

Extended Studies



Continuing Education
COLORADO SPRINGS

Foster Parent Core Training

Participant Workbook

Table of Contents

Introduction	5
Goals and Objectives	6
Brief History of Foster Care	7
Providing a Safe and Secure Environment (General overview of foster care, administrative and legal issues, why children get placed in out-of-home care)	8
Practice Skills	11
Child Abuse and Neglect	13
Eight Factors Which Contribute to Physical Child Abuse	13
Recognizing Abuse	13
Behavioral Indicators of Abuse and Neglect	14
Behavioral Indicators of Child Sexual Abuse	15
Practice Skills	16
Providing a Nurturing Care Environment (Parenting, key concepts of child growth and development, discipline)	18
Empathy	18
Helpful Hints in Initial Placements	19
Communication Disorders	19
Discipline	21
Practice Skills	24
Promoting Educational Attainment and Success	27
Practice Skills	27
Meeting Physical and Mental Health Care Needs	29
Practice Skills	30
Promoting Social and Emotional Development	32
Teaching Problem Solving Skills	32
Teaching Friendship Skills	33
Teaching Appropriate Expression of Emotions	33
Other Correctives	33
Life Skills	34
Praise	34
Practice Skills	34
Valuing Diversity and Supporting children's Cultural Needs (Individual differences, such as ethnicity and culture)	36

Identity Development	36
The Iceberg Theory of Culture	36
Hair.....	37
Skin Care.....	37
Other Issues	37
Hearing Problems.....	38
Other Disabilities	38
Practice Skills	38
Supporting Permanency Plans (Importance of the team approach)	40
Permanency	40
Biological Parents.....	40
Family Service Plan	40
Crisis Situations and Disruption	40
Changes in Your Home	41
Appropriateness of Placement	41
Respite	42
Legal Responsibilities of Foster Parents.....	42
Practice Skills	43
Managing Ambiguity and Loss for the Foster Child and Family.....	45
Loss.....	45
Suicide	46
Practice Skills	47
Growing as a Foster Parent – Skill Development and Role Clarification	49
Training.....	49
Additional Training	49
Creditable Training	49
Role Clarification	49
Practice Skills	50
Managing the Demands of Fostering on Personal and Familial Well-being (Effects of fostering on the family)	52
Building Relationships	52
Support Groups	52
Family Chat	52
Counseling	52
Typical Issues	53

Investigations	53
Practice Skills	54
Supporting Relationships Between Children and Their Families (Working with the biological family)...	56
Helpful Hints for Minimum Involvement	56
Helpful Hints for Moderate Involvement	56
Helpful Hints for Maximum Involvement.....	56
Practice Skills.....	57
Working as a Team Member (Importance of the team approach)	58
Practice Skills.....	60
Appendix A, Placement Checklist.....	62
Appendix B, Definitions of Abuse and Neglect.....	63
Appendix C, Child Development Chart.....	67
Appendix D, Effects of Abuse and Neglect on Child Development	71
Appendix E, Volume 7 rules	77

Introduction

Welcome to Foster Parent Core Training! The format of this training borrows heavily from Buchler, C., Rhodes, K., Orme, J. and Cuddleback, G. (2006), *The Potential for Successful Family Foster Care: Conceptualizing Competency Domains For Foster Parents*, Child Welfare League of America. The authors combined competency domains from the National Commission on Family Foster Care, Child Welfare League of America *Standards for Excellence for Family Foster Care Services* (1995), *Parent Resources for Information, Development, and Education* (PRIDE), Casey Family Program competencies, and an article on assessing and promoting quality kin and nonkin foster care by A.R. Shlonsky and J.D. Berrick. There are twelve competency domains in this model:

1. Providing a safe and secure environment
2. Providing a nurturing care environment
3. Promoting educational attainment and success
4. Meeting physical and mental health care needs
5. Promoting social and emotional development
6. Valuing diversity and supporting children's cultural needs
7. Supporting permanency plans
8. Managing ambiguity and loss for the foster child and family
9. Growing as a foster parent—skill development and role clarification
10. Managing the demands of fostering on personal and familial well-being
11. Supporting relationships between children and their families
12. Working as a team member

This workbook further divides each of these domains into two categories: Knowledge and Practice Skills. Participants should complete the practice activities at the end of each section to enhance the learning experience.

The Colorado State Department of Human Services Volume 7 Rules also requires ten topic areas foster parent core training. These topics have been incorporated into the twelve competencies above and are noted in the subtitle of each section. Specifically, Volume 7 Rules require the following topic areas:

1. General overview of foster care
2. Administrative and legal issues
3. Why children get placed in out-of-home care
4. Parenting and family dynamics
5. Key concepts of child growth and development
6. Importance of the team approach
7. Individual differences, such as ethnicity and culture
8. Discipline
9. Effects of fostering on the foster family
10. Working with the biological family

The appendix section of the workbook contains information and resources that will be helpful during your experience as a foster parent. While the information in the appendix will not be covered in detail during the training, the foster parent should nevertheless, read and become familiar with the information contained in each appendix, especially the Volume 7 Rules regarding the foster family and the foster home.

Foster Parent Core Goals and Objectives

Goals:

1. Understand the legal issues surrounding foster care placement
2. Recognize the symptoms of child abuse
3. Appreciate the importance of providing a safe and secure environment for children in foster care
4. Know the components of providing a nurturing environment for children in foster care
5. Be familiar with the components in promoting educational attainment and success
6. Understand the importance of meeting the physical and mental healthcare needs of children in foster care
7. Understand the components of promoting social and emotional development of children in foster care
8. Recognize the importance of diversity and identity development in children
9. Recognize the importance of permanency plans and the impact of lack of permanency on foster children
10. Understand the importance of appropriate placement and the impact on permanency plans
11. Identify the mixed feelings of loss for foster children and their biological parents when a child is placed in care
12. Realize the importance of training for foster parents
13. Be aware of the impact of foster care on the foster family
14. Understand the importance of working with the biological family to achieve permanency for the child
15. Recognize the foster parent's role as a team member working to achieve permanency for the family
16. Understand the potential of the foster family to impact state and county foster care performance improvement goals

Objectives:

1. Describe the various federal and state rules and regulations pertaining to children in foster care
2. Describe an appropriate and safe physical placement for foster children
3. Explain the procedure for reporting child abuse
4. Recognize appropriate nurturing techniques
5. Identifies relevant resources and policies to advocate for educational attainment and success of foster children
6. Give examples of ways to meet the physical and mental healthcare needs of children in foster care
7. Summarize the methods of promoting social and emotional development in children in foster care
8. Describe at least three ways of caring for children who are from a different culture than the foster parent
9. Explain how to prevent disruption of placement
10. Begin to develop a list of questions to determine appropriateness of placement when children are referred for placement
11. Describe the five stages of grief and loss
12. Summarize the symptoms of suicidal children and describe how to get help for the child
13. Describe at least two ways to minimize the negative impact of fostering on the family
14. Describe at least four ways to develop a positive relationship with the biological family
15. Describe foster parent roles on the team of professionals working with the family
16. Describe ways in which the foster parent can impact state and county goals regarding performance improvement plans

Brief History of Foster Care

Foster care has a long and illustrious history in the United States, beginning as early as 1636, when Benjamin Eaton became the first foster child in the country. Around the 1850s, Charles Loring Brace started the child saving movement in New York City. During this time, New York City had many orphans roaming the streets. These children were engaging in crime, begging for food and money, and becoming victims of crime. Brace believed that these children would be better served if they had the opportunity to grow up in a rural environment, with room to run and play. Brace developed a program to send these children into the farmlands of America on trains, the famous “Orphan Trains.” Unfortunately, not all of the foster parents had the children’s best interest in mind. Brace came under much criticism due to lack of appropriate screening of potential foster parents and lack of follow up services once the children were placed. Many children were running away from their foster parents, becoming a financial burden to the states in which they were placed.

In 1874, Mary Connelly was sentenced to one year of hard labor for the abuse and neglect of Mary Ellen Wilson. One of the most famous cases in the annals of child welfare, Mary Ellen Wilson was placed into the Connelly home due to the poverty of her widowed mother. The following is an excerpt of Mary Ellen’s testimony:

“My father and mother are both dead. I don’t know how old I am. I have no recollection of a time when I did not live with the Connelly’s. Mamma has been in the habit of whipping and beating me almost every day. She used to whip me with a twisted whip—a raw hide. The whip always left a black and blue mark on my body. I have now the black and blue marks on my head which were made by mamma, and also a cut on the left side of my forehead which was made by a pair of scissors. She struck me with the scissors and cut me; I have no recollection of ever having been kissed by any one—have never been kissed by mamma. I have never been taken on my mamma’s lap and caressed or petted. I never dared to speak to anybody, because if I did I would get whipped.... I do not know for what I was whipped—mamma never said anything to me when she whipped me. I do not want to go back to live with mamma, because she beats me so. I have no recollection ever being on the street in my life” Mary Ellen, April 10, 1874 in Watkins, 1990).

Early foster care focused on the physical needs of children in placement, and states were responsible for children in placement. In recent years, the federal government has provided large amounts of funding to the states to help pay for the cost of foster care and related services. Along with funding, the federal government also created rules and requirements concerning the care of children in placement. This has led to a shift from state-driven foster care to federal-driven foster care. Another trend in foster care is the shift from risk to present or impending danger as the standard for placing children into care.

Providing A Safe And Secure Environment

(General Overview of Foster Care, Administrative and Legal Issues, Why Children Get Placed in Out-of-Home Care)

Knowledge:

As a foster parent, you should be aware that there are several federal and state laws that impact your ability to provide a safe and secure environment for children. Some important federal and state laws:

- A. _____ – federal law which states that a caseworker must provide “reasonable efforts” to help a family before placing a child. Once a child is placed, the caseworker must continue to provide “reasonable efforts” to return a child home. Thus, in almost every case, the initial goal will be to return the child home.
- B. _____ – emphasizes the safety of a child, well being of the child, and permanency for the child in out of home placement through reunification, guardianship, and/or adoption.
- C. _____ – state law which also requires reasonable efforts from the caseworker to either prevent placement or return the child home if placement is a necessity. This encompasses most of the Colorado statutes designed to protect children and the community.
- D. _____ – social service code that contains the policies and procedures that caseworkers and foster parents must follow. These regulations are enacted through the administrative branch of government.
- E. _____ – Indian Child Welfare Act: An Indian tribe has jurisdiction exclusive to any State over any child custody proceeding involving an Indian child who resides in a tribe or in a ward of a tribal court. In any adoptive placement of an Indian child under State law, a preference shall be given, in the absence of good cause to the contrary, to a placement with a member of the child’s extended family; other members of the Indian child’s tribe; or other Indian families. In a foster placement, placement with a member of the child’s extended family; a foster home licensed, approved or specified by the Indian child’s tribe; an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child’s needs. Children who qualify under this act are registered tribal members, or children who are eligible to become registered tribal members. This act also requires evidence beyond a reasonable doubt in termination of parental rights for children who fall under this act.

How children are placed:

- 1.
- 2.
- 3.

When a child is first placed in your home, there are a few documents and information you should be sure you receive from the County Department of Human Services or the County Department of Social Services (whichever applies to your area).

1. _____
This document states that the County has placed the child into your home. You will need this form to enroll the child in school, or to change the contact information for the child's school if they are going to continue attending their original school.
2. _____
This document authorizes you to obtain routine medical care for the child. You will need this form in order to take the child to the physical and dental appointments you will schedule.
3. _____
This document or folder contains the foster child's school and medical information. You should keep this document or folder up-to-date while the child is in placement with you.
4. _____
5. _____

Other important information:

1. _____
2. _____
3. _____

The following chart outlines the legal hearings that apply when a child is removed from the biological home.

Action or Proceeding	Approximate Time to Process Through Court	Purpose of Hearing
Referral/removal of child(ren)	72 hours	
File Dependency/Neglect Petition Intake: Investigation/PPP Advisement: D/N Petition Pretrial Conference/Settlement	30 days	
Adjudication	Within 90 days	
Disposition, Treatment Plan	45 days	
Periodic Reviews, Modifications	30-45 days	
*Permanency Planning Hearing	6-18 months	
File Termination Motion	Continually Assessed	
Advisement: Termination	30 days	
Termination Hearing	45-60 days	
Appeal	Varies	
New Treatment Plan	Varies	
Petition to Adopt	Varies	
Estimated Time Frame:	12 Months for EPP Cases* *Add more time for Criminal Charges and Cases moved to District Court	

Practice Skills:

1. What can you do to follow your county's procedure for reporting runaway children?
2. What two pieces of paperwork should you request from the caseworker when (or shortly after) a child is placed with you?
3. Practice answering a person's questions about a child placed in your home, without breaching the child's confidentiality.

Answering a person at the local grocery store:

Answering a co-worker:

Answering a neighbor:

Answering a relative who does not provide care for the child:

4. List at least 3 Volume 7 rules regarding a safe and secure environment.

Notes

Child Abuse and Neglect

Knowledge:

Eight Factors Which Contribute to Physical Child Abuse

1. **History of abuse**
2. **Low Self-Esteem**
3. **Isolation**
4. **Poor Peer Relationships**
5. **High and Unusual Expectations**
6. **Role Reversal**
7. **Precipitating Crisis**
8. **Poor Impulse Control**

As a foster parent, you are required to report abuse if you see or know about it. You are a “mandatory reporter” and failing to report known abuse can cause you to lose your license. Sometimes, children who visit with their parents can come back with bruises or injuries. Most of these bruises or scrapes are the result of the children playing, as most children do. However, some of these injuries may be the result of abuse. It is important to know how to identify possible abuse injuries so they can be reported. If you see injuries that are suspicious, you should call the child’s caseworker to report it, and call the child abuse hotline in the county which the abuse occurred. There are also additional training sessions available for foster parents on recognizing abuse and neglect and other topics. These training sessions can be found on the Colorado Department of Human Services web site, on the Colorado State Foster Parent Association web site, and also through your County Department of Human Services caseworker. Here are some signs you should be looking for regarding abuse:

Recognizing Abuse:

- 1.
- 2.
- 3.
- 4.

Definitions
(See Appendix A)

Abuse:

Types of abuse:

- 1.
- 2.
- 3.

Neglect:

Types of neglect:

- 1.
- 2.
- 3.
- 4.
- 5.

While you should not question the child about every detail of their injury, you can ask the child how the injury occurred. If the story does not appear to match the injury, or if something the child says causes alarm, you should report the injury to the caseworker and the child abuse hotline. If the child comes back to the home with an injury that appears “normal”, such as a scraped knee, this should be documented and passed on to the caseworker. Appendix B in your book describes the legal definition of child abuse and neglect in Colorado.

Behavioral Indicators of abuse and neglect

A foster child placed in your home is likely to act in ways that are unfamiliar to you if you have reared un-traumatized children of your own. Foster children may be hyper vigilant concerning their surroundings and over-react, or react inappropriately, to situations they believe are dangerous to them. Some behaviors you may notice with abused children:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

Some behaviors you may notice with neglected children:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Behavioral Indicators of Child Sexual Abuse

The presence of any of these behaviors is not conclusive. Many are normal signs of upset and may be present due to reasons other than sexual abuse. If these signals are unexplained by other experiences that may be troubling the child; they may indicate sexual abuse.

Some symptoms are more associated with sexual abuse (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Friedrich, in press; Friedrich & Grambach, in press, Kolko & Moser, 1988; Mannario & Cohen, 1986.) These include:

1. Behaviors that go beyond normal sexual play and knowledge of young children.
2. Sexualized play that in young children is not normal.

Physical symptoms are also associated with sexual abuse. Signs would include pain or injury in the genital area, discomfort in walking or sitting, unusual odors or itching around the genitals, or a diagnosed sexually transmitted disease.

Friedrich, Granbach, et al (1991) researched sexual behavior in children who were not sexually abused. Common, frequent behaviors were self-stimulatory behavior and exhibitionism. Sexual behaviors that were least observed in non-abused children were:

1. Placing the child's mouth on a sex object
2. Asking to engage in sex acts
3. Masturbating with an object
4. Inserting objects in the vagina/anus
5. Making sexual sounds
6. French kissing
7. Undressing other people
8. Imitating sexual behavior with dolls

Other symptoms that are often observed in sexually abused children are:

1. Symptoms of anxiety. Including fear, sleep disturbance and nightmares, flashbacks, startle reactions, hyper vigilance, regression, bed-wetting, phobic behaviors, withdrawal from usual activities, nervousness, and clinginess (Broene & Finkelhor, 1986; Mannario & Cohen, 1986).
2. Inappropriate displays of affection, such as attention to adult genitalia.
3. The sudden rejection of normal physical affection, i.e. hugging
4. Sudden over0interest in the child's own genitalia beyond a normal curiosity
5. Self-destructive behavior, i.e. self-mutilation, accident proneness
6. Personality changes – outgoing child now shy and withdrawn or shy now bold

7. Sudden school problems: drop in performance, not acting out, no concentration
8. Arrives early to school, leaves late with few absences
9. Poor peer relationships or inability to make friends
10. Lack of trust, especially with significant others.
11. Non-participation in school and social activities
12. Running away from home, acting out behavior at school
13. Depression, including suicidal ideation or attempts
14. Psychosomatic illnesses, promiscuity
15. Dissociation
16. Eating disorders
17. Adolescent involvement in other abusive relationships
18. Juvenile sex offenders
19. Substance abuse

Practice Skills:

1. List three factors that contribute to child abuse.

2. What can you do to comply with the procedure in your county for reporting child abuse?

3. Identify at least three symptoms of child abuse.

4. Identify at least three symptoms of neglect.

5. Pretend you are calling the caseworker and reporting a suspicious bruise on a foster child in your home. What would you say?

