assistance in properly installing child passenger restraints, contact your fire department, police department or Emergency Medical Services.

Section 10. Support Services

Child Care
Informal Arrangements or Babysitting
Alternate Caregiver
Resource Parent Liability Insurance
Foster Parent Association and Support Groups



Section 10: Support Services

Child Care

If you are a single or a two-parent resource home and each of you is gainfully employed at least 20 hours a week or more, DHS will pay a licensed child care center or a licensed child care home to care for foster children placed in your home when you must be at work. Written verification of employment, including the number of hours and days each resource parent works must be provided to your Resource Specialist or to the child's child welfare specialist. Child care is paid by DHS only for the hours of employment. It is not paid for educational, training or any reason other than employment. An alternate plan for child care must be developed in case of an emergency or when the child care facility is closed. If in-home child care is needed, or there is a need for child care for a purpose other than employment, consult your resource specialist.

Informal Arrangements or Babysitting

Resource parents may make informal arrangements with friends, neighbors or relatives for the occasional care of children, including care before and after school. Additional information regarding informal arrangements is included.

- The resource parent ensures that informal care providers possess the maturity and skills to address the needs of the child in foster care.
- The resource parent secures prior authorization for informal care from the child's child welfare specialist.
- The resource specialist considers whether the needs of the child can be met in informal care.
- Prior authorization may apply to multiple events using the same informal provider.
- A person younger than 18 years of age living outside of the home may not be an informal provider.
- An informal provider living in the home must be at least 16 years of age and related to the resource parent.
- Informal providers must know how to reach the resource parent and other emergency contacts.
- The resource parent does not permit a child in DHS custody to babysit a younger child, unless approved by the child's child welfare specialist.
- The resource parent may allow the child in DHS custody overnight stays with friends of the child if the resource parent:
 - Knows the family
 - Reasonably believes the family and all people in the household are safe for the child to have a relationship with

- Exchanges contact information, including name, address, and phone number
- Uses the same discretion as to the safety and well-being of the child as with the resource parent's own child

Alternate Caregiver

The resource family is required to identify an alternate provider who can care for the children placed in the home in case of family emergencies, family vacations or when the family needs a break. The resource family is responsible for identifying and reimbursing the alternate provider. The alternate provider must be at least 21 years of age and be willing to meet the following policy requirements for approval.

- Submit to a background assessment by Oklahoma State Bureau of Investigation
- Submit to a CW records search for past confirmations of child maltreatment involving the alternate provider
- Consent to a search of Juvenile Justice Information System (JOLTS) records for any child older than 13 years of age living in the house
- Engage in an evaluation of the home to assess the location, condition, and capacity to accommodate the child in foster care
- Provide one reference utilizing the Alternate Caregiver Reference Letter
- Comply with discipline and confidentiality policy

Respite

Resource parents are eligible to receive \$200 in Respite Vouchers for a three-month period. The vouchers are obtained by contacting your resource worker. This \$200 is provided in six vouchers which may be used as long as the total amount for all six vouchers does not exceed \$200 for the three-month period. You, as the caregiver are responsible for completing the "Amount Claimed" portion and for carrying your remaining balance over to the next voucher. For example: six vouchers are issued for \$200 (you don't need to use all the vouchers, the vouchers can be used for any amount up to the total of the vouchers.) In this instance you have been issued \$200 in vouchers.

- Voucher 1 is used for respite in the amount of \$50; your remaining balance on voucher 2 will be \$150
- Voucher 2 is used for respite in the amount of \$25; your remaining balance on voucher 3 will be \$125
- And so forth

Should you use the total before utilizing all the vouchers, the unused vouchers should be returned to your resource specialist. Vouchers used over the total amount authorized are returned to you with notification of your responsibility for the charges in excess of the \$200.

Frequently Asked Questions re: Respite

Is there an age limit on providers? Yes, DHS will not reimburse anyone under the age of 21 years.

Can I use the vouchers to pay other bills, buy clothing, food, etc.? No. ONLY respite services will be reimbursed.

Can I give a voucher to an alternate caregiver before they provide services? No. DHS will only reimburse for services already rendered in accordance with Title 74 of the Oklahoma Statutes.

What if my chosen alternate caregiver wants payment at the beginning of the month for respite services that month? If an alternate caregiver will not agree to wait for payment then you'll need to find another person. Payment will only be made after services have been rendered.

Can a member of my household be approved as an alternate caregiver and provide respite care? No. Only approved alternate caregivers who live outside the home can be approved.

Is there a set amount that I should pay for respite? No. You and your alternate should negotiate the rate of pay.

How long are the vouchers good for? Vouchers are valid for 90 days from the date of issue.

Who do I send the vouchers to? The completed vouchers should be returned to your resource specialist.

Can a kinship family who is not an approved foster home get respite vouchers? No. The kinship family will receive a training stipend to assist with training related expenses and also a Kinship Start-Up Stipend.

Resource Parent Liability Insurance

Liability insurance is provided for resource families for damages incurred by children in DHS custody pursuant to the terms of the policy. Questions related to resource parent liability insurance are referred to the designated insurance company. The current policy can be found at www.okbridgefamilies.com

When should I contact the insurance providers?

- When I am accused of physical or sexual abuse of a foster child.
- When my foster child injures someone outside my household.
- When my foster child damages the property of someone outside my household.
- When my foster child damages something I own. Damages are subject to a \$250.00 deductible.

Foster Parent Associations and Support Groups

Counties across the state have active Foster Parent Associations and/or support groups, with most meeting on a monthly basis. As a resource parent, you are encouraged to participate in a support group in your local area. Valuable information is presented at the support group meetings that will assist you in caring for the children placed in your home. You may contact your resource specialist regarding support groups in your area. You may also go to www.fcao.org and connect to the Area Support Groups link where you will find a listing of associations and support groups in the state of Oklahoma. Information on support groups can also be found under the county tab on www.okbridgefamilies.com.



Section 11. Juvenile Court

Abuse and Neglect Referral Process

Juvenile Court Process

Emergency Custody Hearing

Adjudicatory Hearing

Dispositional Hearing

Review Hearing

Permanency Hearing

Resource Parent Participation

Permanency Planning Report

Notice of Removal

Termination of Parental Rights

Adoption and Safe Families Act

Multi-Ethnic Placement Act of 1994



Section 11: Juvenile Court

Abuse and Neglect Referral Process

The child in your care is a member of a family who has become involved with a juvenile court due to alleged abuse or neglect of the child by a parent or other person responsible for the child. The juvenile court may be located in your county or another county in Oklahoma or perhaps even in another state. The following information describes how this comes about.

It begins with a referral that is usually communicated by phone from either law enforcement or someone in the community (a mandated reporter) who is concerned that the child's health, safety or welfare is at risk because of actual or impending threat of harm. The term mandated reporter includes every person, as we are all required by law to report known or suspected child abuse or neglect.

The chart below illustrates the referral process from the beginning to the point at which a decision is made whether to continue the child in custody or return the child to his or her home.

Police Officer

Takes protective custody of child who is in surroundings/situation that endanger the child's welfare.

Mandated Reporter

Calls statewide Child Abuse Hotline 1-800-522-3511 to report suspected abuse or neglect, or reports in writing or in person to the county office of DHS.

Child Abuse Hotline

Transmits report to appropriate county.

DHS Intake Staff

- Prioritizes referral according to severity of risk to the child's safety or welfare.
- Investigates within required time frame.
- If warranted, contacts police and recommends child be taken into custody, or contacts district attorney to obtain a "pick-up" order from judge.

District Attorney's Office

- Reviews facts of investigation.
- Files Deprived Petition with juvenile court if allegations meet criteria and there is adequate evidence to prove abuse or neglect.

Juvenile Court

- Schedules Emergency Custody Hearing within two judicial days of the child coming into custody.

Juvenile Court Process

The following information describes the progress of a case through the juvenile court system from the conclusion of the referral process until a decision is made to return the child to his own home or to make another permanent placement and custody determination. This is a time when your role as a resource parent is very important in the life of the child involved.

Emergency Custody Hearing

When a child is taken into protective or emergency custody, a petition must be filed in the juvenile court within seven judicial days that requests that the child be adjudicated to be a deprived child and that custody of the child be placed with a parent, relative or other suitable person or with DHS for placement in foster care.

The emergency custody hearing is the first hearing that occurs in a juvenile proceeding and it must be held within two judicial days after the child is removed from home. At this hearing the court determines whether there is sufficient cause for the child to remain in custody. If the child remains in custody, the investigation continues gathering more information for the petition. At the emergency custody hearing, the placement of the child is also reviewed and information considered about a protecting parent or any other potential kinship placement for the child instead of the child remaining in shelter care or emergency foster care.

Adjudicatory Hearing

If the court determines, at the emergency custody hearing, that the child should remain in custody, and the district attorney files a petition, an adjudicatory hearing is scheduled. At the adjudicatory hearing evidence is presented and the judge determines whether the allegations in the petition have been proven and whether adjudicating the child to be deprived is in his or her best interests.

Dispositional Hearing

After the adjudicatory hearing, if the child was adjudicated deprived, a dispositional hearing is held. At this hearing the court considers an individualized service plan, and, if it approves the plan, orders the parents to follow the plan to help correct the conditions that led to the child's adjudication. The family will have had the opportunity to work with their child welfare specialist on developing this individualized service plan. A copy of the individualized service plan approved by the court is made available to the resource parents caring for the child. The resource parents will be involved in those aspects of the plan that pertain to services for the child and likely in the implementation of the family's visitation plan. The court also determines who will have custody of the child at this disposition hearing. Adjudicatory and dispositional hearings are sometimes held on the same day or may be several weeks apart.

Review Hearing

The court must hold review hearings at least every six months after the dispositional hearing. The DHS child welfare specialist gathers information to report to the court about the child's situation and the progress made by the family on the court ordered individualized service plan. Children may be required to attend the court hearings.

Permanency Hearing

The court is also required to hold permanency hearings every six months following the adjudication hearing or date when the child enters out-of-home care, whichever is earlier. The court must consider the permanent placement options for the child, then decide which would be best for the depending on the child's needs and long term best interests. The possible options are for the child to return to his or her own home with one or both parents, or be placed for adoption, in guardianship or some other long term plan.

Permanency hearings may be held at the same time as review hearings or scheduled separately. The court considers, at minimum, the health and safety of the child and what is in the best interests of the child at these hearings.

Resource Parent Participation

Resource parents have the right to participate in the court proceedings that concern the foster children placed in their home and to offer information and comments directly to the court. Resource parents are to be given adequate prior written notice of review and permanency hearings, by DHS Child Welfare.

Permanency Planning Report

Prior to a permanency hearing, the DHS child welfare specialist prepares a report regarding the child for the court's review. Resource parents for the child are asked for information in the preparation of this report and may also submit additional comments for the court's consideration. Open communication and courtesy between the members of the team working for the best interests of a child lead to the best planning and services for the child and the child's family.

Notice of Removal

If a child has resided in the resource home for three months or more, DHS will (except in an emergency), give the foster parent written notice of a minimum of five judicial days in advance of intent to remove the foster child from the resource home. DHS must also provide a copy of this notice to the court and other court participants of intent to remove a child from the resource home. The notice tells the specific reasons for the child being removed. In most circumstances the decision for the child's moving out of the resource home and the reasons for it will have already been discussed and planned for in advance. If an emergency exists, the advance notice is not required. An example of an emergency might be when a request is made by the resource parent to remove a child immediately or when there is a medical emergency. Other emergency circumstances could include, but are not limited to, a pending investigation of abuse or neglect of a child in the resource home, or the resource home not meeting foster care standards, or a court order has been issued for the child to be placed with a parent or sibling.

If a child has resided in the same resource home for six months or more, and the move being planned is not agreed upon, the resource parent may file an objection with the court of jurisdiction within five judicial days after receiving the notice of removal. If the objection is filed and served timely, unless an emergency exists, the child's removal does not occur until the court holds a hearing regarding the proposed removal. The court has 15 working days in which to hold the hearing to consider the resource parent's objection to the child's proposed removal from the resource home.

Termination of Parental Rights

There are several circumstances that can form the legal basis for the filing of a motion or petition to terminate parental rights to a child. DHS may make recommendations for this action; however, the decision to file for termination of parental rights (TPR) rests with the district attorney and the child's attorney, since either may file. However, even when a judge or jury determines there are legal grounds to terminate parental rights, the court must also determine if a TPR would be in the best interests of the child. After a TPR court order has been filed, the affected parent has to right to file an appeal of that court order to the Oklahoma Supreme Court. While an appeal is pending, the child is not legally free for adoption.

Adoption and Safe Families Act (ASFA)

ASFA, passed by Congress in 1997, was an effort by Congress to stop “foster care drift” and move foster children to safe, permanent homes as quickly as possible. Foster care drift is a term applied to the phenomenon of children remaining in foster care, sometimes for years, moving from one short-term placement to another with little hope of reunification or any other permanent placement.

Among other things, ASFA mandated States to hold permanency hearings at set intervals as discussed above under Permanency Hearings. ASFA also established conditions and time frames requiring States to file for termination of parental rights unless this action was determined not to be in the child’s best interests. ASFA also required that foster parents be notified of hearings (see Foster Parents Rights in Section 10 of this book) and required background checks of foster and adoptive parents.

Multiethnic Placement Act of 1994/ Interethnic Adoption Provisions of 1996

The Multiethnic Placement Act of 1994 as amended by the Interethnic Adoption Provisions of 1996 (IEP), is designed to:

- Eliminate discrimination on the basis of race, color or national origin of the child or the prospective foster or adoptive parents
- Decrease the length of time that children wait to be adopted
- Facilitate the identification, recruitment and retention of foster and adoptive parents who can meet the distinctive needs of children awaiting placement

MEPA/IEP prohibits states or agencies that receive federal funds from delaying or denying the placement of any child on the basis of the race, color, or national origin of the child or the prospective foster or adoptive parents.

Placement Considerations

Any decision to consider the use of race as a necessary element of a placement decision must be based on concerns arising out of the circumstances of the individual case and based on the best interests of the child. Only the most compelling reasons may serve to justify consideration of race and ethnicity as part of a placement decision. Such reasons are likely to emerge only in unique and individual circumstances. Accordingly, occasions where race or ethnicity lawfully may be considered in a placement decision are very rare. Children who meet the definition of an Indian child in accordance with the Indian Child Welfare Act (ICWA) [25 U.S.C. Section 1903(4)] are placed according to the placement preferences found in ICWA. MEPA/IEP does not prohibit a preference for placing a child with relatives.

Recruitment Efforts

As part of MEPA/IEP, efforts to recruit resource families must reflect the ethnic and cultural diversity of children in Oklahoma who need foster and adoptive homes.

Section 12. Indian Child Welfare



Indian Child Welfare

Indian Child
Welfare

Section 12: Indian Child Welfare Act

About IWCA

Oklahoma is home to 37 of the 562 federally recognized Indian tribes and has one of the highest populations of Native American citizens. It is important that all partners involved in providing services to families and children involved with Child Welfare Services have awareness and knowledge of ICWA.

The federal Indian Child Welfare Act or ICWA was passed in 1978 as the result of Congressional hearings, which found that Indian children were removed from their homes at a much higher rate than non-Indian children. Many times the removals were unwarranted. In most of the cases, after removal, Indian children were placed in non-Indian homes located away from their tribes. Many times the Indian children were never returned to their families or their tribes. In an effort to support and strengthen the federal Indian Child Welfare Act, Oklahoma enacted the Oklahoma Indian Child Welfare Act in 1982. Both the federal Indian Child Welfare Act and Oklahoma Indian Child Welfare Act are sometimes referred to as the Indian Child Welfare Act or by the acronym ICWA.

The stated purposes of ICWA are to:

- Protect the best interests of Indian children
- Promote the stability and security of Indian tribes and families

ICWA recognizes that tribes are sovereign nations and the tribes' children are the most valuable resource of the tribes. The loss of children from a tribe threatens the tribe's stability. For a tribal child, the loss of contact with the tribe results in the loss of culture and heritage.

ICWA governs the jurisdiction, placement, termination of parental rights and adoption of Native American children. This law sets minimum federal standards that apply in child custody proceedings involving an Indian child.

An Indian child is defined by ICWA as an unmarried person under 18 and is either:

- (a) A member of an Indian tribe
- (b) Is eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe

Tribes determine rules and procedures for membership in their respective tribe. Courts are responsible for judicial determinations as to the status of the child and the applicability of ICWA. These minimum standards keep tribal children connected with their tribes and protect against unnecessary removals of Indian children from their families.

ICWA applies to child custody proceedings involving Indian children. ICWA defines child custody proceedings as any:

- Foster care placement
- Termination of parental rights
- Pre-adoptive placement
- Adoptive placement

ICWA establishes the following order of preference for foster care and pre-adoptive placement:

- A member of the Indian child's extended family
- A foster resource home licensed, approved or specified by the Indian child's tribe
- An Indian foster resource home licensed or approved by an authorized non-Indian licensing authority
- An institution for children approved by an Indian tribe or operated by an Indian organization that has a program suitable to meet the Indian child's needs

An Indian tribe may specify a different order of preference by tribal resolution. The court must address efforts by DHS to place within the established order of preference for placement. Placement preferences must be followed, except when good cause is shown in court.

ICWA requires notice to the child's Indian tribe when there is court involvement. The tribe may intervene in the case and/or may seek to transfer the case to tribal court. The tribal Indian Child Welfare social worker may also be involved in the court proceeding and may participate by visiting the child, visiting the child's parents and by appearing in court.

ICWA also provides for states and tribes to enter into agreements regarding the care and custody of Indian children. Oklahoma has agreements with 35 of the 37 federally recognized Oklahoma tribes. These agreements provide for the approval of tribal foster homes by tribes and the payment of foster care reimbursement by DHS when Indian children in either tribal or state custody are placed in tribal foster homes.

DHS values the partnership of tribes in the provision of services to Indian children and families. Cooperation and communication between DHS and tribes result in more positive outcomes for tribal children and families.

Section 13. Education

Enrollment

Confidentiality

Special Education Services

Rights of Children with Disabilities

Evaluation

Individualized Education Program

Home School

SoonerStart



Education

Education

Section 13: Education

Ensuring a child fully participates in school and school-related activities is an important part of being a resource parent. This includes locating school records, enrolling the child; assuring regular attendance; attending school conferences including Special Education Individualized Education Program (IEP) conferences, when applicable; facilitating the child's participation in appropriate extracurricular activities; and completing OHLAP application for students in eighth through 10th grade. For youth in high school, this includes coordinating with the school counselor to review credit checks and insure appropriate grade standing.

Enrollment

The child placed in your home will attend the accredited school within your school district. The child's child welfare specialist will arrange for school records and transcripts to be sent to the school. Resource parents must enroll the student. It is the resource parent's responsibility to see that the child attends school regularly and, if needed, receives tutoring or special assistance with schoolwork. You should provide your telephone number and the child's child welfare specialist's name and telephone number to the school for emergency contact purposes.

Confidentiality

Personal information about the child and his or her family is confidential and should be shared only with school personnel and other parties who need to know in order to meet a child's educational needs. Teachers or other school personnel try to gather as much information as possible regarding the child in order to make decisions concerning the child's educational needs. However, much of this information may not be necessary for them to work effectively with the child. For example, the teacher/school needs to know that you are the resource parent, but knowing that the child's grandparents are considering adopting the child is not relevant to meeting the child's educational needs. Be sure to decide, with the child welfare specialist, what the school needs to know. Avoid disclosing information the child welfare specialist determines to be confidential.

Special Education Services

The Individuals with Disabilities Education Act of 2004 mandates that all children with disabilities, birth to twenty-two (22), receive special education and related services to meet their individual needs. Oklahoma State Statutes, Title 70, Oklahoma School Code, allows children three through 21 to receive these services through their local school district. Children birth to 3 receive special education services through the SoonerStart Early Intervention Program through their County Health Department.

Special education is instruction specially designed to meet the unique needs of children who have disabilities. This is provided at no cost to parents. Special education may include instruction in a variety of settings, such as the regular classroom, resource room, self-contained special classroom, at home, in hospitals or institutions or other places as appropriate.

Related services are supported services to assist children with disabilities to participate in education. Examples of related services include speech language therapy, occupational therapy, physical therapy, assistive technology services and special transportation arrangements.

Child welfare specialists and resource parents must aggressively advocate for appropriate educational testing and class placement to be accomplished in a timely manner. Such advocacy is an important function of resource family care. Evaluation and special educational placement are important aspects of assistance for the child and support for resource parents.

Rights of Children with Disabilities

The basic rights of all children with disabilities include:

- Every child has the right to a free appropriate public education.
- Children with disabilities should be served in the least restrictive setting possible, meaning these children are educated with children who are not disabled.
- Children with disabilities must be provided with an Individualized Education Plan.
- Children with disabilities have the same rights to transportation to and from school as children without disabilities.
- The child's parents and resource parents have the right to see their children's complete school records.
- Parents must give written permission before children are individually evaluated.
- Schools are responsible for identifying and evaluating children in need of special education and related services.
- It is the responsibility of the school to comply with parents' rights to due process hearings whenever there is a disagreement between the school and parents regarding the identification, evaluation or placement of a child with disabilities.
- A child may not be denied an appropriate educational program because the district has failed to make its school programs architecturally accessible.

Evaluation

If you or the school thinks the child placed in your home may have a disability and may need special education and related services, school officials must evaluate the child before providing these services. This evaluation is available at no cost and will help determine if the child placed with you has a disability, and if so, what type of special help the child might need. Written permission must be given for the evaluation, which will most likely be done by the birth parents or the child's child welfare specialist. Based on the results of the evaluation, the school professionals and the birth parents will determine the eligibility of special education and related services in regards to the child placed in your home.

Individualized Education Program

If the child placed in your home is eligible to receive special services, an educational program will be developed to meet the child's needs. A meeting must be held within 30 days to develop the written Individualized Education Program, usually called an IEP. An IEP is a written statement of the educational program designed to meet a child's individual needs. Every child who receives special educational services must have an IEP. It is a road map for how the school will educate the child.

The process of developing a child's IEP involves two main areas:

- The IEP meeting at which members of the team together decide on the educational program for the child
- The IEP document that puts in writing the decisions made at the meeting

For further information, the following resources are available:

- Oklahoma Special Education Services – 405-521-3301 or www.sde.state.ok.us
- Special Education Parent Handbook – 405-521-4862
- National Dissemination Center for Children with Disabilities (NICHY) at www.nichy.org
- Oklahoma Parents Center – 877-553-4332 or www.oklahomaparentscenter.org

Parental participation is essential in the education of children with disabilities. It is always the first choice to involve the child's parents in this process. When the parents are unable, unavailable or unwilling to participate in the child's school arrangements or the development of the IEP, the resource parents are encouraged to participate and be involved in all matters relating to the identification, evaluation and educational placement of the child.