Notes

Providing a Nurturing Care Environment

(Parenting, Key concepts of Child Growth and Development, Discipline)

Knowledge:

Empathy

Empathy is the key to a nurturing and caring environment. Empathy means to put yourself in others shoes. We are asking you as the foster parents to understand and consider what many of these children have endured from their past biological or placement home. Many of them have been emotional and physically abused, which include but is not limited to being beaten, sexually assaulted, called names, abandonment, not being fed or nurtured properly and being left alone. The impact of abuse and neglect on children can cause many symptoms. Children may engage in behaviors such as bedwetting, self harming, being over aggressive, talking back, acting out in anger and sexually abusing other children. It is important to understand that these children cannot always be treated in the same way as your biological children, if you have any. One important way in which you cannot treat foster children as you might a biological child is with spanking. Foster children may not be physically disciplined in any way. In fact, most foster children are placed by court order, which includes an order prohibiting physical discipline of the foster child. While parents sometimes become angry or frustrated with their own children, it is important to always use a nurturing, caring tone with foster children. This can sometimes be difficult when it appears the foster child is doing everything they can to frustrate you. Surprisingly, sometimes foster children know they are frustrating you. Sometimes they are trying to recreate the conditions that existed in their biological home. If an adult treats them badly or physically disciplines them, their world will start to make more sense because that is the way they are used to being treated by adults. Yelling, threatening or physically disciplining the foster child will only traumatize them more and delay their ability to recover from issues of abuse and neglect. As a foster parent, you should remember to always give a message of acceptance towards the child when disciplining. For instance, "Johnny, I understand you are mad, I would probably be angry, too, if I were you. But just now, you threw that cup across the room, and that behavior is unacceptable."

Empathy, helpful hints

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Brainstorm three other reasons why you think empathy is important

1. _____
2. _____
3. _____

Helpful hints in initial placements

1. **Do not touch the child** (arm around shoulder, pat on head) unless it is initiated by the child. Touch means something different to children who have been abused and neglected. Wait until the child is comfortable with you before hugging the child or touching them.
2. **Orient the child** to your home, especially the kitchen/refrigerator, bathroom and bedroom.
3. **Offer the child something to eat and drink** – even if it is right before dinner. Sometimes children have not eaten in quite some time because of the crisis of placement.
4. **Help** the child put any belongings they brought with them into their room so the child can begin to establish some of their own space. Make sure there are no dangerous or inappropriate items in their belongings.
5. **Let the child know what he/she may call you.** Most foster parents suggest their first name. **DO NOT** request that the child call you mom and dad. This is confusing and disrespectful to the child who already has a family. If the child (usually young) initiates calling you mom and dad on their own, it is not necessary to discourage them. However, it is important that foster parents let the child understand that they know the child has a mother and a father.
6. **Let the child know the rules of the home.** A long list is not necessary. Anything a child can do or say can be captured under these three rules:
 - a) You (the foster child) need to be safe. You can't hurt yourself.
 - b) Everyone (including pets) need to be safe. No one can hurt each other.
 - c) This home needs to be safe; no one can hurt the house or yard.

Child Development, see Appendix C

Communication Disorders FAQ

What Is Meant by "Communication Disorders"?

The term *communication disorders* encompass a wide variety of problems in language, speech, and hearing. Speech and language impairments include articulation problems, voice disorders, fluency problems (such as stuttering), aphasia (difficulty in using words, usually as a result of a brain injury), and delays in speech and/or language. Speech and language delays may be due to many factors, including environmental factors or hearing loss.

Hearing impairments include partial hearing and deafness. Deafness may be defined as a loss sufficient to make auditory communication difficult or impossible without amplification. There are four types of hearing loss. Conductive hearing losses are caused by diseases or obstructions in the outer or middle ear and can usually be helped with a hearing aid. Sensorineural losses result from damage to the sensory hair cells of the inner ear or the nerves that supply it and may not respond to the use of a hearing aid. Mixed hearing losses are those in which the problem occurs both in the outer or middle ear and in the inner ear. A central hearing loss results from damage to the nerves or brain.

Many communication disorders result from other conditions such as learning disabilities, cerebral palsy, mental retardation, or cleft lip or cleft palate.

What Are Some Characteristics of Children with Communication Disorders?

A child with speech or language delays may present a variety of characteristics including the inability to follow directions, slow and incomprehensible speech, and pronounced difficulties in syntax and articulation. *Syntax* refers to the order of words in a sentence, and *articulation* refers to the manner in which sounds are formed. Articulation disorders are characterized by the substitution of one sound for another or the omission or distortion of certain sounds.

Stuttering or dysfluency is a disorder of speech flow that most often appears between the ages of 3 and 4 years and may progress from a sporadic to a chronic problem. Stuttering may spontaneously disappear by early adolescence, but speech and language therapy should be considered.

Typical voice disorders include hoarseness, breathiness, or sudden breaks in loudness or pitch. Voice disorders are frequently combined with other speech problems to form a complex communication disorder.

A child with a possible hearing problem may appear to strain to hear, ask to have questions repeated before giving the right answer, demonstrate speech inaccuracies (especially dropping the beginnings and endings of words), or exhibit confusion during discussion. Detection and diagnosis of hearing impairment have become very sophisticated. It is possible to detect the presence of hearing loss and evaluate its severity in a newborn child.

Students who speak dialects different from standard English may have communication problems that represent either language differences or, in more severe instances, language disorders.

How Many Children Have Communication Disorders?

The overall estimate for speech and language disorders is widely agreed to be 5% of school-aged children. This figure includes voice disorders (3%) and stuttering (1%). The incidence of elementary school children who exhibit delayed phonological (articulation) development is 2% to 3%, although the percentage decreases steadily with age.

Estimates of hearing impairments vary considerably, with one widely accepted figure of 5% representing the portion of school-aged children with hearing levels outside the normal range. Of this number, 10% to 20% require some type of special education. Approximately one-third of students who are deaf attend residential schools. Two-thirds attend day programs in schools for students who are deaf or day classes located in regular schools. The remainder are mainstreamed into regular school programs.

What Are the Educational Implications of Communication Disorders?

Many speech problems are developmental rather than physiological, and as such they respond to remedial instruction. Language experiences are central to a young child's development. In the past, children with communication disorders were routinely removed from the regular class for individual speech and language therapy. This is still the case in severe instances, but the trend is toward keeping the child in the mainstream as much as possible. In order to accomplish this goal, teamwork among the teacher, speech and language therapist, audiologist, and parents is essential. Speech improvement and correction are blended into the regular classroom curriculum and the child's natural environment.

Amplification may be extremely valuable for the child with a hearing impairment. Students whose hearing is not completely restored by hearing aids or other means of amplification have unique communication needs. Children who are deaf are not automatically exposed to the enormous amounts of language stimulation experienced by hearing children in their early years. For deaf children, early, consistent, and conscious use of

visible communication modes such as sign language, finger spelling, and cued speech and/or amplification and aural/oral training can help reduce this language delay. Some educators advocate a strict oral approach in which the child is required to use as much speech as possible, while others favor the use of sign language and finger spelling combined with speech, an approach known as *total communication*. There is increasing consensus that whatever system works best for the individual should be used.

Many children with hearing impairments can be served in the regular classroom with support services. In addition to amplification, instructional aids such as captioned films and high interest/low vocabulary reading materials are helpful. For most children with hearing impairments, language acquisition and development are significantly delayed, sometimes leading to an erroneously low estimate of intelligence.

Students whose physical problems are so severe that they interfere with or completely inhibit communication can frequently take advantage of technological advances that allow the individual to make his or her needs and wants known, perhaps for the first time.

Discipline

Foster children require unique ways of discipline that may be different than the way you disciplined your own children, if you have any. First of all, you cannot spank foster children. In fact, you cannot use any type of physical discipline at all with foster children. Spanking or striking a foster child could lead to child abuse charges and/or loss of your foster parent license. It is imperative that you understand you may not spank or strike foster children! In addition to the prohibition on spanking, Volume 7 rules state you may not use the following discipline practices:

7.708.35 Discipline

- A. The family foster care home or certifying authority shall have written policies and procedures regarding discipline that must be explained to all foster children, parent(s), guardian(s), staff, and placing agencies. These policies must include positive responses to a foster child's appropriate behavior.
- B. Discipline shall be constructive or educational in nature and may include talking with the foster child about the situation, praise for appropriate behavior, diversion, separation from the problem situation, and withholding privileges.
- C. Basic rights shall not be denied as a disciplinary measure.
- D. Separation when used as discipline must be brief and appropriate to the foster child's age and circumstances. The foster child shall always be within hearing of an adult in a safe, clean, well-lighted, well-ventilated room in the family foster care home that contains at least 50 square feet of floor space. No foster child shall be isolated in a bathroom, closet or pantry.
- E. Foster children in care at the family foster care home shall not discipline other foster children.
- F. A family foster care home shall prohibit all cruel and unusual discipline including, but not limited to, the following:
 - 1. Any type of physical hitting or any type of physical punishment inflicted in any manner upon the body of the foster child, such as spanking, striking, swatting, punching, shaking, biting, hair pulling, roughly handling a foster child, striking with an inanimate object, or any humiliating or frightening method of discipline to control the actions of any foster child or group of foster children.
 - 2. Discipline that is designed to, or likely to, cause physical pain.
 - 3. Physical exercises such as running laps, push-ups, or carrying heavy rocks, bricks, or lumber when used solely as a means of punishment.
 - 4. Assignment of physically strenuous or harsh work that could result in harm to the foster child.
 - 5. Requiring or forcing a foster child to take an uncomfortable position such as squatting or bending, or requiring a foster child to stay in a position for an extended length of time such as

standing with nose to the wall, holding hands over head, or sitting in a cross-legged position on the floor, or requiring or forcing a foster child to repeat physical movements when used solely as a means of punishment.

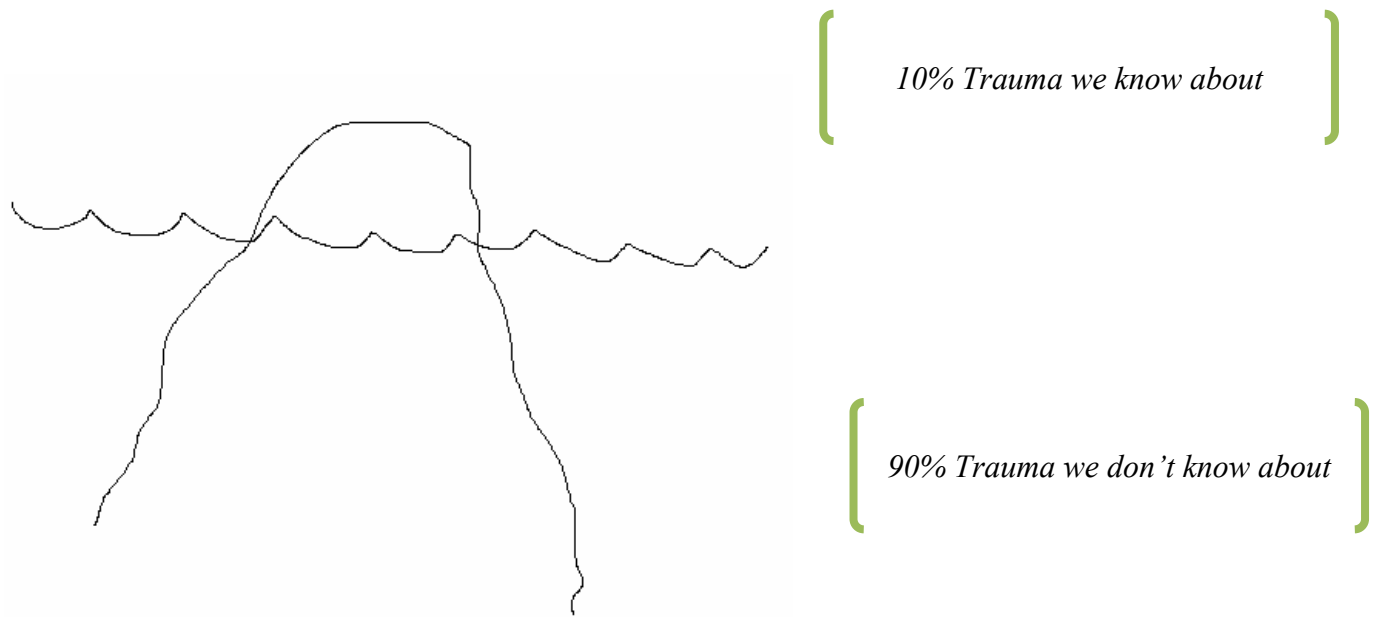
6. Verbal abuse or derogatory remarks about the foster child, his/her family, his/her race, religion, or cultural background.
7. Denial of any essential/basic program service solely for disciplinary purposes.
8. Deprivation of meals or snacks, although scheduled meals or snacks may be provided individually.
9. Denial of visiting or communication privileges with family, clergy, attorney, or caseworker solely as a means of punishment.
10. Releasing noxious, toxic, or otherwise unpleasant sprays, mists, or aerosol substances in proximity to the foster child's face.
11. Denial of sleep.
12. Requiring the foster child to remain silent for a period of time inconsistent with the foster child's age, developmental level, or medical condition.
13. Denial of shelter, clothing or bedding.
14. Withholding of emotional response or stimulation.
15. Discipline associated with toileting, toileting accidents or lapses in toilet training.
16. Sending a foster child to bed as punishment. This does not prohibit a family foster care home from setting individual bed times for foster children.
17. Force feeding a foster child.
18. Isolating a foster child in a locked room for discipline.
19. Use of physical or mechanical restraint as discipline for a foster child, including, but not limited to, the use of handcuffs, shackles, straight jackets, posey vests, ankle and wrist restraints, craig beds, vail beds, hospital cribs, and chest restraints.

7.708.36 Physical Restraint [Rev. eff. 1/1/07]

If a family foster care home uses physical restraint with a foster child(ren) in care in an emergency situation when the foster child is a danger to himself/herself or others, the family foster care home must be pre-approved by the certifying authority to conduct restraints and must be in compliance with all the rules concerning physical restraint as found at Sections 7.714.53 - 7.714.536. The family foster care home must notify the placing caseworker when a child is restrained.

When considering the type of discipline appropriate for foster children, it is helpful to imagine an iceberg. About 10% of the iceberg is visible above the surface. The other 90% remains hidden under the water. The visible 10% of the iceberg represents the abuse, neglect and other trauma that has been disclosed or is within the awareness of professionals working with the child. The hidden 90% is information that the child has not disclosed for any number of reasons: They don't know how to talk about it, they want to forget it happened, they are embarrassed that this happened to them, they don't trust the adults around them, they have deliberately made themselves forget, etc. When foster parents use discipline techniques that are similar to the ways in which these children have been traumatized, it can cause a number of reactions that include:

1. Physical acting out behavior
2. Physically acting the foster parent or another child in the home
3. Self-destructive behavior
4. Severe depression
5. Lack of trust



In order to comply with court orders, state rules and agency directives, as well as to care for the mental health needs of foster children, alternate discipline techniques are needed. Some techniques that are appropriate for foster children include talking with the foster child about the situation, praise for appropriate behavior, diversion, separation from the problem situation, and withholding privileges. Some helpful tips in discipline:

1. _____: Be sure you have the child's attention, Make one statement or request at a time, if possible, make your communication visual. Draw a chart with pictures or write a note, Sometimes have the child repeat back what they heard – be gentle in the request. "sometimes I'm not very clear – what did you hear me say?"
 - a. **Things that hinder communication:** Ignoring (not listening), Advising (giving a lecture), comparing (another child's behavior is better), criticizing (telling what is wrong with them), ridiculing/name calling (making fun of behavior), discounting (not recognizing importance of one's feelings/actions), analyzing (not understanding but arguing with an intellectual reason for why or how something happened), ordering (bossy), questioning (asking who, what, when or how so it feels intrusive), distracting (changing subject).
2. _____: Children may not know what they are feeling. Foster children may only be familiar with the feeling "mad". Help children verbalize what they are feeling.
3. _____: Have you ever noticed children modeling your behavior?
4. _____: SHOW them exactly what you have in mind. Here are the steps for doing that: Describe exactly what you want the child to do, Give the child a reason for doing it, Check that the child understands by asking them to repeat back to you what you are expecting them to do, Show, role-play, or practice with the child. Afterward, tell the child what they did correctly, Encourage each successful step. If the child seems unclear on what you are expecting, repeat all the steps above for what the child had trouble doing. Remember to encourage what the child did correctly.

5. _____ : Children under age 4 are curious and distractible. Use this curiosity when they are playing with something that is “off limits.” Redirect or distract them to another object.
6. _____ : Children need limits to be safe and feel secure
7. _____ : Pay attention to behavior you like and want to encourage, Be very specific in your feedback
8. _____ : This is a great way to influence a child’s behavior. Focus on the child’s strengths and abilities. Help the child develop courage and “can do” attitude. Be prepared for opposition. Often children in out-of-home placement have low self-esteem and have trouble feeling good about themselves and will try to prove you wrong.
9. _____ : Scolding, nagging and yelling are forms of attention – negative, but still attention. Children would rather have negative attention than no attention. The misbehaving child gets all the attention while the one playing happily gets ignored. If you ignore a behavior, be sure you can ignore it even if it escalates.
10. _____ : “First...then” statements let children know privileges are related to responsible behavior.
11. _____ : It can be frustrating when we ask kids to do something, and they just don’t do it.
 - a. Confrontation steps:
 1. Calmly tell your child what you expect them to do
 2. Give a reason why it needs to be done
 3. If the child does not comply, make a confrontational statement (“I” asked you to sweep the kitchen. Do it now!”)
 4. When making the statement, move close to your child and obtain eye contact, use a calm, serious, low voice.
 5. If the child continues to ignore your request, give a consequence
 6. Use a First/Then statement (if the child does not have a choice)
 7. Follow through with a consequence

Remember, auditory receptive language delay may make it difficult for some children to process in their brain what people are telling them or asking them to do. You need to determine whether they are ignoring you by choice or because of a disability. Ask the child to repeat back what they have heard and understood you say. Demonstrate for the child what you are asking and make sure they understand.

12. _____ : These are the “three C’s” of discipline. They are effective because they send the message that: 1. Children have CHOICES. They can choose to follow the rules and get along with people and then get to have privileges. 2. Choose not to follow the rules and choose not to have privileges and have CONSEQUENCES. 3. Children who live with people who CONSISTENTLY give them choices and consequences learn they can depend upon those people. They learn about thinking things through to their conclusion. They learn about making healthy choices. Children’s misbehavior often decreases because they know what is expected of them. They can stop pushing the limits because the limits have been made clear.

Practice Skills:

1. Pretend your partner is a foster child who just broke a rule by yelling and cussing. Practice responding in an empathetic manner.
2. Pretend your partner is a new foster child in your home. How can you show empathy for the child without touching them?

3. Why should you help foster children unpack and put away their belongings?
4. Name two things you can do to help a child with a communication disorder.
5. Determine an appropriate response to the following foster child behaviors:
 - a. Bobby, age 3, keeps sneaking his little brother's teddy bear each night.
 - b. Nancy, age 12, is upset because you won't let her watch her favorite TV show because it is past her bedtime. She threatens to run away.
 - c. Mary, age 11, is going through a phase where every time she is angry with you, she stomps off into her room and slams the door. You have repeatedly asked her not to slam her door.
 - d. James, age 14, hit another child in your home. As a consequence, he is not allowed to play his handheld game for two days. James says, "You can't take away my game! I brought that from home! I want to call my caseworker, NOW!"
 - e. Becky, age 11, steals from you and from your biological children.
 - f. Justin, age 13, doesn't follow your instructions and when he receives consequences, he refuses to do them.

Notes

Promoting Educational Attainment and Success

Knowledge:

Children are required to attend school until the age of 16 years. You should enroll your foster child in school as soon as possible, if necessary. Occasionally, a foster child will continue to attend the school they were attending while they were in their biological parent's home. It is not unusual for foster children to be behind in school, and/or to be designated for special education services. If a foster child is receiving special education services, they will have an Individualized Education Plan (IEP). These plans must be reviewed on a yearly basis. It may be necessary for you to attend school staffings to discuss the child's IEP, and advocate for services for the child. You should be careful about protecting the child's confidentiality in the school system. You can share information with the school regarding your child's behaviors and special needs, but you should be careful not to allow other children in the school to hear information about your foster child. Besides advocating for needed services for your foster child, there are some other things you can do to help the child be successful in school:

- 1.
- 2.
- 3.
- 4.
- 5.

Practice Skills:

1. Pretend you are in a meeting with the school and your foster child is struggling with reading. How can you advocate for the child? What services would you request?
2. Imagine your home. What would be the best area for a foster child to do homework?
3. What are some things you can say to a child who is nervous or scared about going to a new school?
4. Who could you recruit as co-advocate(s) if you believed your foster child was not getting adequate educational services from the school?

Notes

Meeting Physical and Mental Health Care Needs

Knowledge:

When a child is placed in your home, it is important that you get a physical exam and a dental exam as soon as possible. Your foster child should have a Medicaid card for medical services. You must have a physical exam scheduled within 14 days of placement, and a dental exam scheduled within 8 weeks. Call the caseworker when you schedule these appointments and let them know when they are scheduled. Give the caseworker a copy of the paperwork from the appointments and put a copy of them in the child's health passport. The health passport should contain the child's immunization record. Sometimes the immunization record is not in the health passport, especially if it is the child's first placement. You should obtain the record from the biological parent, the child's primary care physician, or the local health department. If you cannot obtain the child's immunization record, you will need to begin inoculations as if the child has not had any immunizations.

Helpful hints for the child's first medical appointment:

- 1.
- 2.
- 3.

Emergency Room Visits/Injuries:

Mental Health treatment:

Some other helpful hints:

- 1.
- 2.
- 3.
- 4.

Practice Skills:

1. Describe the best way to find lice in someone's hair.
2. What form should you request from a doctor so you can give your foster child over the counter medication?
3. List three types of therapy not allowed under Volume 7 rules.

Notes

Promoting Social and Emotional Development

Knowledge:

Social and emotional development impact the child's self-esteem. Lacking these skills can lead to lack of self-discipline and social rejection. Everyone has a need to belong, but some people do not have the skills needed to develop and maintain relationships with others. As foster parents, you can teach these skills to help foster children insure their future success. The goal is to help children develop self-discipline; the ability to control their own behavior and act responsibly, showing respect for oneself and others. Children develop self-discipline when adults have realistic expectations, set clear limits, and build positive relationships with each child. When children learn these skills, they show a growing confidence in their abilities, develop increasing self-control, and are able to develop and maintain friendships with other children, including children who are different from them. When developing these skills try using the strengths perspective. This is when you focus on the positive attributes of the children and not on the negative. In other words, praise them for good behavior and do not lose control when you see inappropriate behavior. Some parents constantly remind children about their past inappropriate behavior, making it difficult for children to move forward.

Abuse and neglect can impact the foster child in many different ways. Abuse can lead to head injury and brain damage, while neglect can lead to decreased brain growth and development. Drug exposure can also impact brain development and growth. As a result, you may discover your foster child lacks age-appropriate emotional maturity or social skills such as:

1. Poor problem solving ability.
2. Poor cause/effect understanding.
3. Poor play or social skills.
4. Low self-esteem.
5. Inability to discriminate between safe and unsafe situations/people.
6. Poor muscle tone and control.
7. Lack of coordination (accident prone).
8. Disability from abuse or withholding of medical treatment.

Appendix D in your workbook describes these effects in greater detail. Physical problems should be addressed with the child's medical provider. You may be asked to provide opportunities for the child to practice physical activities, such as walking up and down stairs, hopping, skipping, jumping, etc. Emotional issues should be addressed with the child's mental health provider. You may be asked to help the child with homework exercises suggested by the mental health provider. In addition to working with the medical and mental health providers as a team member, you can help the child learn social skills and support emotional development in the following ways:

Teaching problem solving skills:

Many children who come into care have not learned to solve problems in an appropriate manner. They may not have had the opportunity to solve problems (someone solved the problems for them), they may not have had appropriate problem solving modeled for them, and/or they may have observed or been encouraged to solve their problems in a violent, impulsive or unlawful manner. As a result, it is imperative that you teach children good problem solving skills. One of the simplest ways to teach these skills is a four step process:

- 1.
- 2.
- 3.
- 4.

This may sound very basic, but remember that our children may not have had the opportunity to problem-solve in this manner.

Teaching friendship skills:

Children who have not learned appropriate social skills generally have difficulty making or keeping friends. Some tips:

1. Teach children how to introduce themselves to others.
 - a. How to state their name clearly, shake someone's hand, maintain eye contact (be aware that in some cultures, eye contact is considered disrespectful).
2. Teach children how to make "small talk."
 - a. What topics are appropriate for casual conversations and which are not.
3. Teach children that arguments do not necessarily mean the end of a friendship.
4. Teach children how to appropriately end relationships.
 - a. You model appropriate relationship ending skills with the child when the child returns home.

Teaching appropriate expression of emotions

Even very young children can be taught to verbalize their emotions instead of acting them out physically. Below are some tips:

1. Label emotions for children.
 - a. During a neutral time after a tantrum or physical/verbal acting out period, talk with the child about what happened and name the emotion the child was experiencing.
2. Describe and practice the appropriate expression of the emotion the child was experiencing (ie., "I'm mad!" or "I need some time alone because I'm angry right now.")
3. Describe to the child the benefits of appropriately expressing emotions (people will see you as more mature, you are more likely to get extra privileges, you might make more friends, etc.).
 - a. Make sure your explanation is age-appropriate and contains information that is important to the child.

Other Correctives:

1. Infants
 - a. Provide consistency, predictability, structure
 - b. Play peek a boo
 - c. Give eye contact while feeding
 - d. Holding to enhance bonding
2. Toddlers
 - a. Provide consistency and structure
 - b. Encourage exploration within safe boundaries
 - c. Don't rescue in task performance unless requested by child

3. Preschool
 - a. Provide opportunities for child to initiate
 - b. Acknowledge child's feelings
 - c. Empower child to make choices
4. School aged
 - a. Provide win/win situations
 - b. Give choices

Life Skills

Many foster parents initially feel sorry for foster children and do not feel comfortable assigning chores to the child. Life skills are important for children at any age, and are especially important for older children, who may emancipate from foster care and live on their own. Assigning chores gives the foster child a chance to practice for when they are on their own. Teach the child how to dust, vacuum, clean a bathroom, wash, dry and fold laundry, wash dishes and other important tasks. Conversations with former foster children reveal some surprising tasks that these children never learned, such as how to mail a letter, how to look up information in a phone book, how to write a check, sorting laundry, and how to set up utilities or a telephone in an apartment. Even if your foster child will be returning home, it is still important that we teach the children these skills.

Praise

Praise is something that humans never outgrow. Even as adults, we appreciate it when our boss tells us we are doing a good job, even if it is something that is in our job description. The only difference between adults and children in this case is that children need a lot more praise than most adults. Practice finding ways to praise the child. Sometimes, parents forget to praise because the child is doing what they are "supposed" to be doing. Yet, adults don't mind getting praise for "just doing their job." Challenge yourself to catch your child doing things right, and give them praise for it. Children are much more likely to accept corrections when they know that their parents are also pointing out the right things they are doing. For foster children, who generally have low self-esteem, praise is vital. The Kindness Campaign has developed a list of 100 Ways to Praise Your Child. Verbal praise is one of the easiest and quickest ways to increase self-esteem and build a strong relationship with the child. Words such as, "Good job!" "Way to go!" "You do that well!" and "I'm proud of you!" impact the foster child tremendously.

Practice Skills:

1. What are three ways abuse and neglect can impact child development?

2. Practice teaching problem solving, teaching friendships or teaching appropriate expression of emotion with a partner pretending to be a foster child.

Notes

Valuing Diversity and Supporting Children's Cultural Needs (Individual Differences, Such as Ethnicity and Culture)

Knowledge:

There are some special considerations in fostering children who differ from foster parents in cultural or religious practices. You cannot force a child to attend religious services with your family, and you must provide a way for the child to attend the religious services of their choice. You must also provide opportunities to attend cultural and/or ethnic activities appropriate to the child. In general, you should consider asking the biological parent, child and caseworker for guidance in celebrating holidays and birthdays.

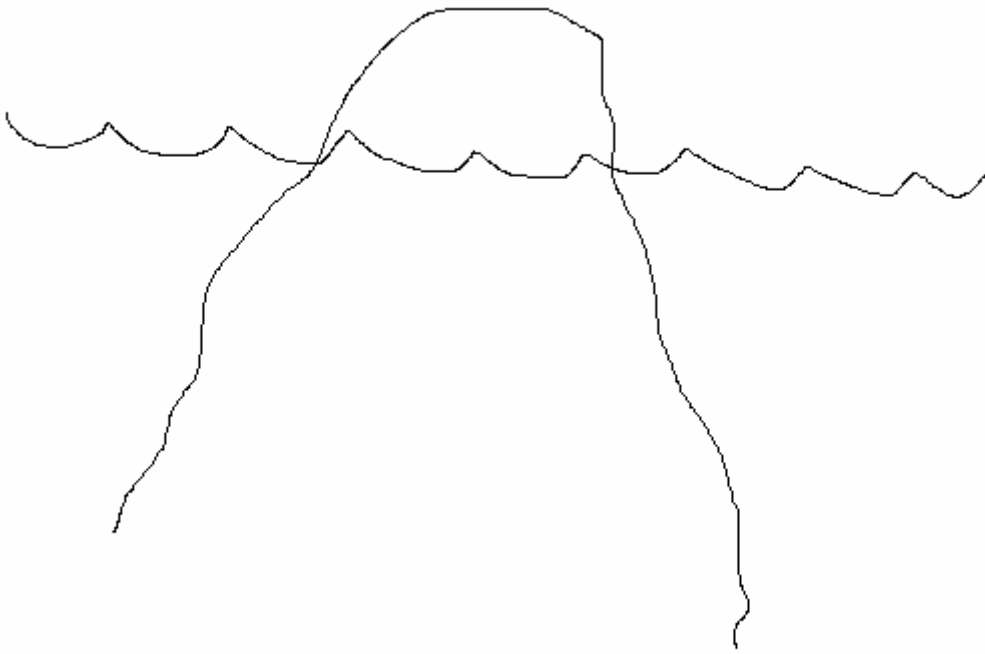
Identity Development

There are many theories about how identity develops in children. The following theory was taken from Lum, D. (2003). *Culturally Competent Practice: A Framework for Understanding Diverse Groups and Justice Issues*. Brooks/Cole: Pacific Grove, CA. There are four basic stages to identity development for people of color.

1. _____
 - a. Characterized by self-hatred of one's own ethnicity and strong desire to be accepted by members of the dominant social group. People in this stage generally suffer internalized stress in this stage.
2. _____
 - a. Anger is usually expressed outward at others, especially towards others of the dominant social group.
3. _____
 - a. In this stage, people turn toward their own culture as a source of strength and support. People in this stage begin to participate in the activities of their own ethnic and social group, reevaluate their identity and experience a lessening of anger.
4. _____
 - a. People in this stage continue to oppose prejudice and discrimination, but are able to distinguish between supportive and unsupportive members of the dominant society.

The Iceberg Theory of Culture

About 10% of an iceberg is generally visible above the water. In the same way, only about 10% of cultural differences are visible to us in everyday interactions. The 10% of visible culture tends to be those things that we "celebrate" when we celebrate cultural diversity. The hidden 90% of culture tends to be more problematic, and leads to tension and stress in relationships. Being aware of the hidden parts of culture can help you understand others better and prevent one from making assumptions about others' behaviors.



Some basic suggestions for physical differences:

Hair:

1. Use large tooth combs for curly hair.
2. To comb out tangles, start at the bottom and work your way up. Use a leave-in conditioner to moisturize the hair while combing, not water (water weakens the hair).
3. Use moisturizer, especially on African-American hair.
4. Use hydrating shampoos and moisturizers.
5. Shampoo African-American hair about every 5-7 days. Rinse with warm water and use a conditioner for days that you do not shampoo.
6. With all curly hair, use products with natural oil. Avoid products with petroleum or other pore-clogging products.
7. Never use plain rubber bands on any type of hair. Use covered bands and elastics.
8. For African-American and Asian children, use hair stylists who understand and know how to cut these different hair types.

Skin Care:

1. African-American skin can sometimes be drier than other skin types. Use a moisturizer daily. The best types of moisturizers are creams.
2. Treat darker skin with care, scars are more visible with this skin type.
3. Never use soap on facial skin, and apply a non-greasy moisturizer in the facial area.
4. Always apply a sunscreen with at least an SPF 15 on exposed skin when outdoors.

Some other issues:

1. Get permission before cutting or dyeing any foster child's hair. Be aware that some cultures, such as Native American, may need a ceremony before cutting their hair.
2. If you have a Native American child with a medicine bag, you should not open it if you suspect drugs or other contraband items unless you contact a tribal elder. They will tell you what to do so you can search the bag to ensure the safety in your home.

3. Some cultures rear children differently. It is not unusual for children of Hispanic or Asian cultures to not know how to tie their shoes or perform other self care tasks even after first or second grade.

Hearing problems:

1. Try to face the person when you talk to them.
2. If the person asks you to repeat yourself, try to say it in another way instead of repeating the same phrase louder and louder. (ex.: “Do you want to come with me to the store?” and “When I go to the store, would you like to come with me?”).
3. Don’t be afraid to let the person know they misheard you.
4. If you are interacting with a deaf person and do not know sign language, ask for an interpreter.
5. When talking to a deaf person through an interpreter, address the deaf person, not the interpreter.
6. When using TTY, speak to the operator in the same way you would speak to the deaf person. The TTY operator will type exactly what you say, so if you say, “Ask them if they would like to make an appointment for tomorrow,” that is exactly what the TTY operator will type.