Home School

Permission to allow a child to be home schooled is made on a case-by-case basis after assessment of the situation and consultation with the district director. If the child is in temporary custody, written approval is required from the child's parents. If the child is in permanent custody, written approval is obtained from the district director in the child's county of court jurisdiction. The following matters are to be considered before the decision to home school is made:

- Discuss and assess if the overall needs of the child will be met in the home school setting
- Evaluate the resource parent's experience and knowledge of home schooling
- Ensure services can be coordinated between the previous public or private school in order that the child's strengths and needs are addressed
- Review curricula to be used by the resource parents to evaluate whether the curricula will meet the child's educational needs

- Assess child's commitment to participate in home schooling
- Discuss socialization activities

SoonerStart

SoonerStart provides special educational services to infants and toddlers, birth up to 3 years of age, with disabilities or developmental delays. Services may include diagnosis and evaluation, case management, family training, counseling, home visits, certain health services, nursing services, nutrition services, occupational, physical and speech-language therapy and special instruction. Services are provided in the resource parent's home, the child care setting or other agree upon locations.

All children under the age of 3, who are in the DHS custody are to be referred to SoonerStart by the child welfare specialist. A resource parent may also make a referral to SoonerStart. After referral, a SoonerStart coordinator will contact the resource parent and arrange a home visit. The child will be screened for eligibility during the home visit. In order to be eligible for services, the child must be delayed in their development or have a condition such as Down syndrome that will most likely cause a developmental delay. If SoonerStart determines a child is not eligible, and the resource parent or child welfare specialist is still concerned in regards to the child's developmental or emotional needs, either individual may request an evaluation.

For more information regarding SoonerStart or to request services, contact your local County Health Department or OASIS (Oklahoma Areawide Services and Information System) at 1-800-426-2747 or www.sde.ok.state.us.



Section 14. Health Care

**SoonerCare
Child Health Check-Up
Records
Psychotropic Medications
Medical Consent
Medical Emergencies
Financial Responsibility
Transportation
Health-Related Responsibilities
Universal Precautions
Proper Handwashing Procedures
HIV
Resources
Signs of Illness
Taking a Child's Temperature
Vaccine-Preventable Diseases
First Aid Kit
Medical Library
First Aid for Poisoning
Nutrition – Healthy Eating Tips
Fitness
Oral Health Care**



Section 14: Health Care

Children and adolescents in out-of-home care are some of this nation's most vulnerable citizens.

These children have significant unrecognized or under-treated illnesses and health conditions. Often, they have not received basic and preventive health care services. Some of the reasons for these health problems are abuse and neglect, separation and frequent moves, and lack of consistent medical care with follow-up treatment.

As a resource parent, you are the most important person to ensure the child placed in your home receives a thorough child health exam as soon as possible after entering care, as well as any recommended follow-up care.

SoonerCare

Children in DHS custody receive medical care through SoonerCare which is Oklahoma's Medicaid program. All children in DHS custody and residing in out-of-home care are assigned to and receive their medical benefits through SoonerCare. When the SoonerCare case is certified, two medical cards are sent to the county office. The child welfare specialist retains one card and the other is given to the resource parent. The medical card should be shown to the healthcare provider to aid in validating SoonerCare membership enrollment.

Resource parents are responsible for making medical appointments, getting the child to the appointment, getting prescriptions filled and following doctor's directions for medical care. The resource parent can take the child to any SoonerCare contracted provider who will agree to see the child. We encourage you to locate a primary care physician and make an appointment for a child health check-up as soon as possible. If assistance is needed to find a SoonerCare doctor, call the SoonerCare Helpline at 1-800-987-7767.

The child's child welfare specialist and resource parent are to ensure that the child receives all needed routine and specialized medical care in a timely manner. Regular health check-ups are important for all children from birth through age 20. Seeing a health care provider on a regular schedule, even when feeling well, may help prevent serious health problems in the future. Children in custody and receiving medical care through SoonerCare need to get their child health check-ups at the ages listed below and at any time a resource parent has a concern:

- Birth
- 1 month
- 2 months
- 4 months
- 6 months
- 12 months (1 year)
- 18 months
- 24 months (2 years)
- 3 years
- 4 years
- 5 years
- 6 years
- 8 years
- 10 years
- 12 years
- 14 years
- 16 years
- 18 years
- 20 years

If the child placed in your home has any special problems or if you have concerns, your child's health care provider may recommend additional checkups. These additional visits will be covered as part of the services provided by SoonerCare. The child's Child Welfare Specialist and supervisor should be informed immediately of any changes in the child's medical needs.

What Will a Child Health Check-Up Include?

At each child health check-up, your child's health care provider will spend time talking with you and checking your child from head to toe. The check-up will include:

- Time to discuss any questions you have about your child's growth and development
- Time to discuss questions about how things are going for you as a resource parent
- A health history
- Growth measurements
- A developmental and behavioral check
- At every check-up, the health care provider will ask questions about how you think your child is learning
- At some check-ups, the health care provider, or others in the office, may ask you to fill out a form about new things your child is learning to do
- Health education and information on:
 1. Keeping your child and family healthy and safe
 2. Preventing injury and violence
 3. Healthy sleep habits
 4. Healthy nutrition
- Vision, hearing and dental screen (age appropriate)
- Immunizations (shots)
- Lab test (if needed)
- Lead testing (at 12 and 24 months)

Because lead exists in places where you would not expect, children should be tested at certain ages. Too much lead can damage a child's body and brain. It can also cause permanent health, behavior and learning problems. SoonerCare requires that blood lead levels be checked at:

- Twelve months (one year)
- Twenty-four months (two years)
- Any age up to 72 months (six years) if there is no record of the child having a lead test in the past

Records

An important part of assuring good medical care for children in out-of-home care is maintaining records to document the services received. Resource parents and the child welfare specialist are the only persons who can ensure the continuity of medical services and records while a child is in out-of-home care. This service is essential to maintaining the child's and parents' connections to medical history. These records are to be a part of the child's Life Book and will be made available to the parent or any subsequent caregiver, or to the child who is leaving care for independent living.

Psychotropic Medications

Psychotropic medications, medications prescribed to alter mood, affect or behavior are considered by Oklahoma Statute, DHS policy, Medicaid policy and DHS out-of-home care contracts as a form of routine medical care for children in DHS custody. Traditional, kinship, therapeutic, contract, emergency and tribal resource parents are required to obtain guardian approval for the use of these medications by children in DHS custody. However, there are instances where a physician or medical facility requests a separate and specific written consent. Informed consent for medical care and treatment or administration of psychotropic medication that requires a separate and specific written consent may only be given by the child's

- (A) Parent whose parental rights are intact
- (B) Legal guardian
- (C) DHS representative after:
 - (i) A reasonable attempt to locate a parent or legal guardian has failed
 - (ii) Consideration of a sufficient explanation by a physician regarding the risks involved in the proposed treatment

If a request for separate and specific written consent is requested, please advise the child's CW specialist.

Who Can Give Consent for Medical Care?

Resource parents can authorize routine medical care for children in their care by presenting their copy of the Placement Agreement for Out-of-Home Care. As a resource parent, you are authorized to provide both legal and informed consent for the child to receive routine child health services such as child health checkup, immunizations, and treatment for minor illness.

You are also authorized to provide consent for school officials to administer prescription or non-prescription medicine to the child as needed. Advise the DHS child welfare specialist of all medical services and medications for which you have provided consent.

Resource parents are not authorized to sign surgery consent forms or consent for psychotropic medications, when a request for written consent is made. Only the child's parents, designated DHS staff, or a judge may sign surgery consent forms or consent for administration of psychotropic medication when a request for written consent is made. You should advise the child's child welfare specialist immediately when the need for surgery arises or when requests for written consent for psychotropic medications is made.

What Happens in Case of Medical Emergencies?

In case of sudden illness or accident, take the child to the nearest emergency room. If there is time, call the child's doctor. You may consent only to emergency admission and treatment for the child. Notify the child's child welfare specialist or supervisor as soon as the child is receiving treatment. They will provide you with other necessary consents for medical care or surgery. Have a copy of the child's Placement Provider Information form or printouts from the Child's Passport with you to assist in giving accurate information. Give the hospital the child's name, birth date, case number, and medical card. You must inform the hospital that you are not responsible for the medical charges, but SoonerCare is to be billed. Do not sign your name as "responsible party." Sign only as the admitting person.

Financial Responsibility

Resource parents are not responsible for the cost of prescribed medical care for a child placed in their home. Medical expenses within the scope of SoonerCare are paid by the Oklahoma Health Care Authority. Not all medical services are covered, so those services must be discussed with the child's Child Welfare Specialist before the services are provided.

Resource parents are expected to pay for any medication or supplies available without a prescription and all personal hygiene items from the foster care reimbursement.

The term Health Care Provider refers to doctors, pharmacists, hospitals, or any persons who have contracted with Oklahoma Health Care Authority to provide medical services under SoonerCare.

You will receive a non-disposable, permanent, plastic medical identification card for most children in your home. This card is to go with the child through changes in placement. The card gives the child's name and the medical ID number. The card should be shown to the health care provider at the time of service to give information used for billing. When a child leaves your home, the card should be given to the child's child welfare specialist. If you receive a card after a child has left your home, please return it to the child's child welfare specialist immediately. Advise the child welfare specialist if you do not receive a medical card for a child in your home. The medical card will indicate a limit of three prescriptions per month for the child; however, children in out-of-home care are eligible for an unlimited number of prescriptions. Have the pharmacist (or other provider) contact the child's child welfare specialist if questions arise regarding the procedure for filing claims.

Some children in out-of-home care will not receive a medical card even though they are eligible for medical coverage by DHS. When that occurs, advise the medical vendor the child is in DHS custody, and if you or the vendor has any questions regarding a child's eligibility for medical care, contact the child's child welfare specialist or the child welfare supervisor.

Again, never sign a medical form as the responsible party. That way, you will not be held responsible for payment. Occasionally a vendor will bill a resource parent for services for a child placed in their home. You are not responsible for payment of the charges and should contact the child's child welfare specialist if you receive a medical bill. Occasionally a situation may arise when you are required by the vendor to pay for medical services or prescriptions at the time of service. DHS will reimburse you for these expenses if it was the only way, during an emergency, to obtain the needed services. It is important, however, that you try to use only vendors who are willing to bill SoonerCare.

Transportation

DHS is responsible for ensuring transportation for children in out-of-home care who are in need of medical services not available in the community of placement. Resource parents are responsible for transportation to routine medical appointments, meeting the child's medical, educational and recreational needs, and providing non-prescription medical and other maintenance supplies.

Resource parents providing care for a child in DHS custody are now eligible for reimbursement for three trips per child per month in the following circumstances:

- The Child Welfare worker would be required to provide transportation for a child if not provided by resource parents including, but not limited to:
- Visits with parents
- Visits with siblings
- Court hearings
- Medical, mental health, dental or vision appointments when not available in the community
- The round-trip mileage for the single event is in excess of 25 miles

When a child in out-of-home care needs excessive transportation to medical or counseling appointments, the child's child welfare specialist may wish to consider requesting a Difficulty of Care payment to offset the resource parents' expense.

Another option is SoonerRide. SoonerRide is available through the OHCA and is designed for people without adequate transportation to medically necessary appointments. SoonerRide does not handle emergency transportation. In case of an emergency, call 911. To make a reservation, you must call at least three business days before your trip is needed (exceptions may be made for some urgent medical needs). Call SoonerRide Monday through Saturday, 7 a.m. to 6 p.m. at 1-877-404-4500 for more information or to make an appointment.

Health-Related Responsibilities of Resource Parents

- Alert the Child Welfare Specialist and DHS immediately about:
 - Significant medical issues
 - Changes in the child's health
 - Any trip to the emergency room or hospital
- Keep each child's medical card available and use as needed
- Take each child for regular health and medical appointments according to their age and individual needs
- Keep each child's immunizations up-to-date
- Take each child to any specialist or any special service recommended by the child's primary health care provider
- Make medical records available to the child welfare specialist to copy for the child's permanent record
- Send the medical card and other records with the child welfare specialist to provide to the next caregiver when the child leaves your home

Universal Precautions for Disease Prevention

Resource parents are expected to utilize these three universal precautions for preventing transmission of communicable diseases and as a matter of good hygiene:

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 (ration of one cup bleach to one gallon water)
3. Consistently wash hands, and teach children to wash hands, with soap and warm water

Children must not share teething toys, feeding bottles or toothbrushes. Adults and youth must not share razors or syringes.

Proper Handwashing

Adults and children should wash their hands:

- After touching trash cans or lids
- Before and after eating
- After toileting
- After caring for or playing with animals
- After cleaning up spills
- After wiping nose or coughing into hand
- After diapering or assisting a child using the toilet
- After messy play such as painting or gluing
- Before and after group water play in the same water table or other container
- Before and after administering medication
- When leaving the home

Proper handwashing procedure:

- Moisten hands with warm running water and use liquid soap
- Rub hands together front, back, wrists and between fingers for at least 10-20 seconds
- Rinse wrists to fingertips until free of soap under warm running water
- Dry hands with paper towel or rub hands together under an air dryer
- Use a paper towel to turn off faucets and throw the paper towel into a hands-free trash container

Gloves, wipes, or alcohol-based hand sanitizers:

- Wipes and hand sanitizers do not count as substitutes for handwashing and should only be used when soap and running water are not available. (Field trips, playground)
- If gloves are used, hands need to be washed with soap and water before applying the gloves and after the removal of the gloves.
- Alcohol-based sanitizers should only be used where no other alternative exists. It is important to follow the manufacturer's instructions and keep the sanitizer clearly labeled and out of the reach of children.

HIV

Resource Parents are expected to utilize universal precautions for preventing transmission of communicable diseases. Per Section 7003-5.4 of Title 10 of the Oklahoma Statutes, DHS shall disclose the test results, after obtaining the proper consent per OAC 340:75-1-116, to placement providers. Disclosure of confidential HIV-related information to a placement provider must be accompanied by the required written statements, dated and signed by the placement providers and a copy filed in the child's separate and confidential case file. HIV-related information disclosure to an DHS employee by a placement provider must be obtained with written consent for release as specified in OAC 340:75-1-116.

Resources

Oklahoma Health Care Authority SoonerCare Helpful Numbers:

- For assistance with finding a SoonerCare provider, call the SoonerCare Helpline at 1-800-987-7767 Monday through Friday, 8 a.m. to 5 p.m..
- For after-hours service to ask questions if you are not sure your child is in need of emergency care, call the Patient Advice Line at 1-800-530-3002 after 5pm on weekdays and any time on weekends and holidays.
- If you have a child with complex and/or unusual health care needs, call the Care Management Department at 1-877-252-6002 Monday through Friday, 8 a.m. to 5 p.m.
- For non-emergency referral or assistance, call the Behavioral Health Department at 1-800-652-2010 Monday through Friday, 8 a.m. to 5 p.m. This helpline is not equipped to deal with emergencies. For an emergency, call your doctor or local emergency room.

Signs of Illness

Any of these signs of illness should be watched carefully and may need a call to your child's doctor:

- Fever is a temperature over 100.4 F. It is often the first sign of illness and should be reported to your doctor. Temperatures less than that are not a cause for concern.
- Exercise or excitement might make the temperature go up. A person's normal body temperature varies with the time of day (lower in the morning, higher in the late afternoon). It also varies from child to child; 98.6 may not be normal for many children.
- Diarrhea means frequent loose stools. Do not confuse it with frequent soft stools (bowel movements) that are common in young infants. Diarrhea may indicate illness.
- Vomiting may indicate illness.
- Unexplained sleepiness may be an indicator of an illness. Observe the child closely if he is sleepy when he is not expected to be.

- Localized pain, if it is steady and will not go away may indicate illness, especially if in the ears or abdomen.
- Difficulty in breathing may indicate an illness. Contact Emergency Medical Services if necessary.
- Constipation is hard marble-like bowel movements and is common in children, especially in those who eat minimal amounts of fruits and vegetables. If there is pain with bowel movements, or blood in the stool, or on the toilet paper, it should be watched.
- Skin rash may be a sign of illness or it may be from an allergy.
- Skin discoloration may be a sign of illness if the discolored areas are red or numerous.
- Normal bumps and falls also may cause skin discoloration.
- Swelling or any abnormal enlargement may indicate injury or illness.
- Watch for and follow any unusual behavior (i.e., irritability, fussiness, prolonged crying, etc.).

Your Response to Signs of Illness in Children

Serious Signs of Illness

Call doctor immediately! Watch the child closely. Do not leave alone. Emergency treatment may be required.

- Severe coughing, high pitched whistling sound, redness or blueness in face, difficulty breathing
- Vomiting with other signs such as headache or fever
- Fever 100.4° or greater, extreme tiredness, difficult to awaken
- Sore throat, difficulty breathing and swallowing

Signs of a Probable Communicable Illness

Call the doctor. Isolate the child as much as possible until you take them to the doctor.

- Redness, swelling, drainage of eye
- Unusual spots/rashes with fever or itching
- Sore throat
- Crusty, bright yellow, gummy skin sores
- Diarrhea (more than three loose stools a day)

- Vomiting (more than two times a day)
- Yellow discoloration of skin and/or the whites of eyes
- Clay colored stools or tea colored urine

Signs of a Possible Communicable Illness

Watch child closely. Notify and discuss signs with doctor if it does not improve.

- Earache (check for fever or discharge)
- Headache
- Itching of scalp (Check for nits; if present, isolate until treated)
- Fever less than 100.4 F
- Runny nose (Check temperature)

Taking a Child's Temperature

A child's temperature is often taken in the armpit (axillary) or in the child's mouth (orally), if the child is old enough to know not to bite down on the thermometer.

How to take axillary temperatures

- Place the tip of the thermometer in a dry armpit.
- Close the armpit by holding the elbow against the chest for four or five minutes, or until the thermometer beeps.
- After four or five minutes, or when the thermometer beeps, take the thermometer out and read the temperature.
- Fever is a temperature over 100.4 F.

How to take oral temperatures

- Be sure the child has not had a cold or hot drink in the last 30 minutes.
- Place the tip of the thermometer under one side of the tongue and toward the back.
- Have the child hold the thermometer in place with his lips and fingers. He should breathe through his nose, keeping mouth closed.
- Leave the thermometer in the mouth for three minutes, or until the thermometer beeps.

- After three minutes, or when thermometer beeps, take the thermometer out and read the temperature.
- Fever is a temperature over 100.4 F.

Immunization Requirements in Oklahoma

	At Birth	2 months	4 months	6 months	12 months	18 months	4 - 6 years	11-12 years
Hepatitis B (Hep B)	x	x		x				
Diphtheria, Tetanus, Pertussis (DTaP)		x	x	x	x		x	x
Rotavirus		x	x	x			x	
Polio (IPV/OPV)		x	x	x			x	
Haemophilus Influenzae Type B (Hib)		x	x	x	x			
Pneumococcal Conjugate (PCV)		x	x	x	x			
Influenza				x	x			
Measles, Mumps, Rubella (MMR)					x		x	
Varicella (Chickenpox)					x		x	
Hepatitis A (Hep A)					x	x		
Meningococcal Conjugate (MCV)								x
Human Papillomavirus (HPV)								x

Source: Oklahoma State Department of Health

This table lists the vaccines that are required for children to attend child care and school.

For more information, call the Oklahoma State Department of Health Immunization Services at 405-271-4073 or 800-234-6196 or visit <http://imm.health.ok.gov>.

Vaccine-Preventable Diseases: The Basics

Chickenpox (Varicella) is an illness caused by a virus. Chickenpox is usually a mild febrile illness with a rash. In adolescents and adults however, this virus may produce more serious disease with complications such as pneumonia. Pregnant women who become infected with the varicella virus are at even greater risk for serious complications than other adults, especially late in pregnancy. In addition, infection early in gestation can occasionally produce serious birth defects in the fetus.

Diphtheria is a serious bacterial disease and is spread person to person by infected secretions. Diphtheria can cause blockage of the airway, making it impossible to breathe. It can also cause heart problems.

Haemophilus influenzae type b (Hib) is a very serious bacterial disease, which causes about 12,000 cases of meningitis (inflammation of the covering of the brain) in the United States each year. For the most part, this disease affects children under the age of 5 (children between 6 months of age and 1 year of age are affected by the most serious Hib disease). One in four children with the disease suffers permanent brain damage and about one in 20 dies. Other problems caused by “Hib” are pneumonia and infections of the blood, joints, bones, soft tissues, throat and the covering of the heart. Please do not be confused with the name. “Hib” does not have anything to do with the flu (influenza).

Hepatitis is a disease characterized by inflammation of the liver. The symptoms of hepatitis are mild fever, loss of appetite, nausea, vomiting, fatigue, stomach pain, dark urine, and sometimes yellow discoloration of the eyes and/or skin. It should be noted that young children (those under 5 years of age) may not seem sick or may appear to have a mild illness like “stomach flu” but can still spread the illness to adults. Several viruses can cause hepatitis, but the most common are A and B.

- Hepatitis A virus is spread from person to person by eating food or drinking water that has been contaminated with human feces. It is estimated that 150,000 people in the United States are infected each year by hepatitis A. The Centers for Disease Control list household or sexual contact, child care attendance or employment, and recent international travel as the major risk factors for hepatitis A.
- Hepatitis B virus can cause a serious form of hepatitis. The infection may occur in two phases. The acute phase occurs just after a person becomes infected, and can last from a few weeks to several months. Some people recover after the acute phase, but others remain infected for the rest of their lives. Over half the people who become infected with hepatitis B never become sick, but some later develop long-term liver disease. Hepatitis B is passed from one person to another in blood or certain body fluids. A baby can get hepatitis B from its mother during birth.

Influenza (flu) is a highly contagious viral infection of the nose, throat, and lungs. It is one of the most severe illnesses of the winter season, and spreads easily when an infected person coughs or sneezes. Influenza may lead to hospitalization or even death, especially among the elderly. Typical symptoms include an abrupt onset of high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Because the virus changes, persons can contract influenza each year.

Measles is a highly contagious disease caused by a virus. Symptoms are rash, high fever, cough, runny nose and watery eyes. Measles can cause serious problems. Nearly 1 out of 10 children with measles will get an ear infection or pneumonia. One child out of 1,000 will develop an inflammation of the brain, which can lead to convulsions, deafness or mental retardation. One or two children out of 1,000 will die from it. A pregnant woman can experience a miscarriage or give birth too early due to measles.

- Immunization for measles has greatly reduced the number of cases occurring in the United States. Ten years prior to the vaccine, an average of 530,000 cases were reported each year in the United States and over 450 people died each year from measles. Today, the number of measles cases is less than 5 percent of what it was before the vaccine was available.
- However, cases continue to occur due to inadequate immunization. Any child who has not been immunized for measles is at risk for getting the disease.