Other disabilities:

1. Remember that a people who are blind or in a wheelchair are not necessarily deaf. It is not necessary to speak louder than usual to them.
2. Do not grab a blind person by the arm and attempt to direct them when walking. Always ask permission first.
3. Do not grab a wheelchair and steer the person to another place unless you have asked for, and received, permission to do so.
4. When speaking to a person in a wheelchair, it is helpful to sit down or squat so you are at eye level.
5. When speaking to a person with any type of disability, direct your comments towards them and look at them. Do not address a person who is accompanying them and expect that person to reply for the person with a disability.

Practice Skills:

1. Using the information from the beginning of this section, what are two ways that you can help a child move towards the fourth stage of identity development?
2. What three components of “hidden” culture in the iceberg theory were surprising or interesting to you? How can they help you when working with foster children or biological parents who are different from you?
3. List two ways you can take care of a child of color’s hair or skin.

Notes

Supporting Permanency Plans (Importance of the Team Approach)

Knowledge:

Permanency

Permanency is the ultimate goal for foster children. All children want a family and a place to call “home”. Foster parents provide a nurturing and caring environment until the permanency plan is achieved. Permanency could mean reunification; Other Planned Permanent Living Arrangement (OPPLA) such as with other relatives and non-relative; guardianship; adoption; and emancipation.

Biological Parents

Studies show that when foster parents work with the biological family, permanency goals are more likely to be met. There are many reasons why you should work with biological families: maintain family relationships; it gives foster children (and their families) hope; to model skills for parents; and to encourage parents, to build a relationship with the child. Maintaining the family relationship continues or enhances the parent/child bond. The relationship gives the parent and child hope that one day they will live as a family again. This hope is sometimes the only thing that helps parents to complete their treatment plan. Some other ways you can help the child and family by working with the parents are modeling parental skills during visits and encouraging parents by being concerned and respectful even if they are not respectful to you. With patience and time you may be able to save a friend and a fellow human being. In time, you may be able to form a lasting and lifetime relationship with the parents and their child or children. We will discuss working with biological parents in more detail later in this training.

Family Service Plan

This plan contains the goals and objectives for the entire family, which leads to permanency for the children. Once the plan is accepted by the court, it becomes a court order. It is very important that you participate in the creation of the family service plan, or read it thoroughly if it has already been created by the time the child is placed in your home. Most likely, you will be invited to a team decision meeting (TDM) to assist in the decision making process for this family. Remember you are now a part of the team, please attend and provide your input because it is important for the children and parents. Make sure you follow the visitation schedule and any goals or objectives set for the care provider (the foster parent) and the child.

Crisis situations and disruption

It is important that you keep the caseworker informed about the well-being of the child. You should complete a behavior log every day to document how the child is doing. Once a month, you should complete the monthly report and send it to the caseworker. Check with the caseworker to find out how they would prefer to be kept updated. Some caseworkers would prefer a phone call, an e-mail or a letter. Please do not wait until the child’s behavior becomes a crisis to inform the caseworker that there is a problem. When you call a caseworker in a crisis, you risk sounding unprofessional and unreasonable. Let the caseworker know when inappropriate behavior occurs so you can problem-solve together as a team. Disruption of placement is very undesirable because it disrupts the connection for the child and can cause psychological harm. Children who are consistently disrupted from foster homes develop a misunderstanding about the nature of relationships and how to end relationships appropriately. You can request increased therapy for the child, work with the caseworker and therapist on a behavior management plan, and sometimes you can even have family preservation services in

your home to maintain the placement of the child. Do not be afraid to ask for help if the child's behavior becomes upsetting to you.

Changes in your home

Keep the caseworker and/or your agency informed of any changes to your home. If you have a new foster child placed in your home, inform the caseworkers for the other children. If you have a friend or relative visit you for longer than a day, you should inform the caseworker. Depending on the agency and the person visiting you, it may be necessary for the person to undergo a background check. Be sure to also let the caseworker and/or agency know if you get a new pet, begin some type of construction to your home, add or lose family members in the home or if there is a family situation that may impact the child (such as a loss, separation, job change, etc.).

Appropriateness of Placement

One of your responsibilities as a foster parent and team member is to ensure you only take placements that are appropriate for your home. Taking children that are not a good fit for your family sets up a situation of failure for both you and the foster child. It is imperative that you think about your family and the type of child who may be successful in the environment you have to offer. Some issues you may want to consider are:

1. Do you have pets? If so, ask if the foster child is allergic to pets or abusive to animals.
2. What sort of behavior issues does the child have? Do you have the appropriate skills or training to handle those issues?
3. Do you have younger children in your home? If so, ask if the child is a sexual perpetrator or is abusive to younger children.
4. Do you currently have a child who is a sexual perpetrator or abusive to younger children? If so, you do not want to take younger children.
5. What sort of things do you and your family like to do for fun? Is it likely the foster child will also enjoy these things? You may not be able to obtain this information if it is an emergency placement, but having a conversation with the person placing the child may help shed some light on the foster child's interests.
6. Do both foster parents work? If so, what sort of arrangements will need to be made for the foster child, and can you afford to pay for these arrangements if necessary?
7. Will the child need to be transported to the home school, or can they be transferred to a school in your district? If they must be transported, can you meet the child's need?
8. Are there any health issues? If so, can you meet those needs?
9. Do you travel out of county on a regular basis? Do you have an out of state vacation planned? If so, ask if you can take the child with you. Sometimes, it may be better to pass on a placement instead of taking a child in crisis on a vacation.
10. What is the visitation plan? Can you meet the required schedule?
11. Is contact with the biological parent allowed?
12. Are there any other family members involved? If so, what is the contact schedule? Can you meet the required schedule?

This list is not all-inclusive. It would be a good idea for you to sit down with your family and have a discussion regarding what sort of children would work best in your home. For those foster parents who take emergency placements, we suggest you keep your questions on a notepad next to the telephone in case you receive a late night or early morning phone calls for placement when you may not be as mentally alert as you would be during the day. Sometimes, you will have the opportunity to have a pre-placement visit with a foster child. This will give you the opportunity to observe the child and their interactions with your family. You should be aware, however, that you generally will not be paid for any pre-placement visits, including an overnight visit.

Respite

It may be necessary at some point in your career as a foster parent to use respite services. Respite is a break for you and/or the foster child. Sometimes, respite is used when a foster parent must take an emergency trip out of state, or a planned vacation when the foster child cannot go with the family. Please be aware that respite should not be used as punishment. Respite should be used to enhance placement permanency, not to disrupt it. To send a child away when you are angry gives a message of rejection to the child. If you feel overwhelmed and need a break from the child, it is okay to use respite, but do not present it as a punishment to the child. An appropriate way of explaining respite to a child when you are overwhelmed is to say something like, “I know you have noticed that we have not been getting along too well recently. I’m sure you need a break and I could use one, too. You will be going to respite for a few days, and I hope you will enjoy it and get a chance to unwind. When you come back, we can sit down and see if we can work something out so we can get along a little better.” You may need to pay for respite services, so you should check with your child’s caseworker and/or agency.

Legal Responsibilities of Foster Parents

_____ : Foster parents have a legal responsibility to maintain confidentiality of the child and his/her parents’ identity and reasons for placement. Foster parents are bound by the same laws of confidentiality that govern caseworkers and attorneys. You cannot share information about the child or the child’s family unless you receive special permission in writing from your county department of social services. This includes your neighbors, best friend, and family members. You may share information about the child’s needs and/or problematic behaviors with the school.

_____ : Foster parents have a legal responsibility to report suspected child abuse and/or neglect to the county department of social services or local law enforcement agency as stated in the Colorado Children’s Code (19.3.304). Persons required to report child abuse or neglect. (1) Except as otherwise provided by section 19.3.307 and sections 12.1.122 (4) (d) and 25.4.1404 (1) (d), C.R.S., any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately report or cause a report to be made of such fact to the county department or local law enforcement agency... (3) In addition to those persons specifically required by this section to report know or suspected child abuse or neglect and circumstances or conditions which might reasonably result in abuse or neglect, any other person may report known or suspected child abuse or neglect and circumstances or conditions which might reasonably result in child abuse or neglect to the *local law enforcement agency or the county department*. 19.3.309. Immunity from liability – persons reporting. Any person, other than the perpetrator, complicator, coconspirator, or accessory, participating in good faith in the making of a report, in the facilitation of the investigation of such a report, or in a judicial proceeding held pursuant to this title, the taking of photographs or x-rays, or the placing in temporary custody of a child pursuant to section 19.3.405 or otherwise performing his duties or acting pursuant to this part 3 shall be immune from any liability, civil or criminal, or termination of employment that otherwise might result by reason of such acts of participation, unless a court or competent jurisdiction determines that such person’s behavior was willful, wanton, and malicious. For the purpose of any proceedings, civil or criminal, and good faith of any such person reporting child abuse, any such person taking photographs or x-rays, and such person who has legal authority to place a child in protective custody shall be presumed.

_____ : In Colorado, the county departments of Human Services invite providers of care and/or services for foster children to attend an administrative review of the case (in person or by phone). The children may also be invited to attend as determined by the caseworker. The county department shall notify all review participants at least two weeks prior to a scheduled review. This notification shall include date, time, location, and purpose of the review. The purpose of an administrative review is to determine if the county

department is in compliance with children's eligibility, out-of-home placement, level of care, core services criteria and that all of these services are in the best interest of the child. The administrative review is not a process for assessing the progress of the family involved in a D&N proceeding. The role of the foster parent is to answer any questions that the reviewer may address to them.

In some situations, when ordered by the court, an administrative review may substitute for a court review (paper review only). The county department submits a copy of the administrative review findings to the court along with the departments court report.

Out of State Travel: Foster parents who want to take foster children out of state for vacations must get a special letter from the caseworker that gives the child permission to travel with the foster family and allows them to obtain medical treatment for the child, if needed, during that travel.

Practice Skills:

1. Working alone or with your partner, create three questions to ask about a potential foster child to ensure appropriate placement.

2. List four things you can do to prevent disruption of placement.
 1. Ask for help
 2. Ask for help
 3. Ask for help
 4. Ask for help

3. Working alone or with your partner, make a list of support resources currently available to you. How can you develop additional resources?

Notes

Managing Ambiguity and Loss for the Foster Child and Family

Knowledge:

Foster children and their families generally go through a grieving process when the child is removed from the home. There are many different types of theories about grief and loss, and you are highly encouraged to seek specialized training in the grief process to help you work more effectively with foster children and their families. The following theory is by Elisabeth Kübler-Ross, and it is quite useful because it can be adapted to a variety of loss situations.

Referred to as “Honeymoon” of placement. Child is in denial of feelings and isolates from the reality of the loss – they are in shock. This is the easiest time for foster parents. Child acts like an angel and behave as they have been asked to behave. Children respond to requests but remember they are denying the loss. Some people think children would be glad to be placed – not true.

Foster parents often want to give up on the child. Children take their anger out on the foster parents by name calling or telling them awful things. It’s important for foster parents to remember the child is going through this process. Think about a time when you were angry and told someone directly. It was probably someone you could trust. One way to look at a child being angry at you during this stage is they trust you not to hurt them. Remember – they have lost everything – parents, siblings, pets, bed, pillow, school, friends, teachers, etc. Children who come from abusive homes usually have not learned ways to get angry. They may express anger by yelling, name-calling, swearing, hitting, and kicking. Your job is to help them express anger appropriately. They need to know it is alright to be angry – hurting others is not! Also – behavior is disciplined – not the anger!

Our suggestion is to discipline the child then talk to them after the anger has calmed down. You will need to provide safe ways to express anger: pictures kick soccer balls, pound clay, etc. If children aren’t allowed to vent anger, they will engage in other behaviors: smearing feces, self-mutilation, using drugs/alcohol, developing sleep disorders, etc. Sometimes, a child will transfer all the anger they feel about their parents, their caseworker, and their current situation onto the foster parent. While it is unfair, foster parents sometimes bear the brunt of a child’s anger. Remember to use your resources for support, remain professional and don’t take it personally when a child yells, cusses or states that they hate you or don’t want to be in your home.

The anger stage is a stage where there is a high risk for disruption of placement. Remember that disruption of placement is undesirable. It is extremely important that you work with the other team members for support and suggestions so you can help the child through this stage. Although at times it appears this stage will last forever, it WILL end, especially if you teach the child alternate ways to express their anger.

Often the child fantasizes about their life – may recant what they said or make up stories about the foster parents so they can return home. In the child’s mind they are not telling a lie. Children create fantasizes about their parents – dad is a jet pilot and mom is the best because she cooks their favorite meals every day. She cleans and drives them to school and is a doctor who knows how to take good care of kids. This can be frustrating as a foster parent – but remember this is a phase in dealing with their loss. This is also the stage where children may make false abuse allegations.

This can be very scary to workers, parents and the child. Think about your own losses – people tried to cheer you up when you were sad – it might have made you mad. It’s important for kids to know they will be accepted by you even if they are sad. They will learn they can be sad, experience it, and work through it. Be careful if the depression extends for several days or a sudden uplift of spirits occurs, the child gives away possessions or is engaging in self-destructive behavior call your caseworker! An assessment may need to be done to assess suicide potential. Do not try to handle this alone... if the child talks about wanting to die or kill themselves, call! Sometimes, it may be necessary to create a safety plan for the child in your home. While the plan is child specific, there may be some adjustments you need to make to your home, such as putting knives and tools out of reach of the foster child, or keeping the child in your line of sight at all times.

This is the acceptance of the change in the relationship. The experiences will never go away for the children. You’ll know the child is in this stage because they identify the limitations and strengths of their parents. Children need to have a reality of who their parents are instead of creating a fantasy of who they want them to be. Another way to know if the child is in this stage is when they anticipate planning activities with your family. “When do we get to go on vacation this summer?” “May I play football in the fall at school?”

Children’s ability to handle loss is directly associated with the frequency of being able to see their siblings and parents. Some foster parents don’t want the children visiting with their parents. They say it upsets the child. Although children get upset, it’s important for them to know their parents are alive, all right, and that they care about them. Visitation is also legally required unless the court has ordered no visitation. Children learn the reality of the capacities of their parents through visits. As painful as it may be for the child, experiencing their parents as they are is helpful to accepting substitute relationships.

Children’s ability to handle loss is also affected by the caregiver’s ability to give them the message that it is okay to have feelings. If you or these children get a message that having and expressing feelings are not acceptable, then the feelings get buried and the behavior becomes more intense and problematic. Children often develop psychosomatic illnesses and conditions. It is important that you realize that the children’s parents experience the same process. So, some of their anger may be directed at you also.

You can also read “**Helping Children Cope With Separation and Loss,**” by Claudia Jewett

Suicide

It can be scary when a foster child self harms or threatens suicide. You should take threats seriously. If you suspect a foster child may be suicidal, ask the child about their intentions. You will not “make” them think about suicide if they are not considering it. Some warning signs to watch for:

1. Previous suicide attempts, “mini-attempts”.
2. Explicit statements of suicidal thoughts or feelings
3. Development of suicidal plan, acquiring the means, “rehearsal” behavior, setting a time for the attempt
4. Self-inflicted injuries, such as cuts, burns or head banging
5. Reckless behavior. (Besides suicide, other leading causes of death among young people in New York City are homicide, accidents, drug overdose, and AIDS.) Unexplained accidents among children and the elderly.
6. Making out a will or giving away favorite possessions.
7. Inappropriately saying goodbye.
8. Verbal behavior that is ambiguous or indirect: “I’m going away on a real long trip,” “You won’t have to worry about me anymore,” “I want to go to sleep and never wake up,” “I’m so depressed, I just can’t go

on,” “Does God punish suicides?,” “Voices are telling me to do bad things,” requests for euthanasia information, inappropriate joking, stories or essays on morbid themes.

If you notice these signs, you should contact the caseworker, therapist and your agency right away. If the child states they want to hurt themselves, or if they have actively hurt him/herself, call 911, take the child to the local emergency room, or take the child to the local crisis center immediately.

Practice Skills:

1. List two ways of helping children cope in each phase of the grief cycle.
 - a. Anger

 - b. Bargaining

 - c. Depression

2. List three warning signs of suicide.

Notes

Growing as a Foster Parent—Skill Development and Role Clarification

Knowledge:

By taking the Foster Parent Core you have started your professional development as a foster parent. All of the training is very important for certification especially training on the Volume 7 rules and investigations. Once you have completed the core training you can use this workbook to refresh your memory.

Below are the general state requirements for training. Your county department of human services or private agency may require more hours than those listed here. Therapeutic foster care, division of youth services, and other specialized care sometimes require more hours. Please check with your agency to ensure you have the correct number of hours required.

Training: hours are for EACH parent

- 12 hours of Foster Parent Core
- 15 hours within 90 days of placement
- 20 additional hours by anniversary (47 total hours for first year)
- 20 hours a year to recertify after the first year

Additional Training

Try to obtain additional skills in parenting because foster children are sometimes more challenging than your biological children, if you have any. The discipline techniques you use with your children may not work with foster children. If possible, try to center your training on the specific type of foster child you are willing to take. By doing so, you will be more prepared to nurture and care for your placements with a little less stress. First aid cannot be counted as training hours.

Creditable Training

Obtain approval from your agency before you attend any training especially ones you must pay for. The best place to learn about other training is your agency and the Department of Human Services. Some agencies will allow you to read books, watch videos or attend college courses for training credit. Always check with your agency for approval before investing time and/or money in training.

Role Clarification

Your role as a foster parent is nurturing and caring for foster children, which sometimes consist of engaging in many roles. Check with your agency and the child's caseworker to clarify the roles the other team members expect you to take. Below are some typical roles you might engage in as a foster parent:

1. _____ – attend meetings, call people or engage in other activities to help the child and/or family access services.
2. _____ – ensure the child and/or family are able to get to appointments in a timely manner, coordinate the scheduling of services for the child and/or family.
3. _____ – teach coping skills to the child and/or parent.

4. _____ – communicate with caseworker and make suggestions regarding services the child and/or family may need.
5. _____ – between the child and family, the caseworker and family, the school and child, and the foster family and the biological family.
6. _____ – for services or compromise in difficult situations.
7. _____ – teach the child and/or family new skills.

Practice Skills:

1. Select one of the roles listed above and describe in detail two ways you would engage in this role.

Notes

Managing the Demands of Fostering on Personal and Familial Well-being

(Effects of Fostering on the Foster Family, family dynamics)

Knowledge:

There is no doubt that fostering families will become attached to foster children. Some of these children will be with you for six months to a year and maybe longer. Your family will miss them and the foster children will miss you and you will never forget each other. Therefore, you and your family need to learn creative ways to overcome the loss of foster children. This process is not easy whether your relationship was positive or challenging. Hopefully this section will give you some ideas on how to manage the loss of foster children and minimize disruptive effects of foster children in the family.

Building Relationships

Building a relationship with the biological parent or kinship is an effective way to manage your loss. Having a positive relationship with the family allows you to have on-going relationship with the child. Sometimes building this relationship is not easy because the parent and/or kin of the children are very frustrated with the social service system. To the family, you are a part of that system and most families will direct their frustration towards you. During this phase of resentment we encourage you to maintain focus on the reason why you are doing this regardless of how the family reacts towards you. Give it your best effort and try to communicate with the children parents and be persistent. You should not tolerate verbal or physical abuse from the family, however. If this occurs, communicate with the caseworker and work with them to create a plan that will keep you emotionally and physically safe.

Support Group

Some counties have support groups that you can join. Sharing your feelings and hearing other foster parents share their feelings may help you to manage your loss of foster children and frustrations in dealing with the child and/or family (if it occurs). If there are no support groups, talk to your agency or caseworker of the child. They may be able to assist you or refer you to someone.

Family Chat

Your family unity is a powerful and effective way to manage the loss of foster children or the managing of challenging behavior. Take time with your family and ask them to share their feelings, thoughts and suggestions about the child. Regular family meetings can identify issues early, before they become a crisis and while solving the problem is relatively easy.

Counseling

There is a stigma attached to receiving “mental health services.” Going to see a counselor does not mean that you are a failure; it means that you need to talk to someone that can help you to develop a plan to manage a challenging situation. All of us will have a need to talk to someone sooner or later. If you feel that you or your children are not coping with the loss of foster children or their challenging behavior issues, then seek counseling.

Typical Issues

While every foster child and foster family is unique, there are some typical issues that tend to develop in foster family homes. Below is a list of examples that may help you develop a proactive plan:

1. Foster child attends the same school as your children and tells other children in the school intimate details of your home.
2. Foster child steals from you and/or your biological child.
3. Your biological child is resentful of the time and attention the foster child requires from you.
4. Family and friends shower the foster child with gifts out of sympathy, and your biological child resents not being included in the gift giving.
5. Foster child acts out after visits or telephone calls from the biological family.
6. Foster child deliberately breaks valuable or sentimental items when angry.
7. Your biological child and the foster child argue constantly.

Investigations

One issue that strikes fear in the heart of a foster parent is an allegation of abuse or neglect. It is not completely atypical for a foster parent to have an allegation, although it is not extremely common, either. One in five allegations is usually founded by the department of human services. Sometimes, foster children are removed from the foster home until the investigation is complete. The caseworker and/or your agency may not discuss the investigation with you while it is on-going. There are some things you can do to minimize your chances of a false abuse allegation:

1. Document everything! If the child falls down or harms themselves in some way, make sure you note this in the behavior log. If it is a serious injury, fill out a critical incident report and get it to the caseworker right away.
2. Ask if the child has been known to make false allegations. If so, make sure it is documented in the file.
3. NEVER use physical punishment or any type of punishment designed to harm or degrade the child. For example, spanking, making them run in place (or laps) as punishment, making them take an uncomfortable position, swatting, slapping, or striking a child in any way or with any type of object.
4. Always provide the child with three meals a day, plus snacks. Don't use food as a punishment.
5. Keep the child under your supervision at all times. If the child is out of your home, ensure that there is a responsible adult who is supervising the child.
6. Do not allow foster children or your biological children to babysit foster children.
7. A vast majority of female children in foster care have been sexually abused. We recommend that you do not allow foster parents of the opposite sex to be left home alone with a foster child who has been sexually abused.

Sample chart of investigative process

Action	Description	Timeframe
Report alleging abuse, neglect or licensing violation received by Department of Human Services	Investigation launched	24 hours
Interview	Agent from Department of Human Services will visit your home to interview foster parent(s), the child alleged to be abused or neglected, and other people in the home. The foster child may be removed from your home while the investigation is being conducted. Foster parents may not be present when the child is interviewed.	24 hours
Notification to the licensing or certifying authority	The licensing or certifying authority of the foster home will be notified if the investigation indicates an immediate threat to the child's health, safety or welfare	Next working day
Investigation complete, findings	The outcome of the investigation can be confirmed, inconclusive, unsubstantiated, not confirmed or unfounded. Despite the outcome, a plan of action could be required.	24 hours to 60 calendar days
Plan of Action	The investigation could be referred for a Stage II investigation, there could be a referral for more training or services, or a referral to the licensing agency to correct licensing violations.	At the same time as, or immediately after the investigation is complete

Practice Skills:

1. Pretend your partner is a biological parent who is responding angrily to you. Practice responding in a non-judgmental, non-threatening manner.
2. Select two of the typical issues that develop in foster family homes. Develop a plan to handle the issues.
3. Make a list of people you can depend on for support (to listen) if you had an allegation of abuse or neglect in your home.

Notes

Supporting Relationships Between Children and Their Families (Working With the Biological Parents)

Knowledge:

As foster parents, you are required to work with biological parents. This will afford you the opportunity to build a relationship with the parents and help them to become better parents. This will also help the children and parents to maintain their bond with each other. Building a relationship with the family may help you to maintain a relationship with the child once they return home.

Help hints for Minimum Involvement:

1. Talk with child about feelings of missing the parent, help child with grief and loss
2. Provide progress reports about child through letters, school papers, and pictures
3. Help child with cards/gifts for parents on special days
4. Encourage parental participation in decision making by providing information about child to worker, requesting parental opinions, feedback through worker
5. Prepare child for visits, encourage child's open expression of feelings about visits when no contact with birth parents
6. Seek information about child from birth parent through worker
7. Share child by allowing child to spend special days with parents when requested
8. Refrain from demeaning child's parents to the child or others
9. Respect confidential nature of all information about the child
10. Allow/encourage post-placement involvement (cards, letters, and pictures)

Helpful hints for Moderate Involvement:

1. All of the minimum hints plus,
2. Allow/encourage phone calls between child and parent
3. Transport children to visits where limited birth parent contact may occur, such as agency
4. Allow/encourage visit in foster home with worker supervising visits
5. Invite birth parents to attend activities such as school conferences and functions, clinic appointments with child and foster parents
6. Allow/encourage similar post-placement involvement

Helpful hints for Maximum Involvement:

1. All of the minimum and moderate hints plus,
2. Allow/encourage unsupervised visits in foster family home or visits with foster parents as supervisors
3. Coordinate visitation arrangements as agreed in the foster care plan
4. Invite birth parents to participate in foster family activities such as picnics and birthday parties
5. Assist birth parents in development of parenting skills through teaching and modeling
6. Encourage birth parents to visit with foster parents when child is not in home
7. Transport child to visits in birth families home
8. Allow/encourage continued relationship with child/birth family post-placement

Practice Skills:

1. List one more hint for each of the categories above.
 - a. Minimum
 - b. Moderate
 - c. Maximum

Working as a Team Member (Importance of the Team Approach)

Knowledge:

_____ with the Foster Care Rules and Regulations.

_____ of accurate family profile, the number, age and gender of the children you are willing to take, the degree of difficult behavior and when you have vacancies.

_____ that will help you make a decision whether or not to take a placement.

If you cannot take a child, make a clear statement as to why. Maintain boundaries with clear reasons.

Assist the agency in coordinating pre-placement activities.

Ask the caseworker about the child's health passport and Medicaid card.

Check with the caseworker about which doctor and dentist you will need to contact for appointments. If the child has no established medical doctors, ask the caseworker to help you set up appointments.

Ask the caseworker how he/she prefers to coordinate the Behavior Log information so it gets to the child's file.

Once the child's D&N case has been adjudicated, talk to the caseworker about reading and signing the Family Service Plan. Before you sign it, you will want to coordinate with the caseworker the plans for transporting children to visits, therapy, and any other necessities.

Talk with the caseworker about how he/she would prefer you communicate with him/her regarding such things as problems in scheduling, difficulties with a child's behavior for which you need help, or questions about the status of the legal procedures. The caseworker may prefer telephone calls, notes in the mail, or email.

If you have difficulty communicating with the child's caseworker, you may contact his/her supervisor, or you might send copies of any written letters to the Caseworker. If you decide to have a child placed in your home, make a plan with the caseworker and supervisor. You may need to schedule a meeting with the caseworker and supervisor to resolve problems.

Contact your child's caseworker, therapist, or teacher for solutions to problems before they become a crisis. You are not expected to deal with everything alone. It helps to maintain professional demeanor if you are not in crisis.

_____ if you will be having contact with the child's birth family. Include observations in your Behavior Log. The Behavior Log is where you document behavior each day. It is important to note "normal" behavior in order to pinpoint when behavior began to change, or when changes in "poor" behavior begin to emerge. Many foster parents use a three ring binder to record information regarding behavior at school, physical aggression at home, addressing inappropriate behaviors or boundaries, accomplishments, and effects of medications

If the caseworker is planning to develop a Family Group Decision Making process for the birth family, ask if you may help. If contact with the birth parents becomes difficult, contact the caseworker immediately to change the plan.

Keep the caseworker informed of the child's progress or lack of with services.

As a foster parent, you are a member of a professional team that provides services to the child and/or biological parent. You will probably have many people visiting your home to check on the welfare of the child and to provide services. Some people you can expect to visit your home are your licensing agency, the family's caseworker, the Guardian ad litem, the Court Appointed Special advocate, and a mentor. Some of the visits will be scheduled with you and others will be unannounced. When someone you do not know comes to your home to see the child, you may ask for identification before providing access to the child.

You will be invited and are highly encouraged to attend the administrative review for a child placed in your home. The administrative review will be scheduled and a letter containing the date and time will be sent to you. If there is a conflict in your schedule, you should contact the Department of Human Services **IMMEDIATELY** to reschedule the meeting. You can appear in person, and in some cases you may be able to appear by phone for the administrative review. As a team member, consider how your actions could impact the outcome of the administrative reviews. In particular:

1. Does the frequency of visitation with mother/guardian adequately address the needs of the child to achieve the permanency goal?
2. Does the frequency of visitation with the father/guardian adequately address the needs of the child to achieve the permanency goal?
3. For a child with American Indian heritage, has the identified tribe of the BIA received appropriate notification that 1) an American Indian child is in need of foster care and/or 2) termination of the parent-child relationship is imminent?
4. For a child with a permanency goal of other planned permanent living arrangement, have other, more permanent goals been considered and appropriately ruled out for this child?
5. For a child with a permanency goal of other planned permanent living arrangement, is a family-like network of significant people being developed to provide life long connection?
6. For a child who is legally free for adoption, and whose goal is adoption, has an adoptive family been identified?
7. If siblings are not placed together, is it in the best interests of one or more of the siblings?
8. If placement change(s) occurred during the review period, were the reasons directly related to helping the child achieve the goals in his/her case plan?
9. Is there any indication through the face-to-face review, or written questionnaire, that the needs of the foster parents, as they relate to providing appropriate care and supervision to the child, are being addressed through appropriate services?
10. Did the child receive a medical exam, medical screening, or was a medical exam scheduled within two weeks of initial placement?
11. Did the child receive a full dental examination or was a dental exam scheduled within eight weeks of initial placement?
12. Has the child received regular health care, including immunizations, and/or treatment for identified health needs?
13. Has the child received regular dental care and/or treatment for identified dental needs?
14. Is the child currently receiving services that match his/her mental health needs?
15. During the review period, were mental health services provided without a waiting period or an interruption of services?
16. Is the child's education/school record, including name and address of current educational provider(s), report cards and/or other pertinent education information, in the case file?
17. Are the child's educational needs being addressed through appropriate educational services?
18. Is there a minimum of monthly face-to-face contact by agency personnel with the child?
19. Is there documentation of every other month face-to-face contact by agency personnel with the child in the facility where he/she is placed?
20. Did the child attend the administrative review, if appropriate?
21. Did the placement provider attend the administrative review?

Practice Skills:

1. List two people who might visit the child in your home.

2. Select two of the issues in administrative reviews above and list two ways you can impact each one of them.

Notes

Placement Checklist

- Health Passport
 - Medicaid card
 - Medical Authorization
 - Medication Authorization/Medication
 - Standing order for over the counter medications
 - Mental Health treatment information
 - Physical exam (within 2 weeks)
 - Dental exam (within 8 weeks)
- Placement Authorization
- Information regarding who the child is allowed to speak to on the telephone
- Information regarding visitation
 - Copy of treatment and visitation plans (detailed/specific)
- Current caseworker name and phone number
- Current GAL name and phone number
- Current CASA name and phone number, if assigned
- Child enrolled in school
- Inventory of child's belongings

Definitions of Abuse and Neglect

(from Colorado State Statute 19-3-303, Appendix F)

1. A. "Abuse" or "child abuse or neglect" means an act or omission in one of the following categories which threatens the health or welfare of a child:
 - I. Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence;
 - II. Any case in which a child is subjected to sexual assault or molestation, sexual exploitation, or prostitution;
 - III. Any case in which a child is a child in need of services because the child's parent, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. The requirements of this subparagraph (III) shall be subject to the provisions of section 19-3-103.
- B. In all cases, those investigating reports of child abuse shall take into account accepted child-rearing practices of the culture in which the child participates. Nothing in this subsection (1) shall refer to acts which could be construed to be a reasonable exercise of parental discipline or to acts reasonably necessary to subdue a child being taken into custody pursuant to section 19-2-201 which are performed by a peace officer, level 1, as defined in section 18-1-901 (3) (1), C.R.S., acting in the good faith performance of his duties.

EMOTIONAL ABUSE

Emotional abuse can be defined as parental behavior which leads to psychological as opposed to physical harm to the child. It is necessary to identify both the specific behavior of the parent and the resultant demonstrable harm or emotional disturbance to the child. Furthermore, parental behavior must be chronic and must take a variety of forms. Parents who persistently tell their children that they are evil, bad, or worthless, or that they are hated are emotionally abusing them. Other behaviors include threatening to send a child away or send the child to foster care or locking a child in a room, cellar, or closet for long periods of time. Dramatically scapegoating one child while favoring others is emotional abuse – for example, a parent who required one child to eat on the floor out of a dog's dish while giving the others especially good meals.

The kinds of symptoms emotionally abused children are likely to exhibit include bedwetting, difficulty sleeping, tics, low self-esteem, developmental lags, school failure, hyperactivity, aggressive behavior, bizarre behavior, and inability to form intimate relationships.

Some degree of emotional abuse probably accompanies most instances of physical abuse. In order to intervene in a case where emotional abuse is the only form of abuse, careful documentation must be made of parental behavior and consequent damage to the child. It continues to be an area where child protective agencies are reluctant to become involved and where intervention which may lead to the removal of the child from the abusive environment is rare. There have been only a small number of terminations of parental rights where emotional abuse has been the only complaint.

NEGLECT

Growth failure — inadequate or inappropriate nutrition

Abused and neglected children often are below average in height and weight and cognitive development. This is because a child's growth and development are highly sensitive to both physical and psychological stress.

There are three separate diagnoses under the more general condition of growth failure: **nutritional deprivation, failure to thrive, and psychosocial dwarfism.**

1. **Nutritional deprivation** occurs when a parent cannot or does not provide a child with adequate or proper food. These children may appear emaciated due to inadequate calories and dehydrated, or have a puffy face and feet and a large belly. Parents who intentionally starve their children in this manner are quite disturbed.
2. **Failure to thrive (FTT)** is a less extreme form of malnutrition and is a condition found in infants. The children's weights are below the fifth percentile; that is, when compared to the general population of their age, 95 percent of babies weigh more than they do. Frequently their length is shorter than average, too. Medical evaluation - is necessary to exclude defective digestion, heart disease, or metabolic disturbances, which can also lead to **FTT**.