Mumps is another disease caused by a virus. Symptoms of mumps are fever, headache and inflammation of the salivary glands (this causes swelling of the cheeks at the angle of the jaw). More serious effects from mumps are meningitis (inflammation of the coverings of the brain and spinal cord) which occurs in one out of ten children. Other problems which can occur are encephalitis (inflammation of the brain), deafness and painful inflammation and swelling of the testicles (one out of every four males).

- Before the vaccine, nearly every child got mumps. Because of the vaccine, the number of cases is much lower.

Pertussis (Whooping Cough) is a highly contagious disease. It is caused by bacteria living in the mouth, nose and throat of the infected person.

- Pertussis causes severe spells of coughing which can interfere with eating, drinking and breathing. Pertussis is most serious in infants less than 1 year of age, and more than half of the infants reported with pertussis are hospitalized.
- Complications are fairly common. One out of every 10 children with pertussis will develop pneumonia. Convulsions (seizures) occur in 20 out of 1,000 children. An average of nine deaths a year has been caused by pertussis.

Pneumococcal disease is the leading bacterial cause of meningitis, pneumonia, ear infections and sinus infections. Pneumonia symptoms include high fever, cough with chest pain and mucus, shaking, chills, breathlessness and chest pain that increases with breathing. Older adults often experience changes in level of consciousness or confusion.

Polio is a very dangerous disease caused by a virus which lives in the throat and intestines of the individual infected with it. Many people can spread the infection to others even though they may not have symptoms of the illness.

- Milder forms of polio usually come on suddenly and last only a few days. Although some individuals do not have any symptoms, others may experience fever, sore throat, nausea, headache, stomach ache, pain and stiffness (neck, back and legs).
- “Paralytic polio” is the serious form of polio and can cause paralysis (inability to move parts of the body). The symptoms are the same as in the milder form, however, they are usually accompanied by severe muscle pain. If paralysis occurs, it does so within the first week. The person may not be able to move his/her arms or legs, and may have difficulty breathing without the help of a respirator or assisted breathing. There is not a specific treatment for polio and the amount of recovery varies with the individual.
- In 1952, the number of cases of paralytic polio in the United States was more than 20,000. Polio has been eradicated from the Western Hemisphere.

Rubella (German measles) Rubella is usually considered a mild disease of childhood. It is caused by a virus which is spread through coughing, sneezing or talking.

- The usual symptoms are mild discomfort, a slight fever for about 24 hours, and a rash on the face and neck that lasts for two or three days. Young adults may experience swollen glands in the back of the neck and temporary pain, swelling or stiffness of body joints. Recovery is usually quick and complete.
- The biggest concern about rubella is its affect on unborn children; they are in the greatest amount of danger from rubella if their mothers get the disease early in the pregnancy. The chances of such babies being born with birth defects may be as high as 80 percent. The most common birth defects are blindness, deafness, heart and major artery damage, abnormally small brains and developmental delays.
- Immunization for rubella not only protects the immunized child but also protects those not able to be immunized.

Tetanus (lockjaw) is caused by a toxin (poison) produced by a bacteria that enters the body through a cut or wound. Tetanus causes serious, painful spasms of all muscles and can lead to “locking” of the jaw so a person cannot open his or her mouth, swallow or breathe. Three of 10 people who get tetanus die from the disease. Everyone should receive a “Td” vaccine (tetanus and diphtheria) every 10 years after their last childhood DTP/DTaP or TD.

First Aid Kit

In any emergency, you or a family member may be cut, burned or suffer other injuries. If you have these basic supplies you are better prepared to help your loved ones when they are hurt. Remember, many injuries are not life-threatening and do not require immediate medical attention. Knowing how to treat minor injuries can make a difference in an emergency. Consider taking a first aid class. However, simply having the following things can help you stop bleeding, prevent infection and assist in decontamination.

Things you should have:

- Two pairs of Latex or other sterile gloves (if you are allergic to Latex)
- Sterile dressings to stop bleeding
- Cleansing agent/soap and antibiotic towelettes to disinfect
- Antibiotic ointment to prevent infection
- Burn ointment to prevent infection
- Adhesive bandages in a variety of sizes
- Eye wash solution to flush the eyes or as a general decontaminant
- Thermometer

Things it may be good to have:

- Cell phone
- Scissors
- Tweezers
- Tube of petroleum jelly or other lubricant
- Non-prescription drugs:
 - Aspirin or non-aspirin pain reliever
 - Anti-diarrhea medication
 - Antacid (for upset stomach)
 - Syrup of ipecac (use to induce vomiting if advised by the Poison Control Center)
 - Laxative
- Activated charcoal (use if advised by the Poison Control Center)

(source: www.ready.gov/first-aid-kit.html)

Medical Library

Preventing Common Household Accidents

A house is an exciting place for infants and small children who love to explore but aren't aware of the potential dangers. Protecting children from household dangers is your job – and it's a job that will always be evolving to keep up with a child's growing mobility and curiosity. Life can't be risk-free, but most household accidents can be prevented by using a household safety checklist. This will help you identify and eliminate potential hazards in your home.

To prevent animal bites:

Pets and children seem like a natural combination – until one oversteps the other's boundaries. Take note of the following to promote household harmony:

- Never leave infants under 1 year old alone with a family pet.
- Don't keep undomesticated animals (ferrets, for example) as house pets.
- When choosing a family pet, look for one with a calm disposition. For example, some dog breeds tolerate children better than others; research breeds to find one that is appropriate for your family.
- Children under 4 years old should be supervised when playing with a dog or cat.

- Teach children never to tease an animal, pull its tail or ears, or bother it while it is eating or sleeping. Children should always stay away from pets with their young.
- Children should be taught never to take a toy or bone away from a dog.
- Teach children never to pet or try to play with an animal that they don't know.

Burn prevention

Burns, especially hot water burns, are some of the most common childhood accidents. Babies and children may be more susceptible to burns than adults are: they're curious, they're small, and they have sensitive skin that needs extra protection. Use these burn-prevention tips when your children are in different parts of the house, the car, and the great outdoors:

Bathroom

Set the thermostat on your hot water heater to 120 F or lower. A child can be scalded in 30 seconds if the temperature is only 5 degrees higher. If you are unable to control the water temperature (for example, you live in an apartment), install an anti-scald device. This will slow water from tub spouts to a trickle if it reaches a certain temperature.

Kitchen/Dining room

- When cooking, always turn pot handles toward the back of the stove.
- Don't hold a baby or small child while cooking.
- If you have to walk with hot liquid in the kitchen (like a pot of soup or cup of coffee), make sure you know where your child is, so you don't trip over him.
- Avoid using tablecloths or large place mats. A small child can pull on them and overturn a hot drink or plate of food.
- Block access to the stove as much as possible.
- Don't warm baby bottles full of milk in the microwave. The liquid may heat unevenly, resulting in pockets of milk that can scald your baby's mouth.
- Fireplaces and wood stoves must be screened. Radiators and electric baseboard heaters may need to be screened, as well.

Outdoors/In the car

- Use playground equipment with caution. If it is very hot outside, use the equipment only in the morning, when it has had a chance to cool down during the night.
- Children can get burns from hot vinyl and metal, so remove your child's safety seat or stroller from the hot sun when not in use. If you must leave it in the sun, cover it with a blanket or towel.

- Before leaving your parked car on a hot day, hide the seatbelts' metal latch plates in the seats to prevent the sun from hitting them directly.

Choking prevention:

Putting things in their mouths is one of the ways that babies and small children explore the world. Anything that fits can be a danger. Choking is usually caused by food, toys and other small objects that can easily lodge in a child's small airway. Pay special attention to the following to prevent your child from choking:

Food

- Don't give a child under age 4 any hard, smooth foods that can partially or completely block the windpipe. These include nuts of any type, sunflower seeds, watermelon with seeds, cherries with pits, raw carrots, raw peas, raw celery, popcorn and hard candy.
- Some soft foods can also cause choking because they are the right shape for blocking a child's windpipe. These foods, including hot dogs, sausages, grapes and caramels, can be served if they are chopped into small pieces. Spoonfuls of peanut butter and chewing gum should also be regarded as potential choking hazards.
- When babies begin eating solids, beware of foods like raw apples and pears, which may be difficult to chew without teeth (or with just a few teeth).
- Encourage children to sit when eating and to chew thoroughly. Teach them to chew and swallow their food before talking or laughing.
- Never let children run, play sports or ride in the car with gum, candy or lollipops in their mouths.
- Be especially vigilant during adult parties, when nuts and other food might be easily accessible to small hands. Clean up early and carefully, and check the floor for dropped foods that can cause choking.

Toys

- Always follow all manufacturers' age recommendations when buying toys. Some toys have small parts that can cause choking, so heed all warnings on a toy's packaging.
- Never buy vending-machine toys for small children; these toys do not have to meet safety regulations and often contain small parts.
- Check toys frequently for loose or broken parts – for example, a stuffed animal's loose eye or a broken plastic hinge.
- Warn older children not to leave loose game parts or toys with small pieces in easy reach of younger children.

Balloons and other small objects

- Never give balloons to a child younger than age 8. A child who is blowing up or chewing on a balloon can choke by inhaling it. Inflated balloons pose a risk because they can pop without warning and be inhaled.
- Safely dispose of button-cell batteries.

- Encourage children not to put pencils, crayons or erasers in their mouths when coloring or drawing.
- Don't reward small children with coins.

To prevent cuts:

It's normal for children to get scrapes and cuts on the playground, but they must be protected from sharp and dangerous items around and outside the house. Take note of the following to prevent injuries from occurring in the kitchen, bathroom, and garage:

Kitchen and bathroom

- Keep knives, forks, scissors and other sharp tools in a drawer with a safety latch.
- Keep glass objects, such as drinking glasses or bowls, in a high cabinet far from reach.
- Store appliances with sharp blades (like blenders or food processors) far from reach or in a locked cabinet.
- Make sure your child is a safe distance away when you load and unload the dishwasher.
- If possible, keep the kitchen garbage can behind a cabinet door with a safety latch.
- If you use a razor to shave, keep it in a locked cabinet in the bathroom. Be sure extra blades are stored in a safe place, along with nail scissors and other sharp tools.

Garage

- Store all tools, including those used for gardening, automotive and lawn care, in a locked container.
- If you recycle glass and metal in your home, keep the recycling containers far from reach.

To prevent drowning:

Infants and small children can drown in only a few inches of water. Protect them from danger by providing constant supervision whenever they are near water:

Bathtub/Bathroom

- Never leave a baby unattended in the bath. If you must answer the telephone or door, don't rely on an older child to watch the baby; wrap your baby in a towel and bring him with you.
- Stand guard over a bathtub that is filling with water.
- Don't use a bathtub seat with suction cups. The seat can overturn and flip a baby headfirst into the water.
- Install a toilet-lid locking device.

- Never leave a small child unattended near a bucket filled with any amount of water or other liquid.

Pool area

- Don't leave children unattended by a pool, wading pool or hot tub – even for a moment.
- Flotation devices like water wings and inflatable rings can give a false sense of security in the pool. Never use these as a substitute for constant adult supervision.
- Dump out all water from a wading pool when you are finished using it.
- If you have a pool in your backyard, install fencing at least 4 feet high on all sides of the pool. Install a self-closing gate with a lock that is out of a child's reach.
- Remove any ladders from an above-ground pool.

To prevent electric shock:

Many household outlets and cords are right at a toddler's eye level. Protect your child from electric shock by following these safety rules:

- Cover all unused outlets with safety caps.
- Unplug all kitchen appliances when not in use, and keep cords from reach.
- Unplug all bathroom appliances (hair dryers, curling irons, electric razors) when not in use.
- Position television and stereo equipment against walls, so small hands don't have access to the back surfaces.
- To prevent injury from chewing on cords from lamps or other electrical equipment, bind excess cord with a twist-tie. You can also purchase a holder or spool specially designed to hide extra cord.
- Make sure all wires in the house are properly insulated.
- Check electronic toys frequently for signs of wear and tear; any object that sparks, feels hot or smells unusual must be repaired or discarded immediately.
- Seasonal lighting, such as Christmas tree lights, can pose an especially inviting hazard. Make sure all wires are properly insulated, bind excess cord, and unplug all lights when they are not in use.

To prevent injury from falls:

Babies and infants can be wiggly and roll around easily; toddlers and small children can climb their way into trouble. Protect your children from falls by paying special attention to windows, cribs and beds, different areas of the house, and outdoor playgrounds.

Windows

- Install safety bars on upper-story windows. These bars must be childproof but easy for adults to open in case of fire.
- If you don't have safety bars on your windows, close and lock windows when children are present. For ventilation, open windows from the top, and provide adult supervision.
- Keep furniture away from windows to prevent children from climbing onto sills.
- Don't rely on window screens to keep children from falling out of windows.

Cribs and beds

- Keep side rails up on cribs.
- Never leave a baby unattended on a changing table or bed. When choosing a changing table, opt for one with 2-inch guardrails.
- Always secure safety belts on changing tables, strollers, carriages and high chairs. Be sure to strap a small child securely into the seat of a supermarket shopping cart.
- Do not put a child under age 6 on the top bunk of a bunk bed. Attach guardrails to the side of the top bunk.

Around the house

- Attach protective padding or other specially designed covers to corners of coffee tables, furniture, and countertops with sharp edges.
- Install hardware-mounted safety gates at the top and bottom of every stairway (pressure-mounted gates are not as secure). Avoid accordion gates, which can trap a child's head.
- Clean up any spills around the home immediately.
- Keep stairways clear.
- Make sure there are no loose rugs on the floor. Put specially designed pads under rugs to hold them securely to the floor's surface.
- Apply nonskid strips to the bottoms of bathtubs.

Outdoors

- Be sure outdoor playground equipment is safe, with no loose parts or rust.
- Playground surfaces should be soft to absorb the shock of falls. Good surface materials include sand and wood chips: avoid playgrounds with concrete and packed dirt.
- Never allow a child to play on a trampoline, even with adult supervision.

To prevent injury from firearms:

Accidental shootings take the lives of 250 children aged 14 and under in the United States each year. The best way to prevent injury and death from firearms is to avoid keeping guns in your home and avoid exposing your children to households where guns are kept. If you do own a firearm, or the parents of your children's playmates do, protect your children by ensuring that these rules are followed in your own home and in any home your children visit:

- Store guns in a securely locked case, out of children's reach. All firearms should be stored unloaded and in the uncocked position.
- Store ammunition in a separate place, in a securely locked container out of children's reach.
- Always use trigger locks or other childproof devices. Make revolvers childproof by attaching a padlock so that the cylinder cannot be locked into place.
- Always practice gun safety, and be sure to emphasize to children that guns are not toys and should never be played with.
- Take a firearm safety course to learn the safe and correct way to use your firearm.

To prevent poisoning:

Accidental poisoning can occur when a child ingests medications, cleaning products, alcohol, cosmetics, or other toxins. Many well-meaning adults fail to recognize how toxic certain substances can be and leave them in accessible places. Protect your child from the dangers of poisoning by following these rules:

Medications

- Store all medications – prescription and non-prescription – in a locked cabinet, far from children's reach.
- Never leave vitamin bottles, aspirin bottles or other medications on the kitchen table, countertops, bedside tables or dresser tops. Small children may decide to emulate adults and help themselves.
- Don't ever tell a child that medicine is "candy."
- Take special precautions when you have house guests. Be sure their medications are far from reach, preferably locked in one of their bags.
- Don't keep aspirin or other medicines in a pocketbook; children may find them when searching for gum or a toy.
- Child-resistant packaging does not mean childproof packaging. Don't rely on packaging to protect your children.
- Always keep pills and liquids in their original containers.
- Never administer medication to a child in the dark: you may give the wrong dosage or even the wrong medication.
- After taking or administering medication, be sure to reattach the safety cap and store the medication away safely.

Cleaning products

- Store household cleaning products and aerosol sprays in a high cabinet far from reach. Don't keep any cleaning supplies under the sink, including dishwasher detergent and dishwashing liquids.
- Never put cleaning products in old soda bottles or containers that were once used for food.
- When you are cleaning or using household chemicals, never leave the bottles unattended if there is a small child present.
- Never put roach powders or rat poison on the floors of your home.
- Keep hazardous automotive and gardening products in a securely locked area in your garage.

Alcohol

- Don't leave alcoholic drinks where children can reach them. Take special care during parties – guests may not be conscious of where they've left their drinks. Clean up promptly after the party.
- Keep bottles of alcohol in a locked cabinet far from children's reach.
- Keep mouthwash out of the reach of children. Many mouthwashes contain substantial amounts of alcohol.

Lead paint

- If you have an older home, have the paint tested for lead.
- Do not use cribs, bassinets, highchairs, painted toys or toy chests made before 1978; these may have a finish that contains dangerously high levels of lead.

Other items

- Never leave cosmetics and toiletries within easy reach of children. Be especially cautious with perfume, hair dye, hair spray, nail and shoe polish, and nail polish remover.
- Learn all the names of the plants in your house, and remove any that could be toxic.
- Discard used button-cell batteries safely, and store any unused ones far from children's reach (alkaline substances are poisonous).

To prevent strangulation:

Babies and children have been strangled by strings on clothing, cords, and infant furniture and accessories. Prevent strangulation by avoiding these sources and modifying certain items in your home:

- Drawstrings, ribbons and cords

- Don't buy garments with drawstrings, which can catch on objects and strangle a child. Cut all drawstrings out of hoods, jackets and waistbands in your child's wardrobe. Cut strings off mittens.
- Clip strings or ribbons off hanging mobiles and other crib toys.
- Always tie up window blind cords so they are out of your child's reach. Cut the cords so there is no loop at the bottom, then secure them with clothespins or specially designed cord clips.
- Don't let long telephone cords dangle to the floor.
- Resist the temptation to put necklaces or headbands on your baby.
- Never tie a pacifier around your baby's neck.
- Don't tether a pacifier to your baby's clothing with a ribbon or piece of string.
- Don't hang diaper bags or purses on cribs – a baby can become entangled in the straps or strings.

Infant furniture and accessories

- Crib bumpers should be not to be used.
- Crib slats should be no more than 2-3/8 inches apart; anything wider can trap a child's head.
- Avoid cribs with cut-outs in the headboard or foot board.
- Never leave a child alone in a stroller; a child can slide down and trap his head.
- Don't use old accordion-style gates. These can trap a child's head.

To prevent suffocation:

Because babies are not yet able to raise their heads, they need special protection from suffocation. But small children are also at risk, primarily due to plastic bags of all sizes. Protect your children from the dangers of suffocation by following these rules:

- Never place an infant face down on soft bedding, such as a waterbed, quilt, sheepskin rug, or mattress cover. The same holds true for any type of soft pillow, such as a beanbag or bead-filled pillow. Avoid large stuffed animals.
- Be sure that a crib mattress fits snugly in the crib. This keeps a baby from slipping in between the mattress and the crib sides.
- Never put an infant down on a mattress covered with plastic or a plastic bag.
- When cleaning up after a birthday party or holiday, pay special attention to all plastic bags from toy packaging. Collect them and throw them out immediately.
(source: <http://www.medem.com/MedLB>)

First Aid for Poisoning

Most poisonings are preventable, and every effort should be made to poison-proof your home. However, if someone in your home is exposed to a poison, the following information is intended to help you do the right thing as quickly as possible.

- Keep calm.
- Act quickly. Action is the most important factor in first aid if you suspect poisoning.

Before You Call for Help

Poisonous Fumes or Gases

Immediately carry or drag the person to fresh air. Minimize your exposure to the fumes. If the victim is not breathing, start artificial respiration immediately and continue it until the victim is breathing or help arrives. Send someone for help as quickly as possible.

Poisons on the Skin

Brush off all dry poisons and flood involved parts with large amounts of plain water. Then wash the skin with bar soap and water and rinse. Remove and discard all affected clothing.

Poisons in the Eye

Pour water from a glass on to the bridge of the patient's eye and allow water to flood the eye gently for 15 minutes. Use plain lukewarm water. Do not allow the victim to rub his eyes.

Swallowed Poisons/Medications

Look into the victim's mouth and remove all tablets, powder or any material that is present. Examine the mouth for cuts, burns, swelling, unusual coloring or odor. Rinse and wipe out the mouth with a cloth.

Calling for Help

Call the Oklahoma Poison Control Center or your doctor.

When calling the Poison Control Center:

- Identify yourself and give your relationship to the patient. Give your phone number in case your call is disconnected.
- Describe the patient by name, age and weight.

- If possible, have the container or poison in your hand and identify as best you can:
 - What was taken?
 - When was it taken?
 - How much was taken?
 - How is the patient acting?
 - Be prepared to answer any questions asked.

Follow the advice given by the Poison Control Center or doctor.

How to Produce Vomiting

The most important item to have in your home when poisoning occurs is ipecac syrup. Ipecac is a plant extract that when swallowed causes vomiting. Vomiting will remove the poison from the stomach. Your doctor or Poison Control Center may not always recommend using ipecac syrup. Do not use ipecac syrup without the advice of a doctor or the Poison Control Center.

Remember: Never produce vomiting unless instructed to do so! This is especially important if the patient has swallowed petroleum products such as gasoline, cleaning fluids and lighter fluids.

Never produce vomiting if the patient:

- Is drowsy or unconscious
- Is having convulsions (fits)
- Has swallowed a strong corrosive such as Drano, Liquid Plumber or acids; if this occurs, give liquids only

Ipecac Syrup

If you are instructed to use ipecac syrup to produce vomiting:

- Give one tablespoonful (15cc) to young children 1 to 12 years of age, and two tablespoonfuls (30cc) to older children and adults. Always consult with your doctor or the Poison Control Center before giving Ipecac syrup to a child under the age of 1.
- Follow the dose with a 4-to-8 ounce glass of water or juice. Encourage the patient to drink more fluids, if possible.
- Do not allow the patient to lie down. Keep him active.
- If the patient hasn't vomited within 15 to 20 minutes, give a second dose and another glass of liquid.

If you come to the hospital, bring the poison and the container with you. Bring any stomach contents you collect from vomiting.

Caution

Antidotes recommended on many product labels may be outdated or incorrect. In addition, salt water, mustard and water and many other home remedies are ineffective and may be dangerous. Don't use them.

Remember

- Visit your local pharmacy and get ipecac syrup for your home today.
- Call a doctor or the Poison Control Center before you produce vomiting. When instructed to do so, give the ipecac syrup as directed. It may save your child's life.

The Poison Control Center located in Children's Hospital of Oklahoma is staffed by pharmacists who provide 24-hour emergency medical information on toxicology to the public and health-care professionals. It also sponsors poison education materials and lectures.