We think that children with **nonorganic FTT** (not caused by a physical problem) may not grow because they are not fed enough or because they are not nurtured appropriately and experience parent figures as stressful. In some cases both causal factors are present.

A parent can fail to adequately nourish a child for a variety of reasons. He/she may not be aware of how much a child needs to eat and not feed the child enough. Sometimes a parent who has little money may dilute baby formula in order to make it go farther and thereby undernourish the child. Other times the parent's feeding techniques does not mesh with the child's pattern. For example, the parent may jiggle the bottle while it is in the baby's mouth or rock the baby excessively, preventing it from sucking.

Parents also fail to feed their infants inadequately when they do not care about them, they lack the attachment, or they feel hostile towards them or competitive with them. Those parents may be oblivious to cries of their infants, or the infants may not be very demanding and thus are ignored. In some cases the **FTT** infant is the third or fourth child in the family. The mother appears to lack the resources to give enough to all of the children, and the least demanding, the **FTT** infant, is overlooked.

In addition, some infants who develop **FTT** are difficult to feed. They may have a poor suck, they may not seem interested in food, or they may vomit or ruminate. These difficulties may arise from physical problems or be of psychic origin.

We think that there are also some infants who have adequate caloric intake but fail to grow and develop because of a hostile or stressful home environment. Such hypotheses are hard to validate because one usually relies upon parental reports about food intake, and these may or may not be accurate. However, we do have studies of institutionalized infant who were fed adequately but did not thrive because they lacked nurturing human contact.

Infants who have physical problems which may affect growth should be distinguished from those with psychosocial growth retardation alone. However, there may be a psychosocial component in **FTT** infants with medical problems because they are often more difficult to accept or love than normal children.

4. **Psychosocial dwarfism (PSD)**, also known as hypsomatotropicism, deprivational dwarfism, and abuse dwarfism, is a syndrome characterized by emotional deprivation, environmentally induced growth impairment, abnormally low growth hormone secretion, and a variety of behavioral disorders. These symptoms cease when the child is removed from their family environment. Psychosocial dwarfism has been diagnosed in children as young as 18 months and as old as sixteen, thus one of the ways it is differentiated from **FTT** is by the age of the group involved. Diagnostic clues of **PSD** are height below what one would expect for the height; bizarre eating pattern such as voracious appetite, indiscriminate

eating, or stealing of food. Abdominal distension and unusual thirst are also common. Pain insensitivity (agnosia) with or without a history of self-injury, night wanderings, and failure to sleep may also be found. The children may exhibit hyperactivity and/or extreme passivity with fatigue. Both enuresis and encopresis may be present. These children usually have disturbed interpersonal relationships, language delay, or immature speech patterns.

PHYSICAL NEGLECT

Physical neglect is failure to provide adequate shelter, clothing, and physical care (including adequate nutrition), leading to harm to the child.

To justify intervention, the condition needs to be chronic and have documentable harmful effects on the child. This type of neglect may in fact be a consequence of parental poverty rather than a lack of concern. The diagnosis of physical neglect is confirmed when adequate income is present or provided and the neglect situation persists.

To illustrate, if a parent continues to live in a dangerous and filthy house after being given money to move and spends the money on drugs or alcohol, the parent is being neglectful.

ABANDONMENT/ADEQUATE SUPERVISION

If parents walk out on their children, turn the children out of the house, or leave them alone for long periods of time, their behavior is regarded as neglectful. There is no hard and fast rule about when leaving children unsupervised is acceptable and when it is not. Factors which must be considered are the length of time the parent is away, the age and relative maturity of the child, whether the child must supervise younger children, whether an arrangement has been made for an adult to be "on call," and whether the parent can be contacted to return.

Nevertheless, there are some general guidelines which can be used in evaluating the risk of the situation. Children under three should not be left unsupervised. Children three to seven can only be left for brief periods. Children eight to ten might be all right for two to five hours provided there is someone "on call" for them. A child needs to be at least eleven or twelve to be capable of baby-sitting for younger children. However, there is likely to be sub-cultural variability in this area. Poor and minority children may be socialized by necessity to take care of themselves and others earlier and thus not become overwhelmed in situations which would traumatize a white middle-class child.

Parents may also be neglectful if they leave their children in the supervision of an adult who is likely to harm them or who is incapable of providing adequate care.

MEDICAL NEGLECT

Medical neglect is failure to provide adequate care for a child's medical problems. Although standards will vary from community to community, parents are defined as medically neglectful only when failure to provide the care results in serious or life threatening consequences for the child. Some parents may not attend to their child's medical needs because they fear they will not be able to pay the medical bills or because they do not fully understand the need for the care. It is the professional's responsibility to see that the family receives the medical benefits for which it is eligible, and see to it that the family understands the importance of the medical procedure. If when these conditions are satisfied, the parents still do not provide medical care, then they are being neglectful.

EDUCATIONAL NEGLECT

Educational neglect is failure on the part of parents to see that a child attends school (or an alternative educational setting): for example, a parent consistently fails to get the child up on time, dressed, etc., so that the child can get to school; or parents keeps a child home to baby sit or provide the parents with company so that the child falls behind grade level.

The situation is defined as educational neglect only when the child's behavior is under the parent's control. Therefore, it applies by and large to smaller children, under the age of eleven. With older children the situation might be more accurately defined as truancy.

Another prerequisite for the behavior to be defined as educational neglect is that it be chronic and frequent. The child must miss several days per month on a regular basis. What this means is that accurate documentation is crucial.

EMOTIONAL NEGLECT

Despite the fact that it is designated as reportable in many child protection laws, emotional neglect, like emotional abuse, is difficult to define. Thus very few cases which are purely emotional neglect are reported.

A general definition is failure to promise emotional support to a child necessary for its health and well-being, such as lack of adequate nurturance, the failure to provide appropriate social, and cognitive stimulation, and the failure to help the child with problems as with emotional abuse, it is necessary to document resultant harm to the child.

SEXUAL ABUSE

Children have been sexually misused and abused for centuries. Only recently have society and the helping professions been willing to recognize and deal with the problem. Most sexual abuse and misuse of children leaves no physical evidence. For example an adult masturbating a child would not leave any physical signs unless force was used. It is for this reason that a comprehensive social and psychological examination should be done.

There are some physical findings, however, that do raise the question of sexual abuse. The most obvious evidence of sexual abuse, and most frequently overlooked, is pregnancy in young females age ten to fourteen. Adolescent pregnancy is generally attributed to peer activity, and in most cases that is true. However, if the girl is very young and refuses to identify the father, or the family seems to be at a loss to explain the pregnancy, one should consider the possibility that it resulted from sexual relations with a family member or adult family friend. This person might be a father, brother, uncle, brother-in-law, or close family friend or acquaintance. One should ask the victim "Is there any chance you could be related to the baby's father?"

Genital infections in young girls should be considered evidence of sexual contact: gonorrhea, syphilis, venereal warts, and genital herpes are sexually transmitted. The disease organism in such cases has such a short life span outside a warm moist area (vagina, mouth, penis) that it is extremely difficult to be infected other than by direct sexual contact.

Signs of physical trauma such as bruises, lacerations, contusions, or bite or suck marks may be found on the inner thighs, genitals, or the anal region. Abnormal or bloody discharge from the vagina, penis, or rectum may also be symptomatic of trauma from sexual abuse.

A frequent concern in cases of suspected sexual misuse with females is whether sexual intercourse or vaginal manipulation can be documented. Unless there is actual trauma, it is extremely difficult to be definite because the tissue around the vaginal area can stretch some without injury. It is also difficult to determine what the vaginal area was like prior to the incident. In addition, through the process of activity, play, and sexual play, such as masturbation, children by themselves may change the appearance of their hymen and vaginal openings. They are however unlikely to hurt themselves in this process.

Behavioral signals of sexual abuse may include excessive masturbation, attempts at sexual interactions with peers and adults, and intimate knowledge about sexual matters beyond the child's developmental level.

Sexually abused children may also present with school failure, running away, and emotional disturbance. A child's report of being sexually exploited should be believed. It is extremely rare for a child to make up such a story. However, children may state that nothing happened when it did, out of shame to protect the perpetrator, or because they are afraid of what will happen if they tell.

Child Development Chart Normal Developmental Behaviors

	Cognitive	Psychological	Motor	Moral	Sexual
0-6 Months	Recognition of mother; no concept of past or future; reaches for familiar people or toys	Attachment to mother/ caretaker; totally dependent; totally trusting; learns intimacy.	Sucking; hands clenched/ grip; neck muscles develop; pulls at clothing; laughs/ coos.	None.	Erections possible; both sexes can be stimulated.
6-12 Months	Objects can be held in memory; learns through routines and rewards; recognizes name; says two to three words besides “mama” and “dada”; imitates familiar words.	Separation from mother; begins to develop a sense of self; learns to get needs met; trusts adults; stretches arms to be picked up; likes to look at self in mirror.	Rolls over; stands with support; creeps/crawls; walks with help; rolls a ball in imitation of adult; pulls self to standing position and stands unaided; transfers object from one hand to the other; drops and picks up toy; feeds self cracker; holds cup with two hands; drinks with assistance; holds out arms and legs while being dressed.	None.	Generalized genital play.
12-18 Months	Experiments with physical environment; understands the word “no”; comes when called to; recognizes words as symbols for objects (cat — meows); uses 10 to 20 words, including names; combines two words such as “daddy bye-bye”; waves good-bye and plays pat-a-cake; makes the sounds of familiar animals; gives a toy when asked; uses words such as “more” to make wants known; points to his or her toes, eyes, and nose; brings objects from another room when asked.	Early social development; egocentric; accepts limits; develops self-esteem (love from family); plays by self.	Creeps up stairs; gets to standing position alone; walks alone; walks backward; picks up toys from floor without falling; pulls and pushes toys; seats self in child-size chair; moves to music; turns pages two or three at a time; scribbles; turns knobs; paints with whole arm movement; shifts hands; makes strokes; uses spoon with little spilling; drinks from cup with one hand unassisted; chews food; unzips large zipper; indicates toilet needs; removes shoes, socks, pants, sweater	Fear of authority figures.	Continued generalized genital play.
18-36 Months	Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conversation with self and dolls; asks “what’s that?” and “where’s my...?”; knows 300 words at 2, 900 words at 3; understand a lot more than what they can say; gives first name; holds up fingers	Autonomy struggles; learns system of meeting needs; seeks adult approval; social development increases; points to things he or she wants; joins in play with other children; shares toys; takes turns with assistance; separation anxiety common (look for lack of separation anxiety in children who have endured	Can run, throw ball, kick ball, jump; goes up stairs with one hand held by adult; turns single pages; snips with scissors; holds crayon with thumb and fingers (not fist) but may ignore adults as they draw since they must concentrate; uses one hand consistently in most activities; rolls, pounds, squeezes, and pulls clay; uses spoon with little spilling; gets drink from fountain or faucet independently; opens door by turning handle; takes off and puts on coat with assistance; washes and dries hands with assistance.	Knowledge of preferences of authority figures.	Continued generalized genital play; early sex-role development; interested in potty behavior; touches and rubs own genitals, disinhibited — no sense of privacy; role playing to understand

	Cognitive	Psychological	Motor	Moral	Sexual
	to tell age; combines nouns and verbs “mommy go”; refers to self as “me” rather than by name; Egocentric: assumes you know what he/she knows; likes to hear same story repeated; may say “no” when means “yes.” Cannot incorporate a doll to represent themselves, but can use other objects in play that represent real life.	trauma)			what adults are doing, such as playing doctor.
3-5 Years	WIDE RANGE OF LANGUAGE SKILLS AT THIS AGE. Can conduct experiments inside head; cannot sequence; understands some abstract concepts: colors, numbers (but this DOES NOT mean they can tell you “how many times” – they can count tangible objects in a room, like chairs, crayons, etc.), knows shapes, time (NOT clock time but days, before/after, “naptime,” “bedtime”); understands family relations (baby/parent); can tell a story; has a sentence length of 4 to 5 words; has a vocabulary of nearly 1000 words; names at least one color; understands “tonight,” “summer,” “lunchtime,” “yesterday”; knows his or her last name, name of street on which he or she lives and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions “I hope”; understands basic concept of right	Can cooperate; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feelings (sad, jealous, embarrassed) but they are all or nothing, meaning a child can be angry at their parent one minute but once the parent apologizes feeling shift and all is good again; plays and interacts with other children; dramatic play is closer to reality, with attention paid to detail, time, and space; plays dress-up; Symbolic representation of self begins (can now use a doll or picture to represent themselves).	Swings/climbs; uses small scissors; jumps in place; walks on tiptoes; balances on one foot; rides a tricycle; begins to skip; dances; bathes and dresses; runs around obstacles; walks on a line; pushes, pulls, steers wheeled toys; uses slide independently; throws ball overhead; catches a bounced ball; skates; jumps rope; pastes and glues appropriately; skips on alternating feet; buttons and unbuttons large buttons; washes hands independently; blows nose when reminded; uses toilet independently; drawing improves and by 4 will trace and draw stick figures.	Self-esteem dependent on authority figures; follows peers’ fads; negotiates to get needs met. Rules very important. Protective of parents.	Generalized genital play (rubbing genitals until raw is <i>not normal</i>); masturbation to orgasm in females is possible; early experimentation; watches/asks about body functions; private parts and funny but also serious; gender identity established.

	Cognitive	Psychological	Motor	Moral	Sexual
	and wrong – punishment centered; at 4 can typically grasp truth vs. lie, but may confuse the difference between a lie and a mistake.				
6-9 Years	Can think using symbols; can recognize differences; makes comparisons; can take another’s perspective; defines objects by their use; knows spatial relationships like “on top,” “behind,” “far,” and “near”; knows address; identifies penny, nickel, dime; knows common opposites like “big/little”; asks questions for information; distinguishes left from right; able to separate fantasy from reality; improved sequencing of events. By 8, should be able to read a face clock.	Early close peer relationships; presence of well-developed defenses; develops identity outside family (school, friends); has likes and dislikes (food, friends, games); chooses own friends; plays simple table games; plays competitive games; engages in cooperative play with other children involving group decisions, role assignments, fair play. Egocentrism crumbles – suddenly question how others think of them.	Is increasing small muscle motor skills; cuts foods with a knife; laces shoes; dresses self completely; ties bow; brushes independently; crosses streets safely.	Has a conscience; refinements in moral development.	Defenses reduce experimentation, but some continues. Play house, wedding, family role play games.
10-15 Years	Can engage in inductive and deductive logic; neurons are present; understands hypothetical situations; conflicts with parents increase.	Increased autonomy struggles; increased focus on identity; focus on peer relationships; rebellious; often moody; romantic feelings; struggle with sense of identity; feels awkward or strange about his or her body; worries about being normal; frequently changing relationships.	Greater body competence (e.g., physical coordination); manual dexterity; growth patterns vary.	Moral development is legalistic; recognition of principles (e.g., justice); selection of role models.	Puberty; sex organs mature; males ejaculate and have wet dreams; both sexes able to masturbate to orgasm with fantasies; girls develop physically sooner than boys; may display shyness, blushing, and modesty.
16-21 Years	Uses formal logic (e.g., opposes racism); debates and can change sides of debate; understands probabilities; uses more flexible abstract thinking; examination of inner experiences; conflict with parents	Interest in relationships; solidifies personal identity; becomes goal directed; sometimes rebellious; increased concern for others; increased concern for future; places more	Heightened physical power, strength, and coordination.	Identifies with moral principles, rules, and limit testing; experimentation with sex and drugs;	Feelings of love and passion; development of more serious relationships; sense of sexual identity

	Cognitive	Psychological	Motor	Moral	Sexual
	begins to decrease.	importance on his or her role in life.		examination of inner experiences.	established ¹ ; increased capacity for tender and sensual love.

Effects of Abuse and Neglect on Infants and Toddlers

The following are typical consequences of abuse and neglect on the development of infants and toddlers:

Physical

- Chronic malnutrition of infants and toddlers results in growth retardation, brain damage, and, potentially, mental retardation.
- Head injury can result in severe brain damage, including brain stem compression and herniation, blindness, deafness, mental retardation, epilepsy, cerebral palsy, skull fracture, paralysis, and coma or death.
- Injury to the hypothalamus and pituitary glands in the brain can result in growth impairment and inadequate sexual development.
- Less severe but repeated blows to the head can also result in equally serious brain damage. This type of injury may be detectable only with a CT scan, and, in the absence of obvious signs of external trauma, may go unnoticed.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Shaking can result in brain injury equal to that caused by a direct blow to the head, and spinal cord injuries with subsequent paralysis.
- Internal injuries can lead to permanent physical disability or death.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, vision problems from untreated strabismus (crossing of the eyes), respiratory damage from pneumonia or chronic bronchitis, etc.
- Neglected infants and toddlers have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills.

Cognitive / Language

- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.
- Brain damage from injury or malnutrition can lead to mental retardation.
- Abused and neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay which can also affect social development, including the development of peer relationships.
- Maltreated infants are often apathetic and listless, placid, or immobile. They often do not manipulate objects, or do so in repetitive, primitive ways. They are often inactive, lack curiosity, and do not explore their environments. This lack of interactive experience often restricts the opportunities for learning.

Maltreated infants may not master even basic concepts such as object permanence, and may not develop basic problem-solving skills.

Psychosocial

- Maltreated infants may fail to form attachments to primary caregivers.
- Maltreated infants often do not appear to notice separation from the parent and may not develop separation or stranger anxiety. A lack of discrimination of significant people is one of the most striking characteristics of abused and neglected children.
- Maltreated infants are often passive, apathetic, and unresponsive to others. They may not maintain eye contact with others, may not become excited when **talked to or approached, and often cannot be engaged** into vocalizing (cooing or babbling) with an adult.
- Abused or neglected toddlers may not develop play skills, and often cannot be engaged into reciprocal, interactive play. Their play skills may be very immature and primitive.
- Abused and neglected infants often fail to develop basic trust, which can impair the development of healthy relationships.
- Maltreated infants are often withdrawn, listless, apathetic, depressed, and unresponsive to the environment.
- Abused infants often exhibit a state of "frozen watchfulness;" that is, remaining passive and immobile, but intently observant of the environment. This appears to be a protective strategy in response to a fear of attack.
- Abused toddlers may feel that they are "bad children." This has a pervasive effect on the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of healthy personality. Children may become chronically dependent, subversive, or openly rebellious.
- Abused and neglected toddlers may be fearful and anxious, or depressed and withdrawn. They may also become aggressive and hurt others.

Effects Of Abuse And Neglect On Development On Preschoolers

The following are common outcomes of abuse and neglect in preschool children:

Physical

- They may be small in stature, and show delayed physical growth.
- They may be sickly, and susceptible to frequent illness; particularly upper respiratory illness (colds, flu) and digestive upset.
- They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, awkward gait, lack of muscle strength.

- Gross motor play skills may be delayed or absent.

Cognitive /Language

- Speech may be absent, delayed, or hard to understand. The preschooler whose receptive language far exceeds expressive language may have speech delays. Some children do not talk, even though they are able.
- The child may have poor articulation and pronunciation, incomplete formation of sentences, and incorrect use of words.
- Cognitive skills may be at a level of a younger child.
- The child may have an unusually short attention span, a lack of interest in objects, and an inability to concentrate.

Psychosocial

- The child may demonstrate insecure or absent attachment; attachments may be indiscriminate, superficial, or clingy. Child may show little distress, or may overreact, when separated from caregivers.
- The child may appear emotionally detached, isolated, and withdrawn from both adults and peers.
- The child may demonstrate social immaturity in peer relationships; may be unable to enter into reciprocal play relationships; may be unable to take turns, share, or negotiate with peers; may be overly aggressive, bossy, and competitive with peers.
- The child may prefer solitary or parallel play, or may lack ageappropriate play skills with objects and materials. Imaginative and fantasy play may be absent. The child may demonstrate an absence of normal interest and curiosity, and may not actively explore and experiment.
- The child may be excessively fearful, easily traumatized, may have night terrors, and may seem to expect danger.
- The child may show signs of poor self-esteem and a lack of confidence.
- The child may lack impulse control and have little ability to delay gratification. The child may react to frustration with tantrums and/or aggression.
- The child may have bland, flat affect and be emotionally passive and detached.
- The child may show an absence of healthy initiative, and often must be drawn into activities; may emotionally withdraw and avoid activities.
- The child may show signs of emotional disturbance, including anxiety, depression, emotional volatility, self-stimulating behaviors such as rocking, or head banging, enuresis or encopresis, or thumb sucking.

The Effects Of Abuse And Neglect On School Age Children

The following are common outcomes of abuse and neglect in school age children:

Physical

The child may show generalized physical developmental delays; may lack the skills and coordination for activities that require perceptual-motor coordination. The child may be sickly or chronically ill.

Cognitive / Language

- The child may display thinking patterns that are typical of a younger child, including egocentric perspectives, lack of problem solving ability, and inability to organize and structure his thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on school work, and may not be able to conform to the structure of the school setting. The child may not have developed basic problem solving or "attack" skills and may have considerable difficulty in academics.

Psychosocial

- The child may be suspicious and mistrustful of adults; or overly solicitous, agreeable, and manipulative, and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms **about her family; may** exhibit "role reversal" and assume a "parenting" **role with the parent.**
- The child may not respond to positive praise and attention or may excessively seek adult approval and attention.
- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by peer expectations for performance, and may withdraw from social contact; may be scapegoated by peers.
- The child may experience severe damage to self-esteem from the denigrating and punitive messages received from the abusive parent, or the lack of positive attention in a neglectful environment.
- The child may behave impulsively, may have frequent emotional outbursts, and may not be able to delay gratification.
- The child may not develop coping strategies to effectively manage stressful situations and master the environment.
- The child may exhibit generalized anxiety, depression, and behavioral signs of emotional distress; may act out feelings of helplessness and lack of control by being bossy, aggressive, destructive, or by trying to control or manipulate other people.
- The child who is punished for autonomous behavior may learn that selfassertion is dangerous and may assume a more dependent posture. He may exhibit few opinions, show no strong likes or dislikes, may not be engaged into productive, goal-directed activity. The child may lack initiative, give up quickly, and withdraw from challenges.

The Effects Of Abuse & Neglect On Adolescents

The following are common outcomes of abuse and neglect in adolescents:

Physical

- The youth may be sickly or have chronic illnesses.
- Sensory, motor, and perceptual motor skills may be delayed and coordination may be poor.
- The onset of puberty may be affected by malnutrition and other consequences of serious neglect.

Cognitive / Language

- The youth may not develop formal operational thinking; may show deficiencies in the ability to think hypothetically or logically, and to systematically problem solve.
- The youth's thinking processes may be typical of much younger children; the youth may lack insight and the ability to understand other people's perspectives.
- The youth may be academically delayed and may have significant problems keeping up with the demands of school. School performance may be poor.

Psychosocial

- The youth may have difficulty maintaining relationships with peers. They may withdraw from social interactions, display a generalized dependency on peers, adopt group norms or behaviors in order to gain acceptance, or demonstrate ambivalence about relationships.
- The youth is likely to mistrust adults and may avoid entering into relationships with adults.
- Maltreated youth, particularly those who have been sexually abused, often have considerable difficulty in sexual relationships. Intense guilt, shame, poor body image, lack of self-esteem, and a lack of trust can pose serious barriers to a youth's ability to enter into mutually satisfying and intimate sexual relationships.
- Youth may display limited concern for other people, may not conform to socially acceptable norms, **and may otherwise** demonstrate delayed moral development.
- Maltreated youth may not be able to engage in appropriate social or vocational roles. They may have difficulty conforming to social rules.
- Maltreated youth may display a variety of emotional and behavioral problems, including anxiety, depression, withdrawal, aggression, impulsive behavior, anti-social behavior, and conduct disorders.
- Maltreated adolescents may lack the internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent and sometimes volatile mood swings.
- Abused and neglected youth may demonstrate considerable problems in formulating a positive identity. Identity confusion and poor self-image are common. The youth may appear to be without direction and immobilized.

- The youth may have no trust in the future and may fail to plan for the future. The youth may verbalize grandiose and unrealistic goals for himself, but may not be able to identify the steps necessary to achieve the goals. These youth often expect failure.

Appendix E – PLEASE BE AWARE THAT STATE RULES AND REGULATIONS ARE UPDATED REGULARLY! PLEASE ASK YOUR CASEWORKER FOR THE MOST CURRENT COPY OF THE RULES! A current copy can be obtained from your agency or on the web at:

[http://stateboard.cdhs.state.co.us:8008/CDHS/rule_display\\$.DisplayVolume?p_vol_num=7700](http://stateboard.cdhs.state.co.us:8008/CDHS/rule_display$.DisplayVolume?p_vol_num=7700)

These rules retrieved 5/29/07.

7.708 RULES REGULATING FAMILY FOSTER CARE HOMES [Rev. eff. 2/1/02]

All family foster homes must comply with the "Rules Regulating Family Foster Care Homes" and the "General Rules for Child Care Facilities".

7.708.1 TYPES OF FAMILY FOSTER CARE HOMES [Rev. eff. 4/1/05]

A. "Family foster care homes" are defined at Section 26-6-102, C.R.S., as a foster care home in which foster children are received for regular twenty-four hour care.

B. "Family foster care homes" are also defined in the this manual at Section 7.701.21 as follows: A family foster care home is a facility providing care and training for a foster child or children not related to the caretaker for regular twenty-four hour care, or a certified kinship care home. The number and age of foster children for which a license may be issued is determined by the following factors:

1. No foster child shall be placed in a foster home if that placement will result in more than four foster children in that home, or a total of eight children (foster and non-foster), or more than two children under two years of age, except in those instances in which the placement of a sibling group in a foster home would exceed the limits. If the placement of a sibling group results in exceeding the above limits, no other foster children can be placed in the home.
2. A family foster care home may serve a maximum of one foster child enrolled in Children's Habilitation Residential Program (CHRP) and 2 other foster children or 2 foster children enrolled in CHRP and no other foster children. Emergency placements will not exceed maximum established limits. Facilities that exceed established capacity at the time the rule takes effect will be grandfathered in; however, with attrition, capacity must comply with the rule.

FAMILY FOSTER CARE HOME (COUNTY OR CPA) MAXIMUM CAPACITY

CHRP	Non-CHRP	Total Children
1 2	3	
2 0	2	
0 4	4	

3. Family foster care providers who are serving foster children enrolled in the Children's Habilitation Residential Program (CHRP) waiver shall be in compliance with rules contained within the Department of Health Care Policy and Financing's Medical Assistance Manual at Section 8.508 (10 CCR 2505-10).
4. Family foster care may be provided to children from birth to 18 years of age and to those persons to 21 years of age who are placed by court order prior to their eighteenth birthday.
5. When a certified family foster care home only provides temporary emergency care for foster children, the home may be certified for up to six foster children with no more than two foster children, including the caretaker's own children, under two years of age. There can be no more than a total of six foster children in the home except in sibling placements. The number of additional foster children under six years of age to be cared for shall be specified on the certificate and in the home study. Such a family foster care home shall be designated as a receiving home. The designation shall appear on the certificate.
 - a. No foster child shall remain in that family foster care home at the receiving home rate longer than 90 consecutive days, in accordance with the requirements of Section 7.417.4.

b. The number of foster children to be cared for at the receiving home rate and any foster children to be cared for at the regular foster home rate shall be included on the certificate.
c. Each receiving home parent shall have two years experience as a foster parent, although the certifying agency may take into account other relevant education and experience.

d. Each receiving home parent shall complete 32 hours of on-going training every year as identified in his/her training development plan. This training shall include the following competencies.

- 1) Issues regarding emergency and crisis placement of children with unknown histories; and,
- 2) Dynamics of victimization issues, with emphasis on appropriate age and developmental levels; and,
- 3) Cultural, spiritual, and religious awareness, consideration for, sensitivity to, and tolerance of each child individually.

e. Because receiving homes are likely to have quick turn-over of the children in care, supervision and monitoring of the receiving home shall be carried out according to the following:

- 1) One face-to-face contact shall be made with the receiving home parent(s) at least every week when children are in placement in the home, with a minimum of two visits per month occurring in the receiving home.
- 2) Documentation of such contact shall be in the provider file, as well as in each file of all foster children in the home.
- 3) The purpose of the contact is to address any questions the receiving home parent has about the children in care, to observe child care when appropriate and to provide support to the receiving home parent.

f. A receiving home shall have a comprehensive annual evaluation, which includes a review of any critical incidents, any allegations of institutional abuse, and the skills, needs, and competencies of the receiving home parent(s).

6. A family foster care home may not be operated without a license or a certificate as required by law and Section 7.701.4 of these rules, and the number of foster children cared for in such facility may not exceed the number authorized by such license or certificate.

C. "Child specific foster care" is care where the foster child has a prior relationship to the foster parent(s).

D. "Kinship foster care" is the full time nurturing and protection of foster children by kin. Kin are relatives or persons ascribed by the family as having a family-like relationship. These relationships take into account cultural values and continuity of significant relationships. Certified kinship care is considered a form of out-of-home placement and a type of family foster care home.

E. "Whole family placement", also known as "shared family care", is a situation in which adult parent(s) and foster child(ren) are placed together in the home of a family trained to mentor and support the biological parents as they develop skills and supports necessary to care for their foster child(ren) and move toward living independently.

7.708.11 DEFINITIONS

A. "Certifying authority" means licensed child placement agencies and county departments of social/human services that have the authority to certify family foster care homes, including kinship care homes.

B. "County designee" is the representative of a county department designated by the county executive director to make certain key decisions regarding foster children.

- C. "Dangerous behavior" is behavior that poses a clear and present safety hazard to a foster child or to others.
- D. "De-escalation" is the use of therapeutic interventions with a foster child during the escalation phase of a crisis. The interventions are designed to allow foster children to contain their own behavior so that acute physical behavior does not develop which would lead to the need for use of a physical restraint.
- E. An "emergency situation" is one in which a foster child is in actual danger to him/herself or others, or when there is a present danger of extensive property damage.
- F. "Escalation" is an increase in intensity of a foster child's out-of control behavior.
- G. The "Family Service Plan" is a case services plan completed by a county caseworker jointly with the foster child, parents, and foster parents within 60 calendar days of placement for each foster child receiving services from a county department of social/human services.
- H. "Mechanical restraint" means the use of devices intended to involuntarily restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention or accidental injury.
- I. "Physical restraint" is the physical intervention by a foster parent(s) in an emergency situation to limit, restrict, or control the dangerous behavior of a foster child by means of physical holding of the foster child. Physical restraint does not include the holding of a foster child for less than five minutes for protection of the foster child.
- J. "Reasonable", as used in these rules, means appropriate and suitable, not excessive or extreme.
- K. "Religion", where used in these rules, includes traditional religious beliefs and spiritual beliefs such as those of Native Americans.
- L. "Therapeutic services" means a program of foster care that incorporates treatment for the special physical, psychological, or emotional needs of a child placed with specially trained foster parents.

7.708.2 REQUIREMENTS FOR CERTIFICATION OF FAMILY FOSTER CARE HOMES

7.708.21 Character, Suitability, and Qualifications of Family Foster Parents [Rev. eff. 12/1/05]

- A. A certificate shall be denied in accordance with Section 7.500.312, D.
- B. Each foster parent in the family foster care home shall demonstrate an interest in, and a knowledge of, foster children and a concern for their proper care and well-being.
- C. A certificate may be denied or revoked if the foster parent(s)' own children have been placed in foster care or a residential treatment facility under circumstances which demonstrated that the foster parent or another resident of the home was abusive, neglectful, or a danger to the health, safety, or well-being of those foster children.
- D. The family foster care home parents shall be able to provide for a foster child's physical, mental and character development.
- E. Applicants shall demonstrate stability in family relationships within the home where family foster care is to be provided.
- F. The licensing or certifying authority must receive at least three written statements which describe the applicant's character, interpersonal relations, and ability to provide care for foster children from references provided by the applicant, at least two from a source/person who are not related to the applicant and who have known the applicant one year or longer (references need not be residents of Colorado). Licensing or certifying representatives may contact others who may have knowledge or information regarding the applicant's character or suitability.
- G. The foster home parent shall possess basic knowledge of child care and good nutrition, and shall cooperate with the licensing or certifying agency in programs designed to increase such knowledge.
- H. Licenses or certificates shall not be granted to applicants who are less than twenty-one years of age on the date of application for such license or who lack adequate physical stamina to care for children.

I. The financial resources of foster parents shall be adequate to assure that the home where the care is provided is maintained in safe repair and in conformity with standards and that the requirements of these regulations can be fulfilled.

J. A license or certificate shall not be granted for a family foster care home unless the applicant has demonstrated the ability to manage a household so that the licensing or certifying authority may determine that the applicant is able to acquire food, materials and other equipment as may be required for child care and to maintain records pertaining to foster children, including records required by statute or regulations.

K. Each foster parent shall have a health assessment within one year prior to certification or within 30 calendar days after certification and thereafter as required, in writing, by a licensed health care professional. The reports of the medical examinations shall be dated and signed by the examining physician or nurse practitioner and shall be provided to the certifying authority. Reports shall include a statement of the evaluation of the person's physical ability to care for foster children.

If, in the opinion of the licensed health care professional or the assessment worker, an emotional or psychological condition exists which would have a negative impact on the care of foster children, the issuance of a license shall be conditioned upon the satisfactory report of a licensed mental health practitioner.

L. Children of the foster home parents and any other persons not placed by the agency and living in the family foster care home shall obtain a medical statement from a licensed health care professional verifying that each such person suffers from no illness or communicable disease which would adversely affect foster children in care. This statement shall be obtained annually or as required in writing by an approved health care professional. A licensed health care professional is defined as a physician, nurse practitioner, or a physician's assistant. This statement shall have been signed within the twelve-month period preceding the original license or full certificate granted to the home.