Oklahoma Poison Center
OU College of Pharmacy
Children's Hospital of Oklahoma
940 N.E. 13th
Oklahoma City, OK 73104
405-271-5454 or
1-800-POISON-1 (1-800-764-7661)

Nutrition - Healthy Eating Tips

- Encourage food choices for a healthy diet. When children are offered a balanced diet, over time they will develop good eating habits.
- Be patient.
- Young children may not be interested in trying new foods. Offer a new food more than once. Show your child how the rest of the family enjoys it. The food may be accepted when it becomes more familiar to your child.
- Be a planner.
- Most young children need a snack or two in addition to three regular daily meals.
- Offer foods from three or more of the major food groups for breakfast.
- Offer foods from four or more of the major food groups for the "main meal."
- Plan snacks so they are not served too close to mealtime, and offer foods from two or more of the major food groups.
- Be a good role model.
- What you do can mean more than what you say. Your child learns from you about how and what to eat.

- Eat meals at the table with your children whenever possible. Turn off the TV and all other electronic equipment and have a conversation with your family.
- Try new foods and new ways of preparing them with your children. Both you and your children can be healthier by eating more dark-green leafy vegetables, deep-yellow vegetables, fruits and whole grain products.
- Walk, run and play with your children. Don't just sit on the sidelines. A family that is physically active together has lots of fun.

MyPlate For Kids

MyPlate for Kids reminds children to be active every day and to make healthy food choices.

Be Physically Active Every Day

Do something active every day, like running, walking the dog, playing, swimming, biking, or climbing lots of stairs.

Every Color Every Day

The colors orange, green, red, yellow, blue and purple represent five different food groups plus oils. Children should remember to eat foods from all food groups every day.

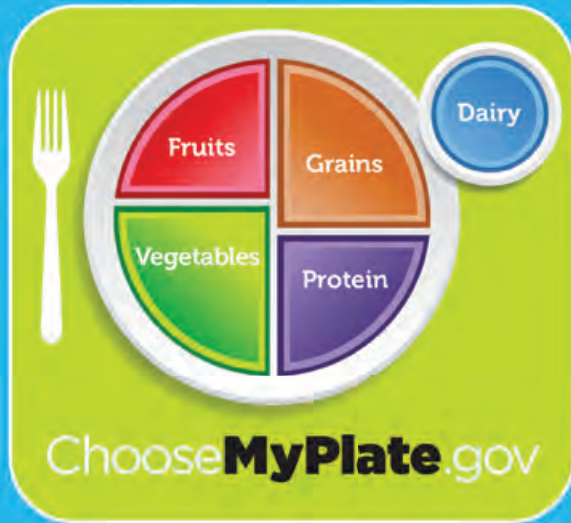
Take One Step at a Time

You do not need to change what you eat and how you exercise overnight. Just start with one new good thing, and add a new one every day.

Make Choices That Are Right for You

ChooseMyPlate.gov is a website that will give everyone in the family personal ideas on how to eat better and exercise more.

What's on your plate?



Before you eat, think about what and how much food goes on your plate or in your cup or bowl. Over the day, include foods from all food groups: vegetables, fruits, whole grains, low-fat dairy products, and lean protein foods.



Make half your plate fruits and vegetables.



Make at least half your grains whole.



Switch to skim or 1% milk.



Vary your protein food choices.

Vegetables	Fruits	Grains	Dairy	Protein Foods
<p>Eat more red, orange, and dark-green vegetables like tomatoes, sweet potatoes, and broccoli in main dishes.</p> <p>Add beans or peas to salads (kidney or chickpeas), soups (split peas or lentils), and side dishes (pinto or baked beans), or serve as a main dish.</p> <p>Fresh, frozen, and canned vegetables all count. Choose "reduced sodium" or "no-salt-added" canned veggies.</p>	<p>Use fruits as snacks, salads, and desserts. At breakfast, top your cereal with bananas or strawberries; add blueberries to pancakes.</p> <p>Buy fruits that are dried, frozen, and canned (in water or 100% juice), as well as fresh fruits.</p> <p>Select 100% fruit juice when choosing juices.</p>	<p>Substitute whole-grain choices for refined-grain breads, bagels, rolls, breakfast cereals, crackers, rice, and pasta.</p> <p>Check the ingredients list on product labels for the words "whole" or "whole grain" before the grain ingredient name.</p> <p>Choose products that name a whole grain first on the ingredients list.</p>	<p>Choose skim (fat-free) or 1% (low-fat) milk. They have the same amount of calcium and other essential nutrients as whole milk, but less fat and calories.</p> <p>Top fruit salads and baked potatoes with low-fat yogurt.</p> <p>If you are lactose intolerant, try lactose-free milk or fortified soy milk (soy beverage).</p>	<p>Eat a variety of foods from the protein food group each week, such as seafood, beans and peas, and nuts as well as lean meats, poultry, and eggs.</p> <p>Twice a week, make seafood the protein on your plate.</p> <p>Choose lean meats and ground beef that are at least 90% lean.</p> <p>Trim or drain fat from meat and remove skin from poultry to cut fat and calories.</p>

For a 2,000-calorie daily food plan, you need the amounts below from each food group. To find amounts personalized for you, go to ChooseMyPlate.gov.

Eat 2½ cups every day	Eat 2 cups every day	Eat 6 ounces every day	Get 3 cups every day	Eat 5½ ounces every day
<p>What counts as a cup? 1 cup of raw or cooked vegetables or vegetable juice; 2 cups of leafy salad greens</p>	<p>What counts as a cup? 1 cup of raw or cooked fruit or 100% fruit juice; ½ cup dried fruit</p>	<p>What counts as an ounce? 1 slice of bread; ½ cup of cooked rice, cereal, or pasta; 1 ounce of ready-to-eat cereal</p>	<p>What counts as a cup? 1½ ounces natural or 2 ounces processed cheese</p>	<p>What counts as an ounce? 1 ounce of lean meat, poultry, or fish; 1 egg; 1 Tbsp peanut butter; ½ ounce nuts or seeds; ½ cup beans or peas</p>

Cut back on sodium and empty calories from solid fats and added sugars



Look out for salt (sodium) in foods you buy. Compare sodium in foods and choose those with a lower number.

Drink water instead of sugary drinks. Eat sugary desserts less often.

Make foods that are high in solid fats—such as cakes, cookies, ice cream, pizza, cheese, sausages, and hot dogs—occasional choices, not every day foods.

Limit empty calories to less than 260 per day, based on a 2,000-calorie diet.

Be physically active your way

Pick activities you like and do each for at least 10 minutes at a time. Every bit adds up, and health benefits increase as you spend more time being active.

Children and adolescents: get 60 minutes or more a day.

Adults: get 2 hours and 30 minutes or more a week of activity that requires moderate effort, such as brisk walking.



U.S. Department of Agriculture • United States Department of Health and Human Services
 MyPlate.gov

Fitness

The Power of Movement in Children's Lives

Physical activity of all kinds stimulates children's development in the following ways:

- Physical development – children learn about their bodies and grow strong through movement
- Intellectual development – physical activities stimulate the connection between mind and body
- Communication – movement is a means of communication and one of the earliest ways children express their thoughts and feelings
- Building strong relationships – movement is an important way we connect with others
- Self-confidence – as children use their bodies to discover their world, they gain knowledge, strength and skills

Children need lots of free time to move, play and discover on their own, but they also benefit from some caregiver directed games and activities. Provide a safe play space inside and outside and be a good role model and get moving too.

Motivation

- Use physical fitness as a positive tool for self-improvement and learning
- Make the activities fun and interesting to specific age groups
- Be a model and interact with the children in the activities

Age Specific Activities

Infant (newborn–1 year)

- Help develop skills to roll over, sit, stand and walk
- Time on their bellies helps develop coordination between upper and lower body
- Dance and move to different types of music

Toddler (1-3 years)

- Develop skills to follow directions and learning limitations
- Activity suggestions: finger play: "Itsy Bitsy Spider," "Ring-Around-The-Rosie," "London Bridges," follow the leader, dance, jump and/or chase bubbles
- At least 30 minutes daily of physically active, structured play, plus 60 minutes of free play.

Preschooler (3-5 years)

- Develop skills for balance and coordination
- Activity suggestions: make up silly movements to songs, dance, skip, navigate obstacle courses, balance on one foot, walk a low balance beam and do jumping jacks
- At least 30-60 minutes daily of physically active, structured play, plus 60 minutes of free play

School-age (6-12 years)

- Develop skills of complex movements and understand rules to games
- Activity suggestions: hopscotch, jump rope, shoot baskets, play catch or kickball, free-style dance, go on a hike with a goal in mind
- At least 30-60 minutes daily of physically active structured play, plus 60 minutes of free play

Adolescent (13-older)

- Develop a sense of individuality and self-worth
- Let them choose activities of interest in both team and individual fitness activities such as swimming, yoga, basketball, baseball, dance, karate, volleyball or track events
- At least 30 minutes of physical activity daily, in addition adolescents should have three to five 20-minute sessions of vigorous exercise weekly

Benefits of Physical Activity

- Strengthens muscles and bones
- Increases classroom participation and attention
- Reduces anxiety
- Increases endurance and flexibility
- Prevents obesity

Oral Health Care

Did you know that...

Cavities (tooth decay) are the most common childhood disease. Left untreated, dental disease can interfere with language development, eating, sleeping and the ability to learn, as well as predispose children to infection and some systemic diseases. Cavities are entirely preventable through education, fluoride and similar treatments, and proper nutrition.

Infants 0-6 months

Clean babies' gums daily with a clean, damp washcloth, finger cot, or gauze pad. Hold babies while feeding them and never put babies in bed with a bottle. Milk and juice left to pool in babies' mouths leads to early childhood cavities. Use only a clean pacifier, and never dip it in honey or anything sweet or alcoholic. Fluoride makes babies' teeth stronger and more resistant to cavities. Starting at about 6 months, babies need fluoride through drinking water or a fluoride supplement prescribed by their physician.

Infants 6-12 months

At this age, the primary teeth begin to appear. These teeth are important to the development of permanent teeth and need to be kept clean and healthy. Babies' teeth, mouths, and gums can show signs of early oral health problems at this age. White or brown spots or lesions behind the front teeth are an early sign of tooth decay. Clean babies' teeth and gums with a soft bristle toothbrush.

Toddlers 12-24 months

Children should be involved at this age to help care for their teeth in order to build good oral hygiene habits. Encourage children to brush as early as 18 months, with assistance. Use songs, games and favorite toys to make brushing a positive experience. Use a pea-sized portion of toothpaste on the child's brush. The tongue needs to be brushed and all surfaces of the teeth. When finished, children should rinse with water and spit if possible. The children's toothbrushes should be identified with their names and air dried without touching each other. Brushes should be replaced every three months and after an illness.

Preschool 3-5 years

Practice brushing with preschoolers, making sure the surfaces of all teeth to the gum line are brushed. Young children cannot get their teeth clean by themselves. Until they are 7 or 8 years old, you will need to help them. Try brushing their teeth first and then letting them finish.

Resources

- Contact Colgate Bright Smiles, Bright Futures for fun downloadable games and color pages that promote dental health. There is also parent information that can be downloaded. www.colgatebsbf.com
- The local library has children's books on dental care available for check-out.
- The local health department may have resources and handouts on dental care for both children and their parents.
- Contact your local dentist in your community about education materials such as disclosing tablets that color plaque left after brushing. Ask him if he will be a resource for dental emergencies. Ask for freebies.
- www.adha.org/kidstuff American Dental Hygienists Association
- www.crestsmiles.com/crest_kids
- www.colgate.com/kids-world



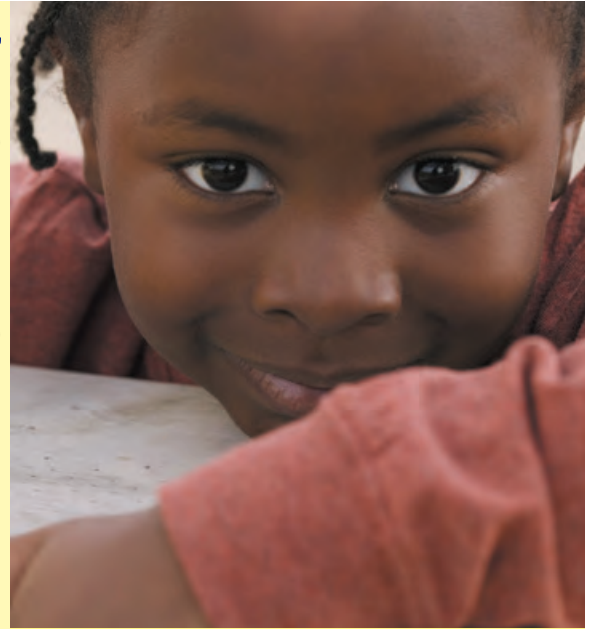
Section 15. Child Development

Discovering Your Child's Developmental Needs

Developmental Checklists Birth to 18

Self-Esteem

Separation and Loss



Section 15: Child Development

Discovering Your Child's Developmental Needs

Every child is born with a set of potential characteristics or traits. Some of these are shared by all human beings and some of these traits come from genetic links inherited from birth parents and family. After a baby is born, development proceeds in stages. No stage can be skipped. Each stage is important for the next one. For example, children often crawl and pull themselves up before they begin to walk.

Each child may go through similar growth and developmental stages, but at a different rate. Though a wide range in development is normal, being significantly behind or delayed can indicate a problem. Trauma and stress can delay developmental growth and progress and even cause regression to earlier stages. For example, children who have been potty trained may start wetting or soiling again when a new baby comes into the family.

Being slow to reach a particular stage, and even the experiences of trauma and stress, do not mean that a child will not eventually reach the next stage of growth and development. But, it will take a lot of care and patience from resource parents, who need specific knowledge and skills, and know when to bring in professional help, to overcome the delays.

The following information provides a quick guide to child development. If your child's development seems delayed, or otherwise not following the expected patterns according to this guide, ask your child's doctor or your child's child welfare specialist about getting help.

Developmental Checklists

1-3 Months

Movement

- Raises head and cheek when lying on stomach (3 months)
- Supports upper body with arms when lying on stomach (3 months)
- Stretches legs out when lying on stomach or back (2-3 months)
- Opens and shuts hands (2-3 months)
- Pushes down on legs when his feet are placed on firm surface (3 months)

Visual

- Watches face intently (2-3 months)
- Follows moving objects (2 months)
- Recognizes familiar objects and people at a distance (3 months)
- Starts using hands and eyes in coordination (3 months)

Hearing and Speech

- Smiles at the sound of voice (2-3 months)
- Cooing noises; vocal play (begins at 3 months)
- Attends to sound (1-3 months)
- Startles to loud noise (1-3 months)

Social/Emotional

- Begins to develop a social smile (1-3 months)
- Enjoys playing with other people and may cry when playing stops (2-3 months)
- Becomes more communicative and expressive with face and body (2-3 months)
- Imitates some movements and facial expressions

Developmental Red Flags (1-3 months)

- Doesn't seem to respond to loud noises
- Doesn't follow moving objects with eyes by 2-3 months
- Doesn't smile at the sound of your voice by 2 months
- Doesn't grasp and hold objects by 3 months
- Doesn't smile at people by 3 months
- Cannot support head well at 3 months
- Doesn't reach for and grasp toys by 3-4 months
- Doesn't bring objects to mouth by 4 months
- Doesn't push down with legs when feet are placed on a firm surface by 4 months
- Has trouble moving one or both eyes in all directions
- Crosses eyes most of the time (occasional crossing of the eyes is normal in these first months)

4-7 Months

Movement

- Pushes up on extended arms (5 months)
- Pulls to sitting with no head lag (5 months)
- Sits with support of his hands (5-6 months)
- Sits unsupported for short periods (6-8 months)
- Supports whole weight on legs (6-7 months)
- Grasps feet (6 months)
- Transfers objects from hand to hand (6-7 months)
- Uses raking grasp (not pincer) (6 months)

Visual

- Looks for toy beyond tracking range (5-6 months)
- Tracks moving objects with ease (4-7 months)
- Grasps objects dangling in front of him (5-6 months)
- Looks for fallen toys (5-7 months)

Language

- Distinguishes emotions by tone of voice (4-7 months)
- Responds to sound by making sounds (4-6 months)
- Uses voice to express joy and displeasure (4-6 months)
- Syllable repetition begins (5-7 months)

Cognitive

- Finds partially hidden objects (6-7 months)
- Explores with hands and mouth (4-7 months)
- Struggles to get objects that are out of reach (5-7 months)

Social Emotional

- Enjoys social play (4-7 months)
- Interested in mirror images (5-7 months)
- Responds to other people's expression of emotion (4-7 months)

Developmental Red Flags (4-7 months)

- Seems very stiff, tight muscles
- Seems very floppy, like a rag doll
- Head still flops back when body is pulled to sitting position (by 5 months still exhibits head lag)
- Shows no affection for the person who cares for them
- Doesn't seem to enjoy being around people
- One or both eyes consistently turn in or out
- Persistent tearing, eye drainage, or sensitivity to light
- Does not respond to sounds around them
- Has difficulty getting objects to mouth
- Does not turn head to locate sounds by 4 months
- Doesn't roll over (stomach to back) by 6 months
- Cannot sit with help by 6 months (not by themselves)
- Does not laugh or make squealing sound by 5 months
- Does not actively reach for objects by 6 months
- Does not follow objects with both eyes
- Does not bear some weight on legs by 5 months

8-12 Months

Movement

- Gets to sitting position without assistance (8-10 months)
- Crawls forward on belly
- Assumes hand and knee position
- Creeps on hands and knees
- Gets from sitting to crawling or prone (lying on stomach) position (10-12 months)
- Pulls self up to standing position
- Walks holding on to furniture
- Stands momentarily without support
- May walk two or three steps without support

Hand and Finger Skills

- Uses pincer grasp (grasp using thumb and index finger) (7-10 months)
- Bangs two one-inch cubes together
- Puts objects into container (10-12 months)
- Takes objects out of container (10-12 months)
- Pokes with index finger
- Tries to imitate scribbling

Cognitive

- Explores objects in many different ways (shaking, banging, throwing, dropping) (8-10 months)
- Finds hidden objects easily (10-12 months)
- Looks at correct picture when image is named
- Imitates gestures (9-12 months)

Language Milestones

- Responds to simple verbal requests
- Responds to “no”
- Makes simple gestures such as shaking head for “no”
- Babbles with inflection (8-10 months)
- Babbles “dada” and “mama” (8-10 months)
- Says “dada” and “mama” for specific person (11-12 months)
- Uses exclamations such as “oh-oh”

Social/Emotional

- Shy or anxious with strangers (8-12 months)
- Cries when mother or father leaves (8-12 months)
- Enjoys imitating people in play (10-12 months)
- Shows specific preferences for certain people and toys (8-12 months)
- Prefers mother and/or regular care provider over all others (8-12 months)
- Repeats sounds or gestures for attention (10-12 months)
- Finger-feeds himself (8-12 months)
- Extends arm or leg to help when being dressed

Developmental Red Flags (8-12 months)

- Does not crawl
- Drags one side of body while crawling (for more than one month)
- Cannot stand when supported
- Does not search for objects that are hidden (10-12 months)
- Says no single words (“mama” or “dada”)
- Does not learn to use gestures such as waving or shaking head

- Does not sit steadily by 10 months
- Does not show interest in “peek-a-boo” or “patty cake” by 8 months
- Does not babble by 8 months (“dada,” “baba,” “mama”)

12-24 Months

Movement

- Walks alone (12-16 months)
- Pulls toys behind him while walking (13-16 months)
- Carries large toy or several toys while walking (12-15 months)
- Begins to run stiffly (16-18 months)
- Climbs onto and down from furniture unsupported (16-24 months)
- Walks up and down stairs holding on to support (18-24 months)

Hand and Finger Skills

- Scribbles spontaneously (14-16 months)
- Turns over container to pour out contents (12-18 months)
- Builds tower of four blocks or more (20-24 months)

Language

- Points to object or picture when it’s named for them (18-24 months)
- Recognizes names of familiar people, objects and body parts (18-24 months)
- Says several single words (15-18 months)
- Uses two-word sentences (18-24 months)
- Follows simple, one-step instructions (14-18 months)
- Repeats words overheard in conversations (16-18 months)

Cognitive

- Finds objects even when hidden under two or three covers
- Begins to sort shapes and colors (20-24 months)
- Begins make-believe play (20-24 months)

Social

- Imitates behavior of others, especially adults and older children (18-24 months)
- Increasingly enthusiastic about company or other children (20-24 months)
- Demonstrates increasing independence (18-24 months)
- Begins to show defiant behavior (18-24 months)
- Episodes of separation anxiety increase toward midyear, then fade

Developmental Red Flags (12 to 24 months)

- Cannot walk by 18 months
- Fails to develop a mature heel-toe walking pattern after several months of walking, or walks exclusively on toes
- Does not speak at least 15 words by 18 months
- Does not use two-word sentences by age 2
- By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- Does not imitate actions or words by 24 months
- Does not follow simple one-step instructions by 24 months

24-36 Months

Movement

- Climbs well (24-30 months)
- Walks down stairs alone, placing both feet on each step (26-28 months)
- Walks up stairs alternating feet with support (24-30 months)
- Swings leg to kick ball (24-30 months)

- Runs easily (24-26 months)
- Pedals tricycle (30-36 months)
- Bends over easily without falling (24-30 months)

Hand and Finger Skills

- Make vertical, horizontal, circular strokes with pencil or crayon (30-36 months)
- Turns book pages one at a time (24-30 months)
- Builds a tower of more than six blocks (24-30 months)
- Holds a pencil in writing position (30-36 months)
- Screws and unscrews jar lids, nuts and bolts (24-30 months)
- Turns rotating handles (24-30 months)

Language

- Recognizes and identifies almost all common objects and pictures (26-32 months)
- Understands most sentences (24-40 months)
- Understands physical relationships (on, in, under) (30-36 months)
- Can say name, age and sex (30-36 months)
- Uses pronouns (I, you, me, we, they) (24-30 months)
- Strangers can understand most of words (30-36 months)

Cognitive

- Makes mechanical toys work (30-36 months)
- Matches an object in hand or room to a picture in a book (24-30 months)
- Plays make-believe with dolls, animals and people (24-36 months)
- Sorts objects by color (30-36 months)
- Completes puzzles with three or four pieces (24-36 months)
- Understands concept of “two” (26-32 months)

Social/Emotional

- Separates easily from parents (by 36 months)
- Expresses a wide range of emotions (24-36 months)
- Objects to major changes in routine (24-36 months)

Developmental Red Flags (24-36 months)

- Frequent falling and difficulty with stairs
- Persistent drooling or very unclear speech
- Inability to build a tower of more than 4 blocks
- Difficulty manipulating small objects
- Inability to copy a circle by 3 years old
- Inability to communicate in short phrases
- No involvement in pretend play
- Failure to understand simple instructions
- Little interest in other children
- Extreme difficulty separating from primary caregiver

3-4 Years

Movement

- Hops and stands on one foot up to 5 seconds
- Goes upstairs and downstairs without support
- Kicks ball forward
- Throws ball overhand
- Catches bounced ball most of the time
- Moves forward and backward
- Uses riding toys

15-10

Hand and Finger Skills

- Copies square shapes
- Draws a person with two to four body parts
- Uses scissors
- Draws circles and squares
- Begins to copy some capital letters
- Can feed self with spoon

Language Milestones

- Understand the concepts of “same” and “different”
- Has mastered some basic rules of grammar
- Speaks in sentences of five to six words
- Asks questions
- Speaks clearly enough for strangers to understand
- Tells stories

Cognitive Milestones

- Correctly names some colors
- Understands the concept of counting and may know a few numbers
- Begins to have a clearer sense of time
- Follows three-part commands
- Recalls parts of a story
- Understands the concept of same/different
- Engages in fantasy play
- Understands causality (“I can make things happen”)

Social Milestones

- Interested in new experiences

- Cooperates/plays with other children
- Plays “mom” or “dad”
- More inventive in fantasy play
- Dresses and undresses
- More independent

Emotional Milestones

- Often cannot distinguish between fantasy and reality
- May have imaginary friends or see monsters

Developmental Red Flags (3-4 years)

- Cannot jump in place
- Cannot ride a trike
- Cannot grasp a crayon between thumb and fingers
- Has difficulty scribbling
- Cannot copy a circle
- Cannot stack four blocks
- Still clings or cries when parents leave him
- Shows no interest in interactive games
- Ignores other children
- Doesn't respond to people outside the family
- Doesn't engage in fantasy play
- Resists dressing, sleeping, using the toilet
- Lashes out without any self-control when angry or upset
- Doesn't use sentences of more than three words
- Doesn't use “me” or “you” appropriately

4-5 Years

Movement

- Stands on one foot for 10 seconds or longer
- Hops, somersaults
- Swings, climbs
- May be able to skip

Milestones in Hand and Finger Skills

- Copies triangle and other geometric patterns
- Draws person with body
- Prints some letters
- Dresses and undresses without assistance
- Uses fork, spoon
- Usually cares for own toilet needs

Language Milestones

- Recalls parts of a story
- Speaks sentences of more than five words
- Uses future tense
- Tells longer stories
- Says name and address

Cognitive Milestones

- Can count 10 or more objects
- Correctly names at least four colors
- Better understands the concept of time
- Knows about things used every day in the home (money, food, etc.)

Social Milestones

- Wants to please and be with friends
- More likely to agree to rules
- Likes to sing, dance and act
- Shows more independence

Developmental Red Flags (4-5 years)

- Exhibits extremely aggressive, fearful or timid behavior
- Is unable to separate from parents
- Is easily distracted and unable to concentrate on any single activity for more than five minutes
- Shows little interest in playing with other children
- Refuses to respond to people in general
- Rarely uses fantasy or imitation in play
- Seems unhappy or sad much of the time
- Avoids or seems aloof with other children and adults
- Doesn't express a wide range of emotions
- Has trouble eating, sleeping or using the toilet
- Can't differentiate between fantasy and reality
- Seems unusually passive
- Can't understand two-part commands and prepositions ("put the cup on the table"; "get the ball under the couch")
- Can't give his first and last name
- Doesn't use plurals or past tense
- Cannot build a tower of six to eight blocks

- Seems uncomfortable holding a crayon
- Has trouble taking off clothing
- Can't brush teeth or wash and dry hands

Stages of Child Development

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
<ul style="list-style-type: none"> ● 6-12 years 	<ul style="list-style-type: none"> ● Enjoys using new skills, both gross and fine motor ● Likes to achieve in sports ● Is energetic and tends to have an increased appetite ● Is increasing in height and weight at a steady rate ● Increased coordination and strength ● Developing body proportions similar to adult 	<ul style="list-style-type: none"> ● Is developing a more defined personality ● Acts very independent and self-assured, but at times is childish and silly ● Enjoys working/playing with others and alone ● Defines self-concept in part by success at school ● Plays almost exclusively with same sex ● Begins to experience conflicts between parents' values and those of peers ● Has a strong sense of fair play ● Believes that rules are important and must be followed ● Likes affection from adults; wants them to be there to help ● Is able to assume responsibility for self and may care for younger siblings 	<ul style="list-style-type: none"> ● Enjoys projects that are task-oriented like sewing, cooking, woodwork ● Is very verbal, enjoys jokes and puns that use language creatively ● Asks questions that are fact-oriented; wants to know how, why and when ● Likes to make up stories, plays and puppet shows ● Is able to deal with abstract ideas ● Judges own success on ability to learn to read, write, and do arithmetic

Age	Physical Milestones	Emotional/Social Milestones	Intellectual Milestones
<ul style="list-style-type: none"> ● 12-18 years 	<ul style="list-style-type: none"> ● Experiencing a dramatic growth spurt; generally boys between 12 and 14 and girls between 10 and 12 ● Anxious about physical changes and may worry if their look is not “ideal” ● Achieves sexual maturity and experiences increased sexual drives 	<ul style="list-style-type: none"> ● Needs help in dealing with changes taking place in order to retain a strong sense of identity and values ● Is likely to show extreme mood swings; often doesn’t know how to express anger ● Enjoys social activities at school ● Relies heavily on peers; struggles to be independent of parents ● Tries to conform to group norms ● Has close friendships and emotional involvements ● Is concerned with meaningful interpersonal relationships and is developing personal moral code ● Seeks emotional alliances outside family; is less dependent on family for affection and emotional support ● Experiences conflicts with parents on expectations, e.g. for achievements ● Strives to define self as separate individual and may adopt extreme hairstyles, clothes, destructive behavior ● Often feels misunderstood by parents 	<ul style="list-style-type: none"> ● Shows increased (or decreased) interest in school and academic studies ● Achieves significant changes in cognitive development ● Is able to reason, to generate hypotheses, and to test them against evidence ● Begins to consider (and sometimes make) vocational choices ● Is interested in making money and may take part-time jobs

Drew, K., Salus, M., and Dodge, D. (1981). *Child Protective Services Inservice Training for Supervisors and Social Workers*, Washington, DC: U.S. Department of Health and Human Services.

Self-Esteem

The preceding information indicates that just as the physical and intellectual development occurs regarding the child placed in your home, so does their emotional development. Self-esteem is a critical component of a child's emotional well-being. Self-esteem is our feeling of self-worth – the picture of ourselves we carry in our heads. Self-esteem affects a child's self-concept and motivates their behavior.

Children in out-of-home care may have low self-esteem. They have been hurt physically and emotionally by abuse or neglect and by not being able to be with their family. They often feel worthless and powerless. Parents and other adults in general, may seem unreliable, unresponsive, and rejecting. The child may lack information about why he has been separated from his family. When a person lacks information, it is very easy to feel worthless and incompetent and to behave irresponsibly. Without understanding why, it is difficult to know who to trust or who to blame. Children who have been in multiple placements may be confused, angry and insecure; they may experience developmental delays due to abuse, neglect, or being separated from significant others. Such delays can cause frustration at their lack of success and satisfaction related to accomplishing physical, emotional, social and intellectual tasks. For example, a dip in schoolwork, causing a child in out-of-home care to repeat a grade, can worsen the child's low self-esteem.

Ways to Build Self-Esteem

Healthy Communication

Closely observing the behavior of the child placed in your home can give you clues to his level of self-esteem. One of the first ways to build a child's self-esteem is to work at developing healthy communication. As self-esteem improves, the child's ability to control his behavior also improves. Healthy communication will help you understand the feelings driving the child's behavior and will also build his or her self-esteem and confidence in you.

Are you a resource parent who thinks the main purpose of communication is to get information to your children? Communicating is not telling children to eat their green beans and reminding them to not talk to strangers. That is sending information one way. Communication is a two-way bridge connecting feelings. Healthy communication does more; it builds a strong relationship between you and the child placed in your home, enabling the child to develop a healthy self-concept and good relationships with you and others.

Building healthy communication helps the child to:

- Feel secure, cared for and loved
- Believe he matters and is important to you
- Feel safe and not alone with his worries
- Learn to tell you what he/she feels and needs directly in words, instead of through behavior

Be Available

Children need to feel that their resource parents are available to them. This means being able to spend time with them. When does the child placed in your home really want to talk to you – after school, before bed? Children rarely talk about feelings on command. Resource parents need to be available when children want to talk.

Show Empathy

Tune in to how the child is feeling, even if you don't agree with him. Empathy is about appreciating feelings – not about who is right or wrong.

Be a Good Listener

Even when you can't do anything to fix a problem, being a good listener makes the child feel loved. Ask him for his ideas and feelings before talking about yours. Try to understand exactly what he is saying to you. What the child is trying to say to you is important to him, even if it doesn't seem important to you. You don't have to agree with what he is saying to be a good listener. When you listen first, the child placed in your home can calm down and be ready to listen to you later.

Listen First – Then, Be a Good Sender

If the child is heard first, he/she will be more receptive to listening to you. Make sure that your tone of voice, body language, and words all send the same message. For example, if you say “No!” and laugh, the child will be confused about what you really want. Use words to communicate directions about what you want the child to do. Send “you” messages and use feeling words when you praise the child. For example, “You really did a good job taking that phone message from the doctor's office! I would have forgotten your sister's appointment day and time if you hadn't taken such a complete message.”

Be a Good Role Model

Children will copy your way of communicating. Young children learn better from copying what a resource parent does than by being told. If you use feeling words, it will help the child placed in your home learn to use feeling words to express himself. When resource parents use feeling words instead of screaming, doing something hurtful, or calling someone a name, children learn that using feelings words is a better way to deal with strong feelings. Saying feelings, rather than acting on them, helps children control themselves.

Separation and Loss: Responses and Needs

The grieving process:

- Is a normal part of life for most people, and certainly for the children in out-of-home care
- Influences feelings which, in turn, direct behavior
- Requires resource parents, biological families and child welfare specialists cooperate to help children manage feelings and behaviors so they can make the most of their out-of-home care experience
- Elicits varied responses including:
 - Shock, denial or protest
 - Bargaining
 - Anger (acting out)

- Depression (anger turned inward)
- Understanding and coping

The pathway through the grieving process begins with a significant loss. This loss typically falls into one of the following categories. Often the children placed in your home have experienced all three:

- Loss of health from being abused or neglected
- Loss of significant persons (parents or siblings) to whom they are strongly attached
- Loss of self-esteem; feeling worthless, inadequate and unable to control the events in their world

As children move along this pathway their behavior may indicate which response they are experiencing. Children also have specific needs related to each developmental stage.

The following chart describes children's responses to separation and loss and ways you can help them deal with the trauma.

Understanding and Helping Children with the Impact of Separation and Loss

Age	Developmental Task	Effect of Separation and Loss	How to Help Minimize Trauma
Infant	Infants develop a sense of security and trust from day-to-day experiences. Their primary task is to develop a sense of trust in others. By 7-9 months, they know family members and often fear others. Dependence on mother decreases as trust develops.	They react to differences in temperature, noise, and visual stimuli. They may lose their sense of being able to rely on the environment and the individuals within it. May become anxious and less flexible. Rebuilding trust in adults is a major task.	Be attentive. Keep changes in daily routine to a minimum.
Toddler	They begin to separate from their mothers, develop self-confidence and self-esteem, and feel capable of doing things themselves.	Their sense of independence, self-confidence, and self-esteem is damaged. Toddlers may regress to younger behaviors.	Provide help developing independence, or a balance between dependency and independence. Tolerate clingy behavior, as they do not trust adults will be there when they need them. Provide opportunities for trust and autonomy, and opportunities to control their environment - making choices. Become aware of the events surrounding separations or losses they have experienced, as similar events in the future will awaken memories.

Age	Developmental Task	Effect of Separation and Loss	How to Help Minimize Trauma
Preschooler	Become good at self-care at home, typically ask a lot of questions, become more individual and more independent. Show tremendous interest in and excitement with the world. Develop language skills. Unable to understand cause and effect.	World is confusing, they fear abandonment and are susceptible to misperceptions as to the reasons for moves, and will blame themselves. They see themselves as the center of everything.	Listen to odd or peculiar statements for clues suggesting a child has misperceptions about the reasons for the placement. Be attentive to the child's development. Language delays are common in children who have been abused or neglected. Provide consistency and predictability so child can regain sense of trust and control.
6-to 10-year-old	Learning in school, developing motor skills. Same-sex peer relationships are important. Moral development includes a heightened sense of right and wrong. Become more assertive; the issue of fairness is very important. Increased ability to understand and conceptualize.	Interferes with ability to learn and develop friendships. Regression to earlier stages is common.	Provide help in dealing with their loss. Get information about their past to help them with identity issues. Provide help with peer relationships, academic performance, and identifying and managing feelings. Children who have been sexually abused need nurturing in nonsexual relationships.
Adolescent	Need to be accepted by peer group versus need to belong in family. Must cope with new and perhaps powerful sexual and aggressive impulses. Beginning to find place in the world. Want independence from family; control battles common. Developing intellectual and reasoning abilities.	Loss is exacerbated by adolescent's emotional instability and impulsivity. Loss complicates issues of identity and self-esteem. Separation from family at the developmental state of desiring independence confuses this normal parent child conflict. The separation is imposed not achieved by the young person.	Allow youth to be a full participant in the helping plan. Make youth feel that his/her desires are considered. Provide help acknowledging and managing sad and angry feelings, and low self-esteem. Acknowledge responsible behaviors. Provide help in resolving sexual issues that arise in nonsexual relationships. Give support in peer relationships; for example help to manage peer pressure.

This chart is a composite of information based on a collection of work by Vera Fahlberg called, Putting the Pieces Together, which includes the book, Attachment and Separation. The collection, Putting the Pieces Together, (1982) was republished and distributed in January 1988 by Spaulding for Children, Michigan.

A move/loss is a time of high anxiety and discomfort for children. Being aware of all their feelings, and responding in a helpful way can support the attachment process between the child and the new family.

Section 16. Behavioral Health

Common Reactions to Placement

Stages of Grief

Tips to Help Decode a Child's Behavior

Biting in the Toddler Years

Toilet Learning

Sexual Behavior of Children

**Caring for Children from Chemically
Dependent Families**

Talking About Substance Abuse

Missing, Runaway or Abducted Children



Section 16: Behavioral Health

Behavior/Mental Health Support Services

Consultation for resource parents concerning day-to-day parenting of children placed in their home is available from a variety of professionals. Do not hesitate to call the child's child welfare specialist if problems arise. Ask for help before the problem becomes an emergency. The child welfare specialist can request behavioral health services for children and families. Resource parents should expect to be full participants in planning and delivery of behavioral/mental health services both prior to placement and after placement of the child in their home.

Coping with Children's Common Reactions to Placement

After a child is placed in out-of-home care, the question is not whether he or she will react to placement, but how and when. Following are general comments on normal behavior and reactions of children. They are based on the experiences of resource parents.

Typical Patterns of Behavior at Placement

Pattern 1

The child starts off with problematic behavior, and in most instances, after a fairly short period of time, the resource parents will see both the frequency and intensity of the problem behavior begin to decline.

Pattern 2

At first the child is withdrawn, but then begins to act out after a few days, causing his or her behavior to become worse. Younger children may have emotional outbursts or be withdrawn or sit in a corner and cry. The older child may be more subtle or show more anger. They may focus on intentionally trying to destroy something or aggravate someone.

Notwithstanding, the reasons a child had to be separated from their family, their feeling of loss, the loss of control in their lives, just being afraid and reacting angrily, can create either of these patterns or other problem behaviors. Many children will eventually respond to the resource family's patient and consistent parenting and adjust to being in the resource home. It might just take a little longer.

Mild Reactions

Many children have a relatively mild reaction to their new placement. They may be shy and withdrawn and slow to warm to kindness and help. They may react by being overly friendly and compliant. They may have occasional verbal outbursts in response to frustration, and they may resist going to school or taking part in activities. But they will typically respond to consistent parenting, a caring attitude, support and understanding.

Moderate Reactions

Other children, especially children who have experienced previous out-of-home placements, are more likely to show their reactions to being placed in an out-of-home placement through behaviors which will test the

resource family's patience and parenting abilities. Based on past experiences, these children may enter the resource home with the expectation that this placement may not work either, and they may cause it to fail. They may fear that sooner or later the resource family will reject them and request they be moved from the home. When the resource family responds to the child's behavior with kindness and understanding, the child may be confused and test the resource parents by pushing limits and creating situations causing the resource parent to act in the way which they (the child) expect, based on their past experiences.

Feelings

All children in out-of-home care will have some angry and sad feelings due to past experiences. They may have low self-esteem and will be in the process of grieving due to the separation from their families. These feelings may be revealed through actions and behavior directed at the resource parents. This behavior should not be taken personally. It is important to remember that any child placed in any resource home is:

- Dealing with feelings in regards to being a victim of abuse or neglect
- Working through the separation from family or previous resource family
- Coping with the separation from friends, relatives, neighbors and sometimes a neighborhood community
- Adjusting to a new resource family
- Having to attend a new school
- Trying to make new friends

Through a trauma informed approach, as a resource parent you will recognize the presence of trauma symptoms and want to ensure you provide support and make every effort to avoid re-traumatizing the child during this transitional period. If the resource parent will put themselves in the child's shoes, it can be helpful in understanding when a little extra attention and support might be just what is needed to help the child adjust. The resource parent should think how they would react to suddenly being separated from all their natural supports – home, job, family, church, community and friends. The feelings of sadness, nervousness about a new living arrangement, uncertainty about new roommates, stress related to moving one's belongings and apprehension about a new job are much like what a child in out-of-home care feels when placed in a resource family's home.

Stages of Grief: Impact on Children's Behavior

Losing a family member or best friend is a serious loss to anyone. Even losing a small thing, such as keys, can lead to feelings of self-doubt and anger. Children in out-of-home care often have experienced multiple serious losses. They did not ever expect to be separated from parents, brothers and sisters, extended family, friends, pets, schools or neighborhoods. Some children have lost their health and an opportunity for normal growth, development and a normal education due to past abuse or neglect. Children, like adults, react to losses by expressing their feelings through behavior that is very similar to the grieving process.

Recognizing that the child placed in your home is grieving, and trying to determine the stage of grief he or she is in, can help you understand what the child is feeling and why his or her behavior might vary and seem unpredictable.

Stage 1: Shock and Denial – “I don’t believe this could have happened to me.”

When a child is first placed in a resource home, he or she may be very eager to please, be cooperative and be generally enjoyable to be with. Experienced resource families recognize these symptoms of shock and denial as the “honeymoon” stage. Enjoy this time and realize that his or her true self and feelings likely have not emerged. Other children in shock and denial may have difficulty eating or sleeping, or they may revert to the behavior of a much younger child, such as wetting the bed or sucking fingers.

Stage 2: Bargaining – “If I could just go home and be a better son, I know everything would be okay.”

Children in this stage will do everything they can think of to get back home. Many children think if they are “good,” then they can go home. They may also decide to be “bad” so the resource family will not want them and will send them home. Or, their bargaining may be somewhere in the middle. For example, a child may ask if he or she can go home if he or she goes to school and makes good grades.

Stage 3: Anger – “Why did this happen to me and my family? Someone doesn’t understand and is picking on us! I hate these people! Help! Let me out of here!”

When bargaining does not appear to work, anger sets in. Most children have trouble expressing their feelings, so they simply act them out. Some children may come to the resource home in the anger stage. They may break things, attempt to run away, refuse to bathe or brush their teeth or find ways to hurt themselves. The anger stage is often the most difficult stage for resource families because it is difficult to cope with the behavior, understand what the child is feeling and feel adequate support for the child emotionally. Anger is the stage in which many resource parents give up and request the removal of the child. When this occurs, the child is likely to be even angrier with the next resource family.

Stage 4: Despair – “Now what will I do? How will I get home? I’ll never find them!”

Eventually, reality sinks in. With help and understanding, the child gives up fighting and his or her behavior changes dramatically to depression. This stage can be dangerous, as the depressed child may also be self-destructive. Watch for symptoms of depression such as loss of appetite, changes in sleep patterns, being withdrawn or listless or trying dangerous or risky behaviors without thought of personal consequences. For example, becoming sexually promiscuous, using drugs, attempting suicide and self-mutilation are all examples of a child in this stage. Younger children may show no fear of doing unusually dangerous things for someone of that age.

Stage 5: Managing Loss, Understanding, and Coping – “It looks as if there is nothing I can do. My mom really needs to clean up her act. Being here is better than being scared all the time. My resource family seems willing to help. I guess I should try to get along here for now.”

At this stage, children begin to form new friendships, especially with adults. They may accept the resource parent’s role and begin to enjoy their new teacher or being part of the school band. They will be able to move into new situations more easily and will act less frustrated. Clues from children transitioning into this stage may range from talking about the resource family’s automobile as “our car” to calling an unrelated child living in the home “my brother.”

Each person works through the grief process at his or her own rate. It may take days, weeks or even years depending on the number of losses experienced, the seriousness of each loss and whether or not the person has learned to deal with loss in the past. Children in out-of-home care often move from one stage of grief to the next and then back again, or they may appear to display the despair and anger stages of grief at the same time.

Tips to Help Decode a Child's Behavior

Understand Normal Behavioral Development

Even experienced parents often forget the normal physical, emotional/social and intellectual milestones of children at different ages. Information included in the Child Development Section of this Handbook provides a quick reference.

Uncover the Child's History

Talk to the child's child welfare specialist about the child's behavior. Ask about the child's history. Understanding where a child came from and his or her reactions and behavior in that environment can provide clues regarding the current behavior.

Provide a Predictable Home Environment

A safe, nurturing and predictable home environment is what every child needs. This goes a long way to help any child overcome fear, anxiety, loss, grief and other emotional trauma. Predictability will also help the child to understand the "cause and effect" of his or her own behavior – "when I do this, I can expect that to happen." This is particularly important for children who come from homes where parenting was inconsistent and consequences of their behavior were unpredictable.

Understand Your Reactions to Problem Behavior

We all have a tendency to think a child's misbehavior in our presence is directed at us. We take it personally. We get angry and we get locked into this emotional power struggle, which frustrates everyone involved.

Many children often act out angrily because, in their previous environment, acting out angrily is the only behavior that got a consistent response. When they were being good and fairly well-behaved, they were ignored. Once a resource parent realizes the child is not out to make them angry – it's just the child's attempt to create some "cause and effect" – the resource parent can stop reacting emotionally.

Identify What Triggers Problem Behavior

There is always a reason for problem behavior. Usually the reasons can be identified by a good observer. When a child displays problem behavior, think about what was happening before the behavior took place. Look for a pattern. For example, a resource parent may see destructive behavior following visits or phone calls from the child's relatives. The child may always react to going to school, or they may react at bedtime. Sometimes, the triggers occur just before the bad behavior happens. Other times, the trigger may be more remote, like the day or week before. Being a good observer can help a resource parent make a good guess about the trigger to the bad behavior.

Bring Trigger Events to the Child's Attention – Listen to Explanations

Remember, not every trigger to behavior is readily observable. For example, a child may be emotional after hearing a song on the radio that evokes a memory. This type of trigger is very difficult to spot and usually can only be identified when the child talks about it. When things calm down after an outburst, ask the child what triggered the behavior. A question such as “What were you thinking right before you got angry?” may allow the child to connect his or her feelings with the behavior and give the resource parent helpful information. Discuss the connection of feelings and behavior with the child. Point out what was observed in regards to what triggered the unacceptable behavior and ask the child to help find a solution.

Example: “I’ve noticed that when I say to you that it’s bedtime, you usually seem to get upset. What can we do together to help you when it’s time for bed?” By asking the child why bedtime is difficult, a resource parent is obtaining information that may help solve the problem. In this example, it could be as simple as the child being afraid of the dark. Providing a night-light for the child’s room could be the solution to the problem.

By bringing these observations to the child’s attention, a resource parent may help the child understand the cause and effect of his or her behavior. The resource parent also demonstrates their willingness and ability to help the child.

Try Not to Label a Child's Behavior

It is easy to slip into the habit of using labels to describe a child. For example, a resource parent may think a child is depressed and communicate that to a therapist. The term depressed has different meanings to different people. It is more helpful if a resource parent observes the child’s behavior and describes it to the child welfare specialist or therapist.

Example: Saying, “Darryl seems withdrawn and very shy. He stays in his room for most of the day and he doesn’t have a good appetite. He acts sad and doesn’t want to play with other kids,” will be more helpful than saying “Darryl is depressed.”

Log Behavior to Help Pinpoint the Problem

Keeping a log of what has been observed in regards to a child’s behavior may help identify what triggers the problem. Over time, record the circumstances under which the child’s problem behavior occurs. A behavioral log will help the resource parent and the therapist or counselor separate behavior ordinarily associated with the trauma of abuse, neglect and out-of-home care from behavior indicative of severe emotional disturbance.

A log is also helpful in measuring progress. If a child starts by acting out 15 times a day, and through logging the events, the resource parent notices the behavior has dropped to five times a day, then good progress is clearly being made. This specific information is also much more helpful to a therapist than commenting “He does this all day long!”

Biting in the Toddler Years

Biting is very common among groups of young children, for all types of reasons. But whatever the reason for biting, many resource parents find it shocking and disturbing, and they want it to stop – quickly! Understanding why the young child bites is the first step in preventing biting as well as teaching the child alternatives to biting.

Most common reasons and solutions for biting

The experimental biter: It is not uncommon for an infant or toddler to explore their world, including people, by biting. Infants and toddlers place many items in their mouths to learn more about them. Teach the child that some things can be bitten, like toys and food, and some things cannot be bitten, like people and animals. Another example of the experimental biter is the toddler who wants to learn about cause and effect. This child is wondering, “What will happen when I bite my friend or mommy?” Provide this child with many other opportunities to learn about cause and effect, with toys and activities.

The teething biter: Infants and toddlers experience a lot of discomfort when they’re teething. A natural response is to apply pressure to their gums by biting on things. It is not unusual for a teething child to bear down on a person to relieve some of their teething pain. Provide appropriate items for the child to teeth on, like frozen bagels, teething biscuits, or teething rings.

The social biter: Many times an infant or toddler bites when they are trying to interact with another child. These young children have not yet developed the social skills to indicate “Hi, I want to play with you.” So sometimes they approach another child with a bite to say hello. Watch young children very closely to assist them in positive interactions with other children.

The frustrated biter: Young children are often confronted with situations that are frustrating, like when another child takes their toy or when an adult is unable to respond to their needs as quickly as they would like. These toddlers lack the social and emotional skills to cope with their feelings in an acceptable way. They also lack the language skills to communicate their feelings. At these times, it is not unusual for a toddler to attempt to deal with the frustration by biting whoever is nearby. Notice when a child is struggling with frustration and be ready to intervene. It is also important to provide words for the child, to help him learn how to express his feelings, like “That’s mine!” or “No! Don’t push me!”

The threatened biter: When some young children feel a sense of danger they respond by biting as a self-defense. For some children biting is a way to try to gain a sense of control over their lives, especially when they are feeling overwhelmed by their environment or events in their lives. Provide the toddler with nurturing support, to help him understand that he and his possessions are safe.

The imitative biter: Imitation is one of the many ways young children learn. So it is not unusual for a child to observe another child bite, then try it out for herself. Offer the child many examples of loving, kind behavior. Never bite a child to demonstrate how it feels to be bitten.

The attention-seeking biter: Children love attention, especially from adults. When parents give lots of attention for negative behavior, such as biting, children learn that biting is a good way to get attention. Provide lots of positive attention for young children each day. It is also important to minimize the negative attention to behaviors such as biting.

The power biter: Toddlers have a strong need for independence and control. Very often the response children get from biting helps to satisfy this need. Provide many opportunities for the toddler to make simple choices throughout the day. This will help the toddler feel the sense of control they need. It is also important to reinforce all the toddler’s attempts at positive social behavior each day.

As with almost all potentially harmful situations involving children, prevention is the key. Resource parents must be active observers of children to prevent biting. In those times when close supervision doesn’t work, the resource parent must intervene as quickly and as calmly as possible.

When your child bites

Comfort the child who was bitten.

- Cleanse the wound with mild soap and water. Provide an ice pack to reduce pain and swelling.
- Provide comfort for the wounded child by saying something like, “That really hurt! You don’t like it when your friend bites your arm!”
- Calmly approach the child who bit. Many times these children feel overwhelmed and afraid after they bite. They need comfort, too.
- Comfort the child who bit by saying something like, “You seem sad that your friend’s arm is hurt from the bite.”
- Help the child who bit to understand the hurt their friend is feeling by offering to let her talk with her friend. Say something like, “Would you like to see Sally now? You can tell her that you hope she feels better soon.” Older toddlers can learn a lot from being allowed to comfort their friend after a bite has occurred.

The child who bit may want to see the injury. That’s okay if the injured child wants to show it. But do not force either child to have this interaction, unless both are willing.

- Reinforce the rule that we don’t hurt people. Help both children understand that your job is to keep everyone safe. Say, “I know you are angry. But I can’t let you bite people.”
- When the environment is calm again, remind the children what they can do to assert themselves, like say “No! That’s mine!” or “Back away!” or if they are preverbal, teach them to “growl like a tiger” to express themselves. The goal is to teach assertiveness and communication skills to both the child who bites and the child who gets bitten.
- Never hit or bite a child who has bitten; that will teach the child that violence is OK.

Young children need lots of practice to learn the fine art of interacting with others in a positive way. They need positive guidance and support from resource parents. When children gain maturity and experience, and become preschoolers (3+ years old), they will likely have developed more appropriate ways of interacting.

For more information contact your county health department.

Source: Child Guidance Program, Family Health Services, Oklahoma State Department of Health

Toilet Learning

Learning to use the toilet is an important developmental milestone that may occur during a time in which a child is in an out-of-home placement.

When Is a Child Ready?

Every child develops differently, so the start of toilet learning should be based on the child’s developmental level rather than age or the resource parents eagerness to start. However, it is recommended that a child be at least 24 to 27 months old.

Signs of readiness include an increased awareness of a need to go, curiosity in other's bathroom habits, demonstrated interest in the toilet, having words for using the toilet and an understanding of "wet" verses "dry." In order to start learning to use the toilet a child must be able to:

- Follow simple instructions
- Cooperate with adults
- Stay dry for at least two hours at a time during the day
- Understand words about the toileting process
- Get to and from the bathroom area
- Help pull diapers or loose pants up and down

Techniques for Success

- Include toilet learning activities as part of the child's daily routine. Read stories, sing songs and play games about using the potty.
- Because toilet learning involves so many steps (discussing, undressing, going, wiping, flushing and handwashing), reinforce the child's success at each step.
- Accept (and help the child accept) that occasional accidents are normal.
- Never force a child to sit on the toilet for long periods of time.
- Children should be dressed in clothing that can be easily pulled up and down on their own.
- Provide child-sized toilets or have an adaptive seat and a secure step stool to make them feel child-sized.

If a child resists toilet learning, he or she may not be ready for the process or find it too stressful. If a power struggle begins, wait a few weeks and try again. Remember to transfer responsibility to the child, provide lots of positive feedback for using the toilet, and change wet or soiled clothing immediately.

Sexual Behavior of Children

Are Babies Sexual?

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 sexual exploration and learning. Some examples of this behavior include:

- Interest in bathroom activities
- Touching their own genitals
- Interest in seeing and touching genitals of others
- Playing doctor

Very young children usually do whatever they want to do at any given time and in any particular place. When their behavior is inappropriate, they can usually be directed to other activities without too much difficulty since their attention spans are so short. 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 an adult's explanation that their behavior is not appropriate in public.

What about Elementary School Aged Children?

When children start school, they become more social. As this happens, their sexual interest increases, and they also become shy and perhaps embarrassed about their behavior. They may 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 with or 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. If their sexual exploration becomes inappropriate they can usually be redirected easily.

What about Teenagers?

Teenagers engage in a wide range of sexual behaviors. Some of these activities may be prankish such as mooning or streaking their friends, or they may settle into serious, steady, romantic relationships which include sex. While we may not approve, or think that the youth are ready emotionally for this, it is not unusual for some youth to experiment with all sorts of sexual behavior. Some teenagers will also engage in sexual activity with members of the same sex. Once again, these activities usually occur with others in their own age group.

Signs of Sexual Behavioral Problems

If you notice any of the following behaviors, discuss them with the child's child welfare specialist. These sexual behaviors may be indications of problems that need immediate attention:

- A child's sexual behavior is different from that 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. We would want to find out how a child so young came to have knowledge of this behavior and intervene appropriately for the child's protection.

- A child engages in sexual activities in public. In this case, the specific activity of a child may be normal, but it is behavior that should occur only in private.

Example: It is not unusual for a 17-year-old boy to masturbate, but we would not expect him to do it in a shopping mall.

- A child engages in sexual behavior with other children who are not the child's friends or peers. Children and youth usually choose others they know and have an ongoing relationship with when they explore or engage in sexual activities. It is unusual for children to engage in sexual activities with children who are strangers or not well known to them.
- A child is preoccupied with sex to the exclusion of other activities. If sexual activities seem to be the central focus of the child's interest or the child appears to be driven to engage in sexual acts, it is cause for concern.
- 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 unusual for him or her to persist to the point of doing physical harm.

- A child engages in sexual activity with children who are younger, smaller or in some other way more vulnerable. We expect normal healthy sexual activity to take place 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 and uses this for sexual gain it is cause for 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.

- A child's sexual behaviors continue after clear and consistent attempts by an adult to redirect the activity or discipline the behavior. If the behavior seems to be out of the child's control, or if the child refuses to change the behavior, this is an indicator of a problem needing intervention.
- Expressions of anger frequently accompany a child's sexual behavior. Children with sexual behavioral problems often learn to use sex to express their anger. This is cause for serious concern and requires intervention.
- A child uses tricks, games, promises, threats or force to get another child to engage in sexual activity. Sexually abusive children may be manipulative in getting another child to cooperate with them in sexual activity. They may promise rewards or threaten to retaliate if the other child refuses or tells anyone.

What Should You Do if the Child Placed in Your Home Shows Any of These Behaviors?

Resource parents who observe any of these behaviors, or any other type of worrisome behavior, should talk to the child's child welfare specialist. While waiting for professional help to begin for the child who exhibits any of these sexual behaviors, provide closer supervision of the child, especially in the bathroom and at night. Do not leave this child alone with others, particularly younger, smaller or developmentally delayed children. The child welfare specialist can help you create a safety plan for the protection of all of the children in your home.

Caring for Children from Chemically Dependent Families

For children coming into care from chemically dependent families, the behavior of those children is rooted in their former environment. Here are some things resource parents may see:

- **Lack of trust.** Often the children have learned that they cannot trust others and may not even trust their own feelings and perceptions.
- **Attachment disorders.** Many children come into out-of-home care with no healthy attachments to their caregivers.
- **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 they assume the role of caregiver for younger brothers and sisters and have other responsibilities inappropriate for their age and ability.

Example: A 9-year-old who becomes “mom” to her 1- and 3-year-old brothers. A child may assume a dysfunctional role in response to the demands of his or her family.

Example: A child who becomes the scapegoat, blamed for all the troubles in the family.

- **Chemical involvement.** Because members of their family may be chemically dependent, children, particularly adolescents, may come into out-of-home care involved with alcohol or other drugs. When a child from a chemically involved family comes into care, his or her behavior may seem inappropriate to you. He or she may be confused about your expectations and may not immediately fit in as a member of your family. Talk to the child's child welfare specialist immediately about getting your child the help he or she needs.

Here are some things your family can do to help children from chemically involved families:

1. Demonstrate how healthy families organize themselves. Create consistent routines. Involve the child in planning and participating in family activities.
2. 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: Children need time to develop these skills.
3. Lying is common in chemically dependent families. Children may need help learning that it is OK to tell the truth.
4. Many children of substance abusers have been verbally abused. It is likely they may have been neglected and physically or sexually abused. Touching of any kind may seem threatening to them.
5. 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 many need help understanding they have value all on their own.
6. Expressions of strong feelings, even affection, may have occurred only during periods of parental substance abuse. Children, especially adolescents, may seek expression of feelings through the use of chemicals.

Talking with Your Children and Youth about Substance Use/Abuse

Many children and youth think using drugs, alcohol and inhalants will make them happy and popular, or help them learn skills they will need when they grow up. All children, no matter what their age, need to know that abusing substances can cause them to fail at all of those things and may even cause their death. If your children think “everybody’s doing it,” they need to know they are wrong, and who better to tell them than you.

Talking Is Important

You already know what surveys show—drug use is less common among children and youth whose parents warn against it than among those whose parents don’t. Warning is not yelling; it’s talking with children and youth at a level they can understand. It 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 they feel like the children or youth already 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

Your child cannot get through childhood, adolescence or teenage years without running into drugs. For many children in out-of-home 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 and youth assume that if they’ve tried a drug once and nothing bad happened, they will be OK the next time. Today, more than half of the youth in high school experiment with drugs before they graduate. Since the 1960s, not only has drug use increased, but so has the variety of drugs available and their potency.

Set a Good Example

Examine your own use of drugs and alcohol. Do you tell your children not to drink and then celebrate important occasions by drinking alcohol? Do you need prescription drugs to relax? Children and youth know what’s going on. You’ve got to practice what you preach.

Know the Facts

Educate yourself about drugs. OK PRIDE Curriculum, Session Three, Meeting Developmental Needs: Attachment, Part III: The Impact of Maltreatment and Trauma on the Child, which is available to all resource parents, covers substance abuse and caring for 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, when you can talk without being interrupted. Know exactly how you feel. Make sure other adults living in your home feel the same way, so children and youth won’t receive mixed messages. Plan 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 his or her right to talk and express an opinion. Clarify family rules about substance abuse. If you don’t know the answer to a question, say so.

Suggest that you find the answer together. Discuss situations in which your child or youth may be pressured to use drugs or alcohol and how to say “No!”

Keeping communication lines open and taking time to talk whenever possible will help your child make good 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
- **Injuries:** falls, bruises, accidents; any unexplained injury is a serious warning

Drug Paraphernalia

Paraphernalia, products designed for use with controlled substances, are legally sold in music stores, head shops, and various other stores. A few examples are: rolling papers, roach clips, stash cans, bongs, pot pipes and spoons.

Everyday 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 other hiding places:

- **Marijuana/hashish:** rolling papers, plastic baggies, stash cans, pipes, bongs, roach clips
- **PCP:** tin foil or baggies (powder), small vials (liquid)
- **Inhalants:** plastic or paper bags (containing gold or silver paint), rags, empty spray cans (cleaning supplies, paint, anything in aerosol cans), tubes of glue, balloons
- **Codeine:** cough syrup bottles, prescription bottles (from Rx containing codeine)
- **Heroin and morphine:** needles, syringes, cotton balls, spoons, medicine droppers, small foil packets, broken balloons (openings tied off)
- **Cocaine:** glassy surfaces, mirrors, single-edged razor blades, rolled-up paper tubes, drinking straws, nasal sprays
- **Crack:** pipes, small glass vials, glass tubes, small screens, crushed aluminum cans with holes in the sides, lighters

Finding any of these items may be cause for alarm. Resource parents should immediately notify and seek help from the child's child welfare specialist if a child placed in their home is suspected of being a substance abuser or if drug paraphernalia is found. Consultation and help is available for both children and families. It is time to have a frank discussion about drug use with the child or youth and the resource parent should seek professional help.

Inhalant Abuse: Sniffing, Huffing

It 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 of others 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 products are commonly abused as inhalants. One in five American teenagers has used inhalants to get high, according to a 1996 report from the National Institute on Drug Abuse. Many young people say they began huffing when they were in grade school. Children start because they think these substances can't hurt them, because of peer pressure, or because of low self-esteem. Once hooked, they find it a tough habit to break. The following questions and answers will help you identify inhalant abuse and understand what you can do to prevent or stop this problem.

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

- Unusual breath odor or chemical odor on clothing
- Slurred speech
- Appears disoriented, drunk, dazed or dizzy
- Signs of paint or other products where they wouldn't normally be, such as on the face
- Red or runny eyes or nose
- Spots and/or sores around the mouth
- Nausea and/or loss of appetite
- Chronic inhalant abusers may exhibit anxiety, excitability, irritability or restlessness

What could be other telltale behaviors of inhalant abuse?

- Holding a pen or marker near nose
- Constantly smelling clothing sleeves
- Hiding rags, clothes, or empty containers of inhalants

Huffing is the deliberate inhalation or sniffing of common products to obtain a high; the products include:

- Glue/adhesive
- Butane lighter fluid
- Nail polish remover
- Gasoline
- Marking pens
- Propane gas
- Paint thinner
- Typewriter correction fluid (whiteout)

- Spray paint
- Cooking spray
- Fabric protector
- Air conditioner coolant
- Household cleaners
- Deodorant
- Whipping cream aerosol
- Room deodorizer

Substance Abuse Resources

Resource parents should immediately contact the child's child welfare specialist if a child placed in their home is suspected of abusing inhalants. Consultation and help is available for children and families. Some resources for help with substance abuse are:

National Inhalant Prevention Coalition

1-800-269-4237

Website: www.inhalants.org

U.S. Department of Health and Human Services

Substance Abuse and Mental Health Services Administration (SAMHSA)

Website: www.samhsa.gov or 1-877-726-4727

National Drug and Alcohol Treatment Referral Routing Service

Center for Substance Abuse Treatment

National Clearinghouse for Alcohol and Drug Information

P. O. Box 2345

Rockville, MD 20847-2345

1-800-729-6686

Website: www.health.org

Al-Anon/Alateen

Family Group Headquarters Inc.

P. O. Box 862

Midtown Station

New York, NY 10018-0862

1-800-356-9996 (to request literature/meeting referral)

Missing, Runaway or Abducted Children

As a resource parent, you may be faced with a foster child or youth who leaves your home or, in very rare instances, is taken by someone else without your permission. As with any parent who would be concerned about their missing child, you should immediately report the situation to:

1) Your local law enforcement agency to file a missing child report, particularly if you have reason to believe the child may have been abducted. When filing the report, please make every effort to obtain the following information:

- The name of the law enforcement agency accepting the report
- Name of the law enforcement officer taking the report
- Phone number of the law enforcement agency
- Law enforcement case number assigned to the missing child report

2) The assigned DHS child welfare specialist. The child welfare specialist will also need the information listed above.

Note: If you do not feel that you are able to make the missing child report yourself, immediately call the assigned child welfare specialist with the date, time, and circumstances. The child welfare specialist will make the report to the local law enforcement agency.

If the child placed in your home makes any contact with you after they have left your home or returns to your home after you have contacted the appropriate authorities, please call the assigned child welfare specialist immediately to advise of the child's situation.

Section 17. Parenting Pregnant Youth

Specialized Services
Involvement of Legal Parents and Father
Counseling
Parenting the Child
Rights of Pregnant and/or Parenting Youth



Parenting Pregnant
Youth

Section 17: Parenting Both Pregnant Foster Youth and Foster Youth who are Parents

Specialized Services

Specialized services are provided to all youth in DHS custody who are pregnant or parenting. These services are designed to assist the youth in making and implementing decisions regarding the pregnancy/child and are in addition to the other services the youth is receiving. The youth in custody has the same rights as an adult parent and is legally and socially responsible for decisions regarding pregnancy and the child.

Involvement of Legal Parents and Father

If the pregnant youth is in temporary custody, her legal parents or other relatives are involved with her in the planning. The named father is also involved, when appropriate, in decision making and planning for the child. He has a right to a relationship with his child and to share in the responsibilities for the child's care. The child welfare specialist addresses these issues with the pregnant youth, the father and the youth's parents.

Counseling

Counseling is provided for the pregnant youth for the purpose of examining the available options regarding the pregnancy. This service is coordinated by the child welfare specialist and can be provided by a child welfare specialist who has experience or in-service training in pregnancy counseling. Prenatal and postpartum care, diagnosis, nutrition, treatment of health problems and other services are also arranged for the pregnant youth.

Parenting the Child

When the youth makes the decision to keep the child, services including parenting skills training and assistance in accessing community resources are arranged. Services address the youth's abilities to meet her child's needs and the parent/child relationship. An assessment is conducted, with the youth's participation. Needs, performance criteria, services and achievement dates are included in the treatment and service plan. The unique dynamic of parenting a youth who is parenting a child presents additional responsibilities for the resource parent which include:

- Modeling how to be a responsible adult
- Modeling parenting for the youth
- Being involved with the other youth parent of the foster youth's child regarding visits, dating, medical care or other situations
- Working closely with the child welfare specialist and medical professionals on issues related to fostering youth who are sexually active
- Letting the youth take personal responsibility for the care of his or her child while ensuring the safety and welfare of the child. Resource parents must be careful observers and are mandated reporters of abuse or neglect
- Working with the child welfare specialist to guide the youth through educational and vocational decisions which will influence his or her future and the future of the child

Rights of Pregnant and/or Parenting Youth

Families caring for or considering caring for a youth who is pregnant or a male or female youth who has a child and is the caregiver of that child, should be aware of the youth's rights and the services that are available to the youth and the child.

Foster youth who are pregnant, or have a child they are caring for have the right:

- To be placed in a stable, safe place to live with their child, unless separate placements are necessary for safety and treatment reasons
- To continue their education and obtain a high school diploma
- To receive day care assistance for their child when eligible
- To receive ongoing prenatal, medical or dental care wherever they live
- To actively participate in the care and support of their child by having regular visits when they do not have physical custody of the child
- To receive appropriate services such as counseling
- To receive assistance in learning to be a better parent
- To receive preparation for living on their own
- To be free from discrimination based on their status as a pregnant or a parenting youth



Section 18. Independent Living Program

DHS Independent Living Program
Independent Living: A Brief History
Independent Living Philosophy
Independent Living Matrix
Assessment and Service Planning
Educational Opportunities
The University of Oklahoma National Resource Center for Youth Services
Youth Development Funds
Independent Living Youth Contingency Funds
Incentive Payments
“Yes I Can” Alumni Network
Fifty Things You Can Do to Help Youth Prepare for Independent Living



Section 18: Oklahoma Department of Human Services Independent Living Program

Oklahoma has one of the premier Independent Living programs in the United States. The information presented here is meant to serve as an introduction to this program and to present resources that may be used when working with youth in your care. A program is only as good as its people, so a successful outcome for these young people is only possible with the day-to-day work that you, as a resource parent, do with them. Teamwork is the key, and you are encouraged to work in partnership with all the other professionals in the child welfare system and the community on behalf of the youth placed in your home.

The IL program seeks to ensure the successful transition of youth ages 16 to 21 from out-of-home care to independent adulthood by assisting them in planning for their futures and by enhancing their individual strengths and abilities.

The goal of OKIL is to fulfill the purposes of the following state and federal laws:

- **The Chafee Foster Care Independent Living Act**

This federal law was enacted to assist young people in out-of-home care with the skills needed for self-sufficiency and successful adult living. Administered locally by the Oklahoma Department of Human Services, this act focuses on education, job and career planning, and support services for youth who left care at age 18. This act also requires that services complement the youth's own effort to achieve self-sufficiency as they transition from out-of-home care to adulthood.

- **The Oklahoma Foster Care Independence Act**

This state law was enacted to support the federal Chafee Act to provide tuition waivers and Medicaid coverage to eligible former foster youth.

DHS Independent Living Services

DHS ILS State Coordinator 405-521-3778

Visit our website at: www.okdhs.org/programsandservices/il

Independent Living: A Brief History

DHS began informal Independent Living services in the late 1970s and early 1980s as a result of the realization by Child Welfare workers that many youth were remaining in care up to, and even beyond, the age of 18. Early services focused mainly on obtaining documents needed for independence such as birth certificates, photo identification and medical history information.

A New York City lawsuit alleging that custody youth were not being prepared for successful adulthood was an impetus for the appropriation of federal funds for IL services in the mid to late 1980s. These appropriations allowed Oklahoma to begin building its own Independent Living program.

Independent Living Philosophy

Some youth in the child welfare system remain in care until they reach majority (age 18). Without adequate preparation, youth who leave care to begin independent living are not equipped for assuming the responsibilities of adult life. Services and programs to assist in preparation for adult life are a part of the continuum of services offered to all children in care. Traditionally, the family provides the nurturing, teaching, cultural ties, heritage, experience in building relationships, development of morals and values, information and formal life skills training, and the financial and emotional support necessary for a youth to make a successful transition to adulthood. The process and experiences which provide all this preparation typically begin at birth and continue through the stages of development leading to adulthood.

When a child enters the child welfare system, for whatever period, this process and experiences are interrupted. Children in out-of-home care, particularly if they have more than one placement, may miss many of the experiences they need to prepare for independence and adult life. We must begin preparing children for adult life at the point of their entry into the system, not just a few months before they turn 18.

Services to prepare for adult life become the ultimate form of permanency planning. Whether the youth leaves care for reunification with the birth family, adoption, or independent living, the skills acquired in this preparation will follow him or her. These skills can then be incorporated into a lifelong process of learning to live independently. As resource parents, you have an opportunity to make a difference in the lives of the youth who are entrusted to your care. Whether a youth resides in your home for days, weeks, or months, or even years the approach remains the same.

Resource parents are much more than just providers of a place to sleep and eat. Resource parents are teachers, mother or father figures, therapists, friends, and most important, role models. Every day is a learning experience for youth in care and resource parents are the individuals who have the greatest opportunity to teach and model the things youth need to learn.

It may be difficult for busy resource parents to focus on this work with the youth in your homes. The following list of goals and activities, which, while not all-inclusive, may be helpful:

- Acknowledge the youth's need to resolve emotional issues from his or her past
- Help the youth become aware of his or her self-identity, including goals, values, strengths, abilities, interests and history
- Assure that each youth who leaves your care has access to or is given his or her birth certificate, some form of ID, such as driver's license, school and medical records, Social Security card, and any other documents necessary for independent living
- Complete a life skills assessment with the youth beginning at age 16, and provide opportunities for the youth to practice and learn more about daily living skills including, but not limited to, budgeting and financial management
- Assure that the youth has an educational screening to assess academic skills and need for academic remediation.
- Expose youth to educational and vocational options, such as obtaining a high school diploma, vocational training, and preparation for post-secondary training and education

- Help the youth explore career opportunities by learning how to obtain employment, as well as learning job retention skills.
- Address health issues such as substance abuse prevention and preventive health activities.
- Use teamwork to develop a support system of mentors and dedicated adults available to assist and support the youth in the development of a written plan with individual objectives and goals to guide his or her preparation for adult living.

Living Service Matrix

Age	Service
16 or upon entry into custody after 16	<ul style="list-style-type: none"> ● Identify and enroll IL-eligible youth. ● Introduce IL program to youth. ● Initiate life skills assessment. ● Determine if youth is enrolled in OHLAP.
16 to 16-and-a-half	<ul style="list-style-type: none"> ● Assess youth's educational needs and provide tutoring or remedial education assistance if indicated. ● Develop individualized independent living case plan. ● Discuss incentive funds. ● Identify and assess available resources in youth's community, such as life skills groups, career tech and workforce services. ● Attend Teen Conference. ● Assess youth development funds needs. ● Attend IL seminars. ● At dispositional or review hearing, inform the court of the Independent Living services the youth is receiving.
16 -and-a-half to 17	<ul style="list-style-type: none"> ● Meet with youth at transition meeting to review and update individualized IL plan. ● Review Introduce/Discuss exit plan. ● Provide youth with "A Future Near Me" or "Path Before Me" workbook. ● Assess youth development fund needs. ● Request mentor or tutor for youth. ● At dispositional or review hearing, inform the court of the IL services the youth has received.

Age	Service
17 to 17-and-a-half	<ul style="list-style-type: none"> ● Meet with youth at transition meeting to review and update an individualized IL plan including the exit plan. ● Discuss with youth the option of voluntary care. Youth may remain in care until age 21 if high school or GED has not been completed. ● Attend IL Seminar (second seminar for youth who has been in care since age 16). ● Discuss youth's post-secondary education plans and determine youth's eligibility for educational scholarships. ● Attend Teen Conference (second conference for youth who has been in care since age 16). ● Assess youth development fund needs. ● At dispositional or review hearing, inform the court of the IL services youth is receiving.
17-and-a-half to 18	<ul style="list-style-type: none"> ● Update individualized IL treatment plan to focus on voluntary care or exit plan (may include education services, military, Job Corps, return to biological family). ● Assess youth development fund needs. ● Place youth on tuition waiver list if eligible. ● At dispositional or review hearing, inform the court of the IL services the youth is receiving. ● Complete youth exit interview, exit assessment, and request earned incentive funds for youth. ● Discuss Education and Training Voucher Program. ● Discuss "Yes I Can!" aftercare network with youth. ● Discuss application process for continuing Medicaid coverage 18 to 21.
18 to 21	<ul style="list-style-type: none"> ● Youth continues to follow IL plan if in voluntary care. ● Youth assesses tuition waiver at Oklahoma colleges, universities and career tech centers and Educational and Training Vouchers for all eligible colleges, universities and career tech centers if pursuing secondary education. ● Youth contacts "Yes I Can!" Network to access IL supportive services if they were in DHS or tribal custody and in out-of-home placement for any nine months between the ages of 16 to 18. ● Youth contacts "Yes I Can!" Network for housing assistance if youth exited care at age 18 or after. ● Youth reapplies for Medicaid IL 18 to 21 annually until age 21.

Assessment and Service Planning

Assessing a youth's level of functioning is crucial to developing a plan of action to assist him or her in becoming successful in the adult world. At age 16 a youth must complete a Life Skills Assessment. Youth entering your home after age 16 but before age 18, should receive this assessment as soon as possible. The assessment focuses on seven key elements (health, housing, education, employment, essential documents, life skills, permanent connections). The assessment can be accessed at www.okil.ou.edu free of charge.

Contact your youth's child welfare worker to arrange for your youth to complete this assessment. After a youth has been assessed an IL plan will be developed. This is a youth-driven plan that focuses on steps the youth will take to become a self-sufficient individual. This plan should be developed as part of a team effort by you, the youth, and Child Welfare worker. Others familiar with the youth such as school staff and medical or counseling professionals can contribute to the development of this plan. The IL plan is updated regularly.

In addition to the IL plan, you, the Child Welfare worker and others familiar with the youth help them develop a Transition plan during the 90-day period immediately before a youth exits from care at 18. The plan must be as detailed as the youth chooses and include specific option on housing, health insurance, education, local opportunities for mentoring, continuing support services, work force supports and employment services. The Transition plan is then submitted to the court for review.

Educational Opportunities

Many youth in care face disruptions in their education because of turmoil in the homes of their birth families or due to placement changes while in out-of-home care. Particular attention should be paid to determining whether a youth in your care needs special assistance to do his or her best work in school. This may involve meeting with your youth's Child Welfare worker, the school counselors, and teachers to develop a plan of action. Tutors are available to help students who are not performing up to their capability.

One of the keys to a successful adult life is a good educational background. Studies have shown that family stability, job success, and earning power are directly related to the level of education achieved in one's life. DHS recognizes the importance of working with and supporting custody youth in pursuing education. The following educational programs are available to custody youth:

Tutoring Initiative

The DHS Independent Living program recognizes the need to assist our custody youth improve their high school graduation rate and readiness for post-secondary education. A new position has been created to assist in locating and funding tutoring for youth who need assistance improving their academic level. In order to be considered as a participant, the student must be in DHS custody placed outside of the home. Paid tutors will only be available for youth, 16 years of age and up to age 21, as funding for this initiative comes from federal IL funds. For additional information please contact your youth's Child Welfare worker or call 405-521-3778.

Oklahoma Higher Learning Access Program (OHLAP)

The Oklahoma Higher Learning Access Program is a unique program set up by the Oklahoma Legislature for eighth, ninth, and 10th grade students that will help pay for tuition at an Oklahoma public two-year college or four-year university. Once enrolled in the program, youth are eligible for benefits regardless of whether or not they remain in DHS custody as long as they maintain the behavioral, scholastic and other requirements established by the OHLAP. In November 2003 DHS began a drive to enroll all eligible custody youth in the OHLAP. If at any time you have an eligible youth placed in your home who needs to enroll in the OHLAP, please contact 405-521-3778. You may learn more about the OHLAP at www.okpromise.org.

College and Vo-Tech Tuition Waivers

State law provides tuition waivers for post-secondary vocational/technical programs and undergraduate resident tuition at institutions within the Oklahoma state system of higher education for youth who were in out-of-home placements and in DHS or tribal custody for nine months between the ages of 16 and 18. Eligible youth have three years after obtaining their high school education or GED to begin accessing the waiver. Waivers are valid until youth reach age 26 or complete a baccalaureate degree, whichever comes first.

Oklahoma Education and Training Voucher Program

The Education and Training Voucher Program is a newly authorized program under the Chafee Foster Care Independence Program. The Education and Training Voucher Program makes available additional funding for post-secondary training and education for eligible youth. Youth eligible for services under the DHS ETV Program are:

- Youth eligible for services under the Oklahoma Chafee Foster Care Independence Program.
- Youth who were likely to remain in out-of-home care but obtained permanency through a legal guardianship after age 16.
- Youth adopted from out-of-home care after reaching age 16.
- Youth participating in the ETV program on the 21st birthday, who are enrolled in a post-secondary education or training program and are making satisfactory progress towards completion of that program, can continue to be eligible for the ETV program until age 23.

The funding can be used at any institution of higher education as defined by the Higher Education Act. The ETV funds can be used for tuition, books, fees, rental or purchase of equipment, materials and supplies, room and board, personal and healthcare expenses, transportation, child care for dependents, and tutoring. The cost of these items cannot exceed the total cost of attendance at the institution or \$5,000, whichever is less.

Resource parents may obtain more information about these programs by contacting their assigned Child Welfare worker or by calling 405-521-3778.

Youth Development Funds

The DHS IL program contracts with NRCYS and a fiscal agent to provide youth in care with a variety of miscellaneous services. Some, but not all, of these services (numbers indicate limits) are:

- Birth certificate (one)
- Driver's education classes
- Photo IDs
- College entrance exams (two)
- Required work uniforms
- Transportation vouchers
- GED prep classes
- Tutoring fees
- Teen panel reimbursements
- Gas cards for work/school
- Luggage

Contact your youth's Child Welfare worker for more information about any of the above services, or call the National Resource Center for Youth Services at 918-660-3700.

Independent Living Youth Contingency Funds

These funds supplement the needs and activities of young people as they prepare for independence. These services are contingent on funding availability and eligibility requirements for youth. Youth ages 14 to 16 are eligible for services related to educational and mentor/tutor needs (proposed). Youth 16 to 18 may request supportive services to assist with graduation expenses, education related expenses, and certain other miscellaneous services. Youth remaining in care in your home past the age of 18 in order to complete high school or receive a GED are eligible for these preparation services.

Incentive Payments

Incentive payments are a one time monetary reward for a youth, based on accomplishments achieved from the time Independent Living services are initiated at age 16 until the youth leaves care. The incentive payment is the total of monetary rewards for all the youth's accomplishments in categories related to education, employment, volunteerism, placement stability, life skills development, and future planning. The incentive payment reward is calculated as part of an exit interview conducted by the youth's Child Welfare worker with the youth shortly before he or she leaves care.

“Yes I Can” Alumni Network

“Yes I Can” provides aftercare services to eligible youth who have aged out of DHS or tribal care to live as well-adjusted, active members of the community. Case management services are available when needed. Youth ages 18 to 21, no longer in custody, can access this service toll free by calling 1-800-397-2945.

The University of Oklahoma National Resource Center for Youth Services (OUNRCYS)

The DHS IL program contracts with OUNRCYS to provide training, teen conferences, technical assistance, and resources to eligible youth. Some of the services provided are:

Technical Assistance

Have a question about independent living? Direct access to an independent living specialist is available via e-mail at okil@ou.edu or you can contact us at 918-633-2144. IL specialists are available to provide assistance to anyone working with an eligible youth by request. Services include general information about independent living, direct or targeted information regarding specific youth, and direct and/or one-on-one assistance to those that serve eligible youth. Specialists assist child welfare, tribal staff, placement providers, resource parents, and other community partners with information necessary for a comprehensive IL plan for youth placed in out-of-home care.

Training

OUNRCYS provides Independent Living training workshops throughout the state for workers, placement providers, community resources, and other individuals who work with eligible youth. Visit the events portion of our website at www.okil.ou.edu or email us at okil@ou.edu for more information or to request training.

Teen Conferences

Teen conferences are offered each year. Youth, along with adult sponsors, attend the conference, usually on a college campus, to learn independent living skills. Workshops and recreational activities provide opportunities for young people and adults to network with other youth and adults in the system. Resource parents are encouraged to attend these conferences in order to share in the experience firsthand.

Independent Living Seminars

Multiple Independent Living seminars are offered for adult sponsors and youth 16 and older each year. These seminars provide youth with opportunities to learn information specific to the seven key elements of independent living: health, housing, education, employment, essential documents, life skills, and permanent connections. At seminars, youth gain an awareness of important information and practice skills they need to know to successfully transition from care. Register for events at www.okil.ou.edu.

Things You Can Do to Help Youth Prepare for Independent Living

Help her get an original copy of her birth certificate.

Help him get a Social Security card.

Enroll her in a school program in which she can succeed.

Help him get a photo identification card.

Find out if she is eligible for a Medicaid card.

Help him get copies of medical records.

Start a Life Book that will contain important papers.

Help her open a bank account.

Teach him how to write and cash a check.

Line her up with a dentist that she can continue to use when she is on her own.

Line him up with a doctor he can continue to see when he is on his own.

Help her make a family scrapbook.

Help him renew contact with family members.

Help her develop at least one friendship.

Line him up with a counselor/therapist he can continue to see when he is on his own.

Take her to join a local recreation center.

Teach him some inexpensive ways to have fun.

Connect her with a church group.

Help him find a better paying job.

Make sure she really understands birth control.

Show him the best places to shop for food, clothing and furniture.

Help her learn how to look up resources in the phone book.

Help him work through an independent living skills workbook.

Teach her how to read a map.

Take him on a tour of the city.

Teach her how to use the bus system and read the bus schedules.

Buy him an alarm clock and teach him how to use it.

Show her how to use the library and get a library card.

Help her get a driver's license and compare insurance rates before buying.

Role play, with her, contacts with police, bank tellers, doctors and others.

Role play, with him, several styles of job interviews.

Help her write a resume and an application fact sheet.

Make a list of important phone numbers for him.

Teach her how to cook five good meals.

Teach him how to store food.

Teach her how to use coupons and comparison shop.

Teach him how to read a paycheck stub.

Teach her how to use an oven and microwave.

Teach him how to thoroughly clean a kitchen and bathroom.

Take her to sessions of adult traffic and criminal court.

Teach her how to get a lawyer and when to get one.

Help him understand a lease or rental agreement.

Teach her how to do her taxes.

Teach him how to write a letter and mail it.

Help her find a safe, inexpensive place to live.

Teach him how to budget.

Help her select and get along with a roommate.

Talk to him often about his feelings about going out on his own.

Section 19. Oklahoma Post-Adoption Services Program

Determination of Special Needs

Funding Sources

Adoption Assistance Benefits

Duration of Benefits

Application and Amount of Adoption Assistance

Frequently Asked Questions

Resource Family Information Chart

Reuniting Families

Confidential Intermediary Search Program



Section 19:

Oklahoma Post-Adoption Services Program

The Oklahoma Department of Human Services Post-Adoption Services Program helps secure and support safe and permanent adoptive families for children with special needs. Adoption assistance is designed to provide adoptive families of any economic stratum with needed social services and medical and financial support to care for children considered difficult to place. Unlike the Bridge Resource Family Program, adoptive parents are primarily responsible for the child's support. Benefits provided through the Post-Adoption Services Program are designed to supplement the resources of the adoptive family.

Title IV-E of the Social Security Act provides for a federal adoption assistance program to assist states in providing assistance to eligible children with special needs. If a child with special needs is not eligible for federally funded adoption assistance, the child may be eligible for state funded assistance under the Oklahoma Adoption Assistance Act.

Determination of Special Needs

A child must be determined to have special needs to be eligible for federally funded adoption assistance, state funded adoption assistance or reimbursement of non-recurring adoption expenses. A child is determined to have special needs by meeting all the following criteria.

1. Child cannot return home. DHS recommends that the child must not return to the home of his or her parents, and the child was determined by the court to be legally free for adoption.

2. Special factors or conditions. DHS determines that due to one or more factors or conditions listed in A through G below, the child may not be placed with the adoptive parents without providing adoption assistance:

A. Physical disability. The child has a physical disability that requires regular treatment with a specific diagnosis given by the child's physician.

B. Mental disability. The child meets the eligibility criteria for educable multihandicapped (EMH) or trainable multihandicapped (TMH) classes, and has been evaluated by a licensed psychologist, psychometrist, school, or recognized diagnostic center. A child with a demonstrable need for intensive adult supervision beyond that required by other children of the same age also qualifies.

C. Age Eligibility. Based on the child's age, is determined according to the following:

i. Kinship Placement. There is no age requirement for a child placed with a relative who provides paid or nonpaid kinship care and who meets the specified degree of relationship.

ii. Nonrelated and other relative placements. When no other special needs are determined, the child must be 8 years of age or older.

D. Sibling relationship. The child is part of a sibling group as specified in (i) through (iv):

i. A child of any age and at least one sibling are placed in trial adoption status in the same home

ii. A child younger than 3 years of age, not determined eligible to receive an adoption assistance payment at the time of the adoption assistance application, becomes eligible due to a sibling relationship

iii. If the adoptive parent, within one year of the child's adoption finalization, finalizes the adoption of the child's sibling, the subsequent child is, and the child originally adopted, if not eligible at the time of the adoption would then be, eligible for an adoption assistance payment

iv. The effective date of the adoption assistance payment begins for the child is also the effective date the adoption assistance would begin for the sibling

E. Emotional disturbance. This requires determination by a physician, psychologist, behavioral therapist or social worker and documentation of a specific diagnosis and prognosis, if applicable. It should further be corroborated by the social worker, caregiver, or child care personnel.

F. Racial or ethnic factor. The child is American Indian, Hispanic or Latino, Asian-American, Native Hawaiian and Other Pacific Islander or African-American, and 3 years of age or older.

G. High risk potential for physical or mental disease. The child who has a high risk potential for physical or mental disease from conditions that are not currently being treated may qualify. When no other special factors or conditions exist, no monthly payment is made until there are documented symptoms of physical or mental disease. Indicators of high risk potential for physical or mental disease are:

i. Social and medical history such as mental illness of a biological parent or family member

ii. Events or life experiences such as severe sexual abuse

iii. Prenatal exposure to drugs or alcohol

3. Unsuccessful efforts to place the child without assistance. A reasonable but unsuccessful effort was made to place the child without adoption assistance, except in cases where it would not be in the child's best interest due to such factors as a strong emotional tie to a resource parent who plans to adopt the child or placement with a relative.

Funding Sources

There are two funding sources for Adoption Assistance, Title IV-E (federal) funds and state funds. Both programs can provide eligible children with a monthly assistance payment, Medicaid, reimbursement of nonrecurring adoption expenses, and certain special services not covered by any other program. There are four ways that a child can be eligible for Title IV-E adoption assistance:

Child is eligible to Aid for Families with Dependent Children and meets the definition of a child with special needs – Adoption assistance eligibility that is based on a child's AFDC eligibility is predicated on a child meeting the criteria for such at the time of removal. In addition, the state must determine that the child meets the definition of a child with special needs prior to finalization of the adoption.

Child is eligible for Supplemental Security Income (SSI) benefits and meets the definition of a child with special needs – A child is eligible for adoption assistance if the child meets the requirements for Title XVI SSI benefits and is determined by the state to be a child with special needs prior to the finalization of the adoption.

Child is eligible as a child of a minor parent and meets the definition of a child with special needs – A child is eligible for Title IV-E adoption assistance in this circumstance if, prior to the finalization of the adoption, the child's parent was in foster care and received a Title IV-E foster care maintenance payment that covered both the minor parent and the child of the minor parent and is determined by the state to meet the definition of a child with special needs.

Child is eligible due to prior Title IV-E adoption assistance eligibility and meets the definition of a child with special needs – In the situation where a child is adopted and receives Title IV-E adoption assistance, but the adoption later dissolves or the adoptive parents die, a child may continue to be eligible for Title IV-E adoption assistance in a subsequent adoption. The only determination that must be made by the state prior to the finalization of the subsequent adoption is whether the child is a child with special needs consistent with the requirements in section 473(c) of the Act. Need and eligibility factors in section 473(a)(2)(A) of the act must not be re-determined when such a child is subsequently adopted because the child is to be treated as though his or her circumstances are the same as those prior to his or her previous adoption. Since Title IV-E adoption assistance eligibility need not be re-established in such subsequent adoptions, the manner of a child's removal from the adoptive home, including whether the child is voluntarily relinquished to an individual or private agency, is irrelevant.

The child who receives federally funded adoption assistance is assured that if the adopting family moves to any other state Medicaid coverage will still be available.

For children who do not meet the Title IV-E criteria, state funds may be available for adoption assistance. The child must meet the definition of special needs and, at the time the adoption was initiated, be in the court-ordered custody of DHS or a federally recognized Indian tribe as defined by the federal Indian Child Welfare Act and the Oklahoma Indian Child Welfare Act. If the child moves to another state, that state may or may not provide Medicaid coverage; the majority of states are providing this coverage.

Adoption Assistance Benefits

Adoption assistance benefits may include Medicaid coverage, a monthly assistance payment, special services, reimbursement of nonrecurring adoption expenses, or any combination of these. Children eligible for Title IV-E assistance are also eligible for available Title XX services.

Medicaid. The child is eligible for the Oklahoma Medicaid program or the Medicaid program in the state of residence if the child is Title IV-E eligible. All necessary medical and dental care under the scope of that program is compensable at usual and customary charges.

Monthly assistance payments. A child may be eligible for monthly assistance payments to provide financial support to families who adopt children considered difficult to place. Payments are made to eligible families as long as DHS has sufficient funds available and is authorized to make payments under Form 04AN002E, Adoption Assistance Agreement, as allowable within the DHS budget.

Some children may qualify for Difficulty of Care (DOC) rates. The DOC descriptions are guidelines from which the most appropriate DOC rate is determined for the eligible child. Not every situation will clearly fit into one DOC rate category.

Special services. Special services are used to meet the child's needs that cannot be met by the adoptive parents and that are not covered under any other program for which the child would qualify. A special services payment is usually a one-time payment made to purchase medically or physically necessary equipment (leg braces, prostheses, or similar appliances).

Reimbursement of nonrecurring adoption expenses. Certain nonrecurring expenses incurred by or on behalf of the adoptive parents in connection with the adoption of a child with special needs may be reimbursed. This benefit is available to any family adopting a child who meets the special needs criteria. Reimbursement of non-recurring assistance is paid after the adoption is finalized and may not exceed \$1,200 per child except in special circumstances as outlined in DHS policy. Actual expenses may include attorney fees, court costs, transportation and home assessment fees directly related to finalization of the adoption.

Duration of Benefits

After an agreement for adoption assistance is signed and in effect, it is only terminated if one of the following conditions is met:

- Child becomes an adult. The child reaches age 18 years, except the child may continue to receive assistance until the child's 19th birthday if the child:
 - Continues to attend high school or pursues General Educational Development
 - Meets the criteria for an adoption assistance DOC rate, as determined by DHS
- The adoptive parents fail to submit, no later than 60 days prior to the child reaching age 18, a request for adoption assistance to continue beyond age 18.
- DHS determines that the adoptive parents is no longer legally responsible for the support of the child.
- DHS determines that the adoptive parents are no longer providing financial support to the child. If a child is placed in out-of-home care including psychiatric, residential, therapeutic, or foster family care and the adoptive parents continue to provide financial support to the child, adoption assistance may continue. The rate of payment may be renegotiated, as appropriate.
- All of the child's adoptive parents are deceased. Any child who was receiving Title IV-E adoption assistance at the time of the death of his or her adoptive parents, or at the time an adoption dissolves, may be eligible for adoption assistance if he or she is adopted again.
- A child receiving state funded adoption assistance is eligible if adopted after May 29, 1988. To be eligible, the child must continue to meet the special needs criteria and all of the requirements in (1) through (4):
 - (1) The prospective adoptive parents must make application
 - (2) The prospective adoptive parents must provide from a district or tribal court a copy of a file-stamped Petition for Adoption if requesting prefinalization adoption assistance or a Final Decree of Adoption if requesting adoption assistance to begin after assistance

(3) DHS must be able to document the child was receiving IV-E or state-funded assistance at the time of the death of the adoptive parents or at the time the adoption dissolved

(4) DHS must be provided documentation that the new adoptive parents is not the biological parents

Adoptive parents are asked to complete an annual review form that serves to determine whether the terms of the Adoption Assistance Agreement are still met and to keep DHS informed of changes affecting children receiving benefits.

Application and Amount of Adoption Assistance

To apply for adoption assistance, the prospective adoptive parents, custodial agency, or tribe completes Form 04AN001E (DCFS-54), Adoption Assistance Application, on behalf of the child and family and submits the form to the State Office, Child Welfare Services, Adoption Assistance Section for approval.

An important program requirement is that an adoption assistance agreement must be signed by all parties (namely the adoptive parents and the DHS director's designee) prior to the final decree of adoption as required by federal and state law and DHS policy. (See last Q.A.)

When a child has been determined to be eligible for Adoption Assistance, it is very important for the placing agency and the prospective adoptive parents to discuss the special needs of the child and how the needs will be met after the child is placed in the adoptive home. It is also the time for the placing agency to discuss with the adopting family what the agency's role with the child and family will be after placement occurs. The placing agency should discuss the various programs that may be available either through community resources or agency resources to assist the family in meeting the special needs of the child. Although the Adoption Assistance payment can never exceed the amount the child received (or would have received) in family foster care at the time of adoptive placement, that maximum amount of Adoption Assistance is not automatically provided.

After the exchange of information has occurred, the family and agency should arrive at an amount (not in excess of the allowable amount) that the family feels is satisfactory for a monthly payment. It must be kept in mind that Adoption Assistance is to meet the special needs of the child and is not to be confused with a foster care payment. This amount may be renegotiated at a later date as long as the renegotiated rate does not exceed the current adoption assistance maximum rate.

Frequently Asked Questions

How long can the adoption assistance continue?

To age 18 or to age 19 if the child continues to reside in the home of the adoptive parents and has a documented serious mental or physical disability or continues to attend high school.

Must the child remain in Oklahoma to receive adoption assistance?

No, adoption assistance agreements remain in effect even if a family moves out of Oklahoma. Oklahoma continues to make monthly payments, if applicable, and IV-E children can receive Medicaid regardless of where the family resides. State-funded children may be eligible to receive Medicaid in the state where they reside. The scope of the Medicaid coverage may vary from state to state. DHS staff assists adoptive families with securing Medicaid benefits in other state's of residence and helps assure that proper paperwork is submitted timely.

If a child receives benefits such as SSA, VA, or other beneficiary payments, can the family receive those after adoption?

After the adoption is finalized, the parents may apply to receive those benefits. These benefits should be considered when the amount of the adoption assistance is negotiated with the family. If a child receives Supplemental Security Income prior to adoption, the child may not be eligible for this benefit after adoption or may be eligible for a different amount. Adoptive families should contact the Social Security Administration for benefit information.

If the adoptive parents add the child to their health and medical insurance, is Medicaid of benefit?

Yes, however, the insurance must be claimed first. Medicaid will pay only if a Medicaid eligible child is using a Medicaid vendor and then only if the insurance amount is less than the amount Medicaid would pay, or if a service is Medicaid compensable but not compensable on the family insurance. Currently, under Oklahoma's Medicaid program, when a Medicaid child uses a Medicaid vendor and the insurance company pays, the family does not owe the balance, as the Medicaid vendor has agreed to accept the insurance payment as payment in full. This may not be the case in other states, and the family would then owe the difference between the total fee and the amount the insurance pays if they are using a non-Medicaid vendor.

Is adoption assistance reviewed?

Yes, annually. DHS must determine that the need still exists, and that the adoptive parents continue to have legal and financial responsibility for the child.

Can the amount of the subsidy ever be changed?

Yes, the parents and DHS can renegotiate the adoption assistance amount anytime there is a change in the child's needs. The amount cannot increase, of course, if the child was already receiving the maximum.

What if I do not agree with DHS decision regarding my application for adoption assistance or subsequent requests?

You have a right to an administrative fair hearing if your application is denied, not acted on with reasonable promptness, approved in an amount less than requested, modified without your concurrence, or terminated.

Is there an instance in which an adoptive family may apply for adoption assistance after an adoption is finalized?

Yes, both federal and state-funded programs have provisions for adoption assistance after finalization if certain circumstances exist and eligibility criteria are met. Inquiries should be directed to the Adoption Assistance Section of Children and Family Services Division.

For general information about Adoption Assistance:

Call 405-521-2475 Visit: www.okdhs.org/programsandservices/adopt

Write : Oklahoma Department of Human Services Adoption Assistance Program,

PO Box 25352, Oklahoma City, OK 73125

Resource Family Information Chart

Requirements	Foster Care	Adoption
Motivation	Desire to help children in need of a family and to help strengthen families	Desire to expand their family
Primary Goal	Reunification; placement is temporary and the child is a ward of the court	Permanence; legal relationship is established; child has same privileges as children born into the family; no longer wards of the court
Training	27 hours preservice training	Same
Smoking	Not allowed in the home or automobile	Same until finalization
OSBI Name Search	OSBI records search, Department of Public Safety check, Sex Offenders Registry check	Same
Fingerprinting	Required for all adults in the home. However, when the home is approved, children can be placed pending fingerprint results if the adults have lived in Oklahoma the last five consecutive years. If not, results must be received before children can be placed	Same
JOLTS Check (Juvenile Information System)	For youth in the home over the age of 13	Same

Requirements	Foster Care	Adoption
Assessment of the Home	<ul style="list-style-type: none"> •Safety requirements including pets, swimming pools, guns, etc •Medicals, including immunization records for children •Vehicles 	Same
Health Insurance	None required	Availability is assessed
Rates of Reimbursement	<p>Monthly reimbursement and clothing rates per age:</p> <p>0-5 years: \$365.00</p> <p>6-12 years: \$430.00</p> <p>13+ years: \$498.33</p>	<p>If the child is approved for adoption subsidy, the rates are negotiated up to the maximum:</p> <p>0-5 years: \$270.00</p> <p>6-12 years \$324.00</p> <p>13+ years: \$378.00</p>
Difficulty of Care	Available when child meets criteria	Same; may not be approved at the same level received in foster care
Child Care	Foster care/day care is paid for families who work a minimum of 20 hours per week outside the home	Not available
Re-evaluations	Yearly	Yearly

Reuniting Families

Mutual Consent Voluntary Registry

What is the Mutual Consent Voluntary Registry?

The Mutual Consent Voluntary Registry is a service established by the DHS for adult adoptees and individuals separated from birth family members through termination of parental rights proceedings but not adopted. It allows these individuals and their birth family relatives to indicate their willingness to have their identities and whereabouts disclosed to one another. If an adoptee and one of his birth family members both register, a match between the adoptee and any birth family member can result in a reunion. The same applies to individuals and their relatives separated by a termination of parental rights proceeding.

What can it do for me?

You may register if you or a relative were placed for adoption in Oklahoma. You may also register if you were separated from birth family members as a result of termination of parental rights proceedings in Oklahoma. If the person you are seeking has also registered with the Mutual Consent Voluntary Registry, you may have access to your relative's name, address and other identifying information if all agree. You can make contact at your own discretion.

What if I don't want to be found?

The registry is totally voluntary and you may withdraw your willingness to be reunited with birth family members at any point. DHS will protect your privacy if you choose not to have contact with birth family members.

Will DHS help me with a reunion?

DHS can act as a third party intermediary if you do not wish to arrange the reunion yourself. You need to specify in a notarized registry affidavit whether or not DHS can release your name, address or phone number, and to which relatives.

Who may register?

Any person 18 years or older who was adopted in Oklahoma and their birth relatives. Also, any person 18 years or older who was separated from birth family members by termination of parental rights proceedings in Oklahoma.

Will DHS help me search for my relatives?

Yes. DHS has a Confidential Intermediary Search program that provides search services for eligible persons to locate their birth relatives. There is a \$400 fee for the first search and a \$200 fee for each additional search. You must register on the Mutual Consent Voluntary Registry six months before requesting a search. The person who is the subject of the search must sign an agreement that they wish to be found. If they do not wish to be found, their identity will not be disclosed. There is no refund for the search fee, regardless of the outcome of the search.

How do I get on the Registry?

Complete the Oklahoma Mutual Consent Voluntary Registry form. It must be notarized before you mail it. You must submit one of the following as proof of your identity:

- A photo copy of your current driver's license
- A photo copy of your birth certificate
- A photo copy of your social security card

If you move, it is essential that you notify us of your new address and phone number so we can notify you if a relative contacts DHS.

Is there a cost to be on the Mutual Consent Voluntary Registry?

Yes. There is a \$20 registration fee. The fee must be included with your completed, notarized Oklahoma Mutual Consent Voluntary Registry form.

Pay by check or money order only and make either payable to the Oklahoma Department of Human Services Reunion Registry.

Where do I write?

Send your letter to:

Oklahoma Department of Human Services
Child Welfare Services Adoption Section
PO Box 25352
Oklahoma City, OK 73125

If you have any questions you may call the DHS Adoption Section at 405-521-2475 or your local DHS adoption specialist.

DHS Confidential Intermediary Search Program

What is the Confidential Intermediary Search Program?

DHS administers a search program that allows individuals who were separated from their birth family members through adoption or termination of parental rights proceedings in Oklahoma to have a confidential intermediary search for members of their birth family.

Who will conduct the search?

DHS will contract with confidential intermediaries who have met eligibility standards, training requirements, and have been certified as confidential intermediaries through the DHS search program. The search is confidential, as is the outcome of the search.

Who can request a search?

- Any adult (age 18 or older) adoptee or person affected by a termination of parental rights proceeding done in Oklahoma
- The legal parent or guardian of any minor child of a deceased adopted person
- An adult descendant of a deceased adopted person
- The legal parent or guardian of any minor child of a deceased person whose biological parents' parental rights were terminated
- An adult descendant of a deceased person whose biological parents' parental rights were terminated
- An adult birth sibling or grandparent of an adult adoptee or of an adult person who has a parent whose parental rights were terminated
- The sibling of a deceased biological parent whose parental rights were terminated

Who cannot request a search?

- Anyone who has not registered with the Mutual Consent Voluntary Registry at least six months before requesting a search
- An adult adoptee or adult whose parents's parental rights were terminated, who has a minor biological sibling in the same adoptive family or other placement whose location is known to the adult whose parents' parental rights were terminated
- The biological relative of a birth parent who has filed an affidavit of nondisclosure with the Bureau of Vital Statistics

How do I request a search?

You must register with the Mutual Consent Voluntary Registry six months prior to requesting a search. You must make application for a search by completing the Request for Search form, 04CI001E, (DCFS-23), and providing satisfactory proof of identity. These documents must be sent to the search program administrator, along with the fee for the search, before a search can be initiated.

Is there a fee to have a search done?

There is a \$20 registration fee for the Mutual Consent Voluntary Registry. You must be registered for six months prior to requesting a search.

There is a \$400 fixed fee for all initial searches for any one eligible person. There is a \$200 fee for any additional searches by the same requester. The search fee is non-refundable regardless of the outcome of the search, even if the person being searched for is not found.

What if my relative does not wish to be contacted?

The DHS search program recognizes that while some people may have a strong desire to establish contact with birth family members, others do not. It is an individual and totally voluntary decision. All parties must consent in writing before contact is initiated. If the person being sought does not want contact, none will be initiated.

The DHS search program can search simply to contact your relative to obtain medical history or physical description information without your having any contact with your relative.

How do I begin the process?

You may write to us to receive a Request for Search form. If you have not registered on the Mutual Consent Voluntary Registry, we will send you an application to register there too.

Please send your request to:

Oklahoma Department of Human Services
Child Welfare Services
Adoption Section
PO Box 25352
Oklahoma City, OK 73125

<http://www.okdhs.org/programsandservices/adopt>

If you have questions, you may call the DHS Confidential Intermediary Search Program at 405-521-2475, or your local DHS adoption specialist.

Section 20. Resources

Foster Parent Resources
Oklahoma Tribes
General Resources
Health and Development
Child Care
Education
Tax Deduction
Support Services



Section 20: Resources For Resource Parents

Foster Parent Hotline

Call the statewide foster parent hotline at 1-800-376-9729 for information on foster care services or to file a complaint or grievance.

Foster Care Association of Oklahoma

The Foster Care Association of Oklahoma Inc. is located at www.fcao.org or FCAO, 2934 SW 6, Newcastle, OK 73065, 405-387-5052. Their goal is to improve the quality of life for foster and adoptive children. FCAO invites the participation of every resource parent (foster and adoptive), Child Welfare Specialist, CASA, PARB member, counselor, and other allied professional and concerned citizen who serves children in Oklahoma. They provide low-cost training and Continuing Education Units (CEUs) for resource parents (foster and adoptive) and other professionals at their annual conference. Visit www.fcao.org to find out more about their mission and membership.

The National Foster Parent Association is at www.nfpaonline.org. The purpose of the National Foster Parent Association is:

To bring together foster parents, agency representatives and community people who wish to work together to improve the foster care system and enhance the lives of all children and families.

To promote mutual coordination, cooperation, and communication among foster parents, foster parent associations, child care agencies and other child advocates.

To encourage the recruitment and retention of foster parents.

Contact NFPA at: National Foster Parent Association Inc.
2313 Tacoma Avenue South
Tacoma, WA 98402
1-800-557-5238
Fax 1-253-683-4249
www.nfpaonline.org

Oklahoma Tribes

To locate the website for each Oklahoma tribe, go to the American Indian Tribal Home Page at www.law.ou.edu/indian/ainations.html.

General Resource Information

211

211 provides information about and referrals to resources and services in your community for everyday and crisis needs. See www.211oklahoma.org or call 211.

OASIS

OASIS is a statewide information and referral system. Contact them for information, referral and assistance for adults and children with special health care needs or disabilities. See www.oasis.ouhsc.edu or call 1-800-426-2747.

Health and Development

SoonerCare/Medicaid/Oklahoma Health Care Authority has several helpful phone numbers.

Call the SoonerCare Helpline at 1-800-987-7767 (Monday through Friday, 8 a.m. to 5 p.m.) to find a medical provider who accepts Medicaid.

Call the **Patient Advice Line** at 1-800-530-3002 (after 5 p.m. on weekdays and any time on weekends and holidays) to ask questions if you are not sure your child is in need of emergency care.

Call **SoonerRide** at 1-877-404-4500 (Monday through Saturday, 8 a.m. to 5 p.m.) to arrange transportation to a medical appointment.

WIC (Women, Infants and Children Supplemental Nutrition Program) through the Oklahoma State Department of Health provides resource information and food for infants and children up to age 5. See www.ok.gov/health/Child_and_Family_Health/wic or call your local health department for more information.

Child Care Warmline has recorded messages on topics such as toilet training, biting and ADHD. A nurse and child development specialist are also available to answer questions. Call 1-888-574-5437 or go to www.okdhs.org/childcare. Click on the “Provider” tab and click on the Warmline under Quick Links.

American Academy of Pediatrics provides health information categorized by developmental stages and by topic at www.aap.org/topics.html.

The **Center for Disease Control and Prevention** provides an overview of child development and links to positive parenting tips for infants and children ages birth through 8 years of age at www.cdc.gov/ncbddd/childdevelopment.htm

Zero to Three is a national advocacy group promoting good health, strong families and positive early learning experiences. Their website at www.zerotothree.org contains information on how the brain develops in young children and what you can do to help with this development.

Child Care

DHS Child Care Services provides information on licensed child care providers in your community. Go to <http://childcarefind.okdhs.org/childcarefind>.

The **Oklahoma Child Care Resource & Referral Association** provides information on child care resources. Call 1-888-962-2772 or go to www.oklahomachildcare.org

The **Child Care Consultation Program** is for children having difficulty in child care. If your child is in danger of being expelled, this program provides a trained consultant who will visit the facility on a regular basis to support staff, connect staff and families to resources, and assist in program planning. Call the Warmline at the Oklahoma State Department of Health at 1-888-574-5437 for more information and to talk to a consultant.

Education

Oklahoma State Department of Education is at 405-521-3301 and at www.sde.state.ok.us. The State Department of Education, Special Education Services, provides oversight for all special education programs in public schools. Call 405-521-4862 for a copy of the Special Education Parent Handbook, a resource book for families about special education services and parent rights.

Oklahoma Parents Center is Oklahoma's statewide parent training and information center serving parents of children with disabilities. Their goal is to educate and support parents, families and professionals in building partnerships that meet the needs of children and youth with the full range of disabilities ages' birth to 26. OPC provides training on a variety of topics related to children with disabilities including IEPs (Individualized Education Plan). They sponsor a statewide conference and a quarterly newsletter. Call 1-877-553-4332 or www.oklahomaparentscenter.org.

www.wrightslaw.com provides information about special education law, education law, and advocacy for children with disabilities.

Tax Deduction

There is a deduction for a taxpayer who contracts with a child-placing agency, as defined in Section 402 of Title 10 of the Oklahoma Statutes, in the maximum amount of \$2,500 for single persons or a deduction in the maximum amount of \$5,000 for married persons filing a joint return for expenses incurred to provide care for a foster child. If you have any questions regarding the impact on your family, please contact a tax advisor.

Support Services

Oklahoma Family Network (OFN) is a support group for parents who have children with special health care or disability needs. To speak with someone who has a child with the same disability or health care need as your child, contact OFN. They will connect you with a family who understands and can also help you find resources and services. OFN recruits resource and adoptive parents as mentors. See www.oklahomafamilynetwork.org or call 1-405-203-8745.

Social Media: Tips for Foster Care Workers, Youth in Foster Care, and Foster Parents

The Child Welfare Information Gateway published tip sheets on social media for foster care workers, youth in foster care, and foster parents. Each tip sheet briefly describes the advantages and challenges that may be encountered when using social media, explores issues that should be considered, and offers tips for addressing these issues. (October 2013)

- **Youth in Foster Care** https://www.childwelfare.gov/pubs/smtips_youth.cfm
- **Foster Parents** https://www.childwelfare.gov/pubs/smtips_parent.cfm



20-4