7.708.22 Physical Requirements for a Safe and Adequate Family Foster Care Home

A. Licensing or certifying representatives are authorized but not required to consult the state or county department of health regarding sanitary standards and to consult local fire departments regarding questions of fire safety. A license or certificate may be denied or revoked in the event an applicant or licensee refuses to permit an investigation by these authorities if requested by a licensing or certifying representative, or if such authority advises that a license or certificate not be issued.

B. The following shall be required of all family foster care homes:

1. There shall be an outdoor play space free from hazards of not less than 75 square feet per child in care who is between 12 months and five years of age. This area shall be fenced or otherwise protected. If the area is not fenced, outdoor play shall be supervised by the foster care provider or designee and a specific plan for how safety is to be assured shall be documented in the case file.

2. The presence of firearms and ammunition is strongly discouraged in any home in which foster children are cared for. Any weapons such as firearms, air rifles, bows, hunting knives or hunting sling shots shall be unstrung and unloaded at all times when foster children are in the home and shall be stored in locked containers out of the reach of foster children. Ammunition and arrows shall be stored in separate locked containers. Firearms which are solely ornamental are excepted from the storage requirement. Weapons shall not be transported in any vehicle in which foster children are riding unless the weapons are made inoperable and inaccessible. Law enforcement professionals are exempted from the requirements of this section if conditions of their employment require them to carry weapons.

3. At least 35 square feet of usable indoor space exclusive of halls, baths and sleeping area shall be available for each child. However, when a sibling group is placed together in a single foster home, a variance from the minimum space standards is permitted. All floor space shall have carpets, tile or smooth finish which may be easily cleaned. Interior walls shall be constructed of

solid material and be free from holes. Unfinished basements must be inaccessible to foster children when safety hazards are present.

4. Exterior doors shall be maintained in such a manner which would permit easy exit. Interior doors shall be designed to prevent children from being trapped.
5. A basement which will be used regularly in the care of children in any manner shall be equipped with more than one exit; such exit may be an accessible window. See Section 7.708.31, G, for additional requirements for nighttime care.
6. The home shall be equipped with refrigeration, and provisions shall be made for the washing, rinsing and storing of dishes in a safe and sanitary manner.
7. Toys and outdoor play equipment meeting the requirements of Section 7.708.31, F, 2, a, shall be available.
8. A comfortable bed, cot or crib in a clean, well-ventilated room, which is not customarily used for other purposes such as a kitchen, dining room, hall or bathroom, shall be available for all children in the home, including birth or adoptive children or foster children. There shall be a minimum of 40 square feet of floor space for each foster child's bed, and the beds should be placed at least two feet apart when arranged in parallel.
9. No family foster care home shall be used for a rental income business or an adult foster care facility. A business of a nature which might be hazardous to the health, safety, morals or welfare of foster children shall not be operated on the premises of the foster home.
10. Mobile homes used as foster homes shall have at least two exits, be skirted and properly installed and stabilized.
11. Safety issues related to swimming pools shall be assessed by the certification worker, addressed by the county or state health department as necessary, and documented in the case file.
12. If there is a trampoline on the foster home property, safety issues regarding its use must be agreed upon with the foster parents and addressed in writing in the case file.

C. A certificate shall be denied, suspended, revoked or made probationary for failure to repair or otherwise comply with any of the preceding requirements when a defect or noncompliance with such requirement has been noted by the licensing or certifying representative and brought to the attention of the licensee or applicant in writing.

7.708.23 Foster Home Site

- A. The family foster care home must be located in an area that is accessible to health resources, public and private utilities, adequate and safe water supplies, sewage disposal, and fire and police protection.
- B. The family foster care home must comply with local zoning department requirements.
- C. The entire premises of the family foster care home are subject to inspection for licensing or certification purposes, including, but not limited to, the residence where care is to be provided, the grounds surrounding the family foster care home, the basement, the attic (if accessible), any storage buildings, and a garage or carport, if applicable.
- D. The family foster care home, including indoor and outdoor space, shall be maintained in a clean and safe condition free from hazards to health and safety.

7.708.24 Foster Home Maintenance

- A. The family foster care home shall be kept in good repair and maintained in a safe, clean, and sanitary condition.
- B. All areas of the family foster care home available to foster children's activities including equipment, materials and furnishings shall be of sturdy, safe construction, easy to clean, and free of hazards, such as

- sharp points or corners, splinters, protruding nails, broken play and recreational equipment, or paint that contains lead or other poisonous materials and might be dangerous to the life or health of foster children.
- C. All areas of the family foster care home shall be kept free from accumulation of significant amounts of non-essential materials such as furnishings, newspapers, or magazines that could pose a fire or health hazard.
- D. Provision shall be made for collection, storage, and disposal of trash to prevent infestation by rodents.

7.708.25 Fire Safety

- A. Fire hazards, such as defective electrical appliances and electric cords, dangerous or defective heating equipment or flammable material stored in such a manner as to create a risk of fire shall be corrected or eliminated.
- B. The family foster care home shall contain at least one U.L.-approved fire extinguisher, highly visible, easily accessible, and in working condition, weighing not less than five pounds, that has a rating of 2A, 10BC. This requirement may be waived if more extensive fire-control measures are required by a local fire department.
- C. A smoke detector, in working condition, must be installed on each level of the family foster care home and near sleeping areas.
- D. No gas space heaters, open-flame gas or oil stoves, hot plates, or un-vented heaters shall be used in the family foster care home for heating purposes. No electric space heaters shall be used in the family foster care home for permanent heating purposes.
- E. Flammables, aerosol paints, insecticides, chemicals, and other dangerous materials shall be locked or stored so they are inaccessible to foster children and must be stored in areas separate from sleeping or living areas. Flammables shall be stored in an approved container.
- F. Heating devices such as radiators, registers, fireplaces, wood-burning stoves, and steam and hot water pipes that pose a fire or burn hazard to foster children shall be screened or otherwise protected.
- G. Flammable material must not be stored near a furnace, hot water heater, or other heating device.
- H. There shall be no candles or other burnable objects permitted in foster children's sleeping areas. Foster children shall not be permitted to smoke in sleeping or storage areas.
- I. Exit doors shall be clearly identified to all foster children. No lock or fastening to prevent free escape from the inside of any room used by the foster children shall be permitted.
- J. Exit routes shall be kept free of discarded furniture, furnishings, laundry, and stacks of newspapers or magazines that could interfere with the prompt evacuation of the family foster care home.

7.708.26 General Comfort and Safety [Eff. 2/1/02]

- A. All hazardous chemicals, tools, and other equipment, including matches, plastic bags, paints, gasoline, medicines, insecticides, and cleaning and laundry materials, shall be stored out of reach of young foster children. Products which could cause poisoning or contamination shall not be stored in areas where food is stored or prepared.
- B. Water from any source other than a regular municipal water supply shall be tested annually for compliance with water quality requirements. (Sterilized containers for free laboratory tests of drinking water may be secured from the county health department or by writing to the Colorado Department of Public Health and Environment, 4210 East 11th Avenue, Denver, Colorado 80220.)
- C. The family foster care home shall be equipped with adequate light, heat, ventilation, and plumbing for safe and comfortable occupancy.
- D. The family foster care home must be equipped with hot and cold running water.
- E. All stairways containing more than four steps shall be equipped with a handrail.

F. The family foster care home shall have immediate access to a working telephone, and emergency numbers shall either be posted near the telephone or be immediately available, including those related to medical care, fire, law enforcement, and poison control where available. Numbers for the agency or person having legal custody of each foster child shall also be readily available.

7.708.3 REQUIREMENT FOR THE ONGOING OPERATION OF FAMILY FOSTER CARE HOMES

7.708.31 Care of Foster Children [Rev. eff. 4/1/05]

A. Foster parents shall provide supervision and care appropriate to each child's age, level of development and ability to accept independence and responsibility.

B. Within 24 hours of arrival at the family foster care home, a foster child shall be given an orientation to the home, consistent with the foster child's age and ability to participate, which includes at least the following:

1. Tour of the home and instruction on fire alarm and fire evacuation procedures, escape routes and exits.
2. The rules/regulations of the home.
3. Procedures affecting the foster child's behavior, including limiting or restricting a foster child's rights where allowed, the type of discipline used in the family foster care home, and consequences for certain behaviors.
4. The complete foster children's rights and foster children's grievance procedures as developed by the family foster care home or by the certifying authority.

C. At any time when foster parents are unable for any reason (including, but not limited to, illness or temporary absence from the home) to provide supervision and care, they shall arrange for a qualified substitute who is familiar with these rules and with the foster children in care to provide temporary supervision and care to the foster children in the child(ren)'s identified family foster care home. If in care for up to 6 hours, it is preferable that the provider of substitute care be at least sixteen years old. Exceptions based on age and maturity can be made with concurrence of the foster parent and the certifying authority, but in no case should the provider of substitute care be less than 14 years of age. If care is provided for more than 6 hours including overnight and respite care, the substitute care provider must be at least 18 years of age, trained in first aid and CPR, and must have completed the following background checks:

1. Colorado Bureau of Investigation (CBI)
2. State Department's automated system.

Waivers to these requirements may be requested by filing an appeal and receiving approval from the Colorado Department of Human Services' designated appeal panel. Waivers must be documented in the provider and foster child's record.

D. Respite care for a foster child(ren) in a certified foster home, other than the foster child(ren)'s identified foster home, that exceeds the license capacity of the foster home, shall occur for short term temporary relief of the foster parent(s) for not more than seven (7) consecutive days per month not to exceed 28 days in a calendar year. During the time when respite care for a foster child(ren) is occurring, the respite home may not exceed six (6) foster children or a maximum of eight (8) total children with no more than two (2) children under two years of age. The respite home must be in compliance with all other applicable rules for family foster care homes.

E. Care shall include the requirements of the following sections, numbered F through I.

F. Health Care

1. Suspected mental or emotional disorders which are observed by foster parents shall be reported to the certifying authority and the child's caseworker so that appropriate care may be obtained.

2. Where pets or other animals are present, additional precautions shall be taken as required to insure both safety and good hygiene. Dogs and cats shall be vaccinated as required by State law or as designated by a veterinarian. Foster children shall not be permitted to mistreat animals. Any animal that poses a threat to a foster child's safety or health must be confined in a place away from the foster child(ren).

G. Home Environment and Family Activity

1. It is the purpose of family foster care to provide constructive family living experiences for foster children during the period of placement.
2. Daily activities shall be designed to encourage normal physical, mental, social and emotional development of foster children. This requirement shall be met in the following manner:
 - a. Materials and equipment appropriate for the age of foster children in care shall be available for both active and quiet play.
 - b. An effort shall be made to provide for contact and friendship between children in foster care and other children of a comparable age. Opportunities shall be provided for both group and individual play.
 - c. Foster children shall be encouraged to relate or to communicate with each other and with adults.
 - d. Outdoor activity shall be available to each foster child each day, weather permitting.
3. Foster parents or a designated representative from the certifying authority with knowledge of the child shall attend Administrative Reviews for the foster children in their care and participate in the planning for such children. They shall receive a copy of the Family Services Plan for each foster child in their care.

H. Nighttime Care

1. Foster children shall be provided with a bed, cot or crib as required by Section 7.708.22, B, 8.
2. Two sheets and suitable warm covering shall be provided to each foster child. Sheets shall be changed weekly or more frequently if needed, and no foster child shall be allowed to remain sleeping in a wet bed.
3. Except for emergency placements, foster children over the age of 18 months shall not sleep in the same room as unrelated adults on a regular basis. Sleeping rooms for unrelated foster children shall not be shared by foster children of the opposite sex when one foster child is over 4 years old. Siblings of the opposite sex that are over the age of 4 years and share bedrooms shall do so only with the written approval of the certifying authority and the county designee. The written documentation must be maintained in the foster child's and provider's file. Teen parents and their children may share a room.
4. Each foster child shall be provided with adequate sleep wear, and a complete set of clean sleep wear shall be available in the event that a change is necessary.
5. Sleeping rooms for foster children under 5 years of age shall be near the bedroom of the foster parents or other responsible person. Monitoring systems may be utilized to ensure safety. Foster children under 12 years of age shall not be permitted to sleep in a detached structure unless a responsible person sleeps in the same structure. Foster children who sleep in a detached structure must have written approval of the county department that placed the foster child, who will assess the foster child's abilities and needs.

I. Infant Care

1. Not more than two infants, whether birth, adoptive or foster children under the age of two years, shall be cared for in a family foster care home, except under unusual circumstances such as multiple births.
2. In addition to the applicable provisions of paragraphs A through G, above, infant care shall include the following:
 - a. Infants shall be held during bottle feeding and at other times during the day. Infants shall not be confined but shall be allowed freedom of movement insofar as practical and shall be provided with an environment designed to stimulate their senses.

- b. Diapers shall be changed as required and used diapers cleaned or disposed of consistent with the practices of good hygiene. Toilet training shall not be attempted with any foster child less than 18 months of age and shall be done in a non-disciplinary manner.

7.708.32 Suspected Child Abuse

Where child abuse is suspected, the foster parent shall be alert for evidence of signs of abuse and report such evidence promptly to the county department of social/human services. A written report of any external signs of injury, such as bruising, scratching or swelling, shall be placed in the foster child's record. If there is any suspicion of abuse or illness, the foster child shall be seen by medical personnel immediately.

7.708.33 Foster Children's Rights

A. The certifying authority shall have written policies and procedures that address and ensure the availability of each of the following core rights for foster children in residence. These rights may not be restricted or denied by the family foster care home or certifying authority. Every foster child has the right to:

1. Enjoy freedom of thought, conscience, cultural and ethnic practice, and religion.
2. A reasonable degree of privacy.
3. Have his or her opinions heard and considered, to the greatest extent possible, when any decisions are being made affecting his/her life.
4. Receive appropriate and reasonable adult guidance, support and supervision.
5. Be free from physical abuse or neglect and inhumane treatment. Every foster child has the right to be protected from all forms of sexual exploitation.
6. Receive adequate and appropriate medical care.
7. Receive adequate and appropriate food, clothing, and housing.
8. Live in clean, safe surroundings.
9. Participate in an educational program that will maximize his/her potential in accordance with existing law.
10. Communicate with "significant others" outside the family foster care home, such as a parent or guardian, caseworker, attorney or guardian ad litem, current therapist, physician, religious advisor, and, if appropriate, probation officer.

B. The following foster children's rights may be limited to reasonable periods during the day or restricted according to routine of the family foster care home to ensure the protection of the foster children and foster family. Every foster child has the right to:

1. Have access to letter-writing materials, including postage, and to have a foster parent(s) assist him/her if unable to write, prepare, and mail correspondence.
2. Have access to telephones to both make and receive calls in private.
3. Have convenient opportunities to meet with visitors.
4. Wear his/her own clothes, keep and use his/her own personal possessions, and keep and be allowed to spend a reasonable sum of his/her own money.
5. Receive and send sealed correspondence.

C. Family foster care homes must develop a plan, in conjunction with the certifying authority, regarding the following rights of foster children and these rights must be explained to the foster children upon admission. The notification must be communicated in a language or mode of communication the foster child can understand. There must be plans for:

1. How and when telephone and written communications will take place.

2. How, when and where regular visits of the foster child with relatives, friends, or others interested in his/her welfare will take place.
3. Extenuating circumstances and emergency situations affecting the foster child and his/her family.

7.708.34 The Prohibited Use of Cruel and Aversive Therapy

The family foster care home shall refrain from engaging in all cruel and aversive treatment or therapy including, but not limited to, the following:

- A. Any intervention designed to or likely to cause a foster child physical pain.
- B. Releasing noxious, or toxic, sprays, mists, or substances in proximity to the foster child's face.
- C. Any intervention that denies a foster child sleep, food, water, shelter, access to bathroom facilities, adequate bedding, or appropriate physical comfort.
- D. Any intervention or type of treatment that subjects a foster child to verbal abuse, ridicule, humiliation or that can be expected to cause excessive emotional trauma.
- E. Interventions that use a device, material, or object that is designed to simultaneously immobilize all four of the foster child's extremities.
- F. Any treatment intervention that deprives a foster child of the use of his/her senses, including sight, hearing, touch, taste, or smell.
- G. The use of mechanical restraints, including but not limited to, the use of handcuffs, shackles, straight jackets, posey vests, ankle and wrist restraints, craig beds, vail beds, and chest restraints.
- H. Physical restraint, except as described at 7.714.90, and locked seclusion.
- I. Use of rebirthing therapy or any therapy technique that may be considered similar to rebirthing therapy as a therapeutic treatment, as defined by Section 12-43-222(1)(t)(IV), C.R.S.

7.708.35 Discipline

- A. The family foster care home or certifying authority shall have written policies and procedures regarding discipline that must be explained to all foster children, parent(s), guardian(s), staff, and placing agencies. These policies must include positive responses to a foster child's appropriate behavior.
- B. Discipline shall be constructive or educational in nature and may include talking with the foster child about the situation, praise for appropriate behavior, diversion, separation from the problem situation, and withholding privileges.
- C. Basic rights shall not be denied as a disciplinary measure.
- D. Separation when used as discipline must be brief and appropriate to the foster child's age and circumstances. The foster child shall always be within hearing of an adult in a safe, clean, well-lighted, well-ventilated room in the family foster care home that contains at least 50 square feet of floor space. No foster child shall be isolated in a bathroom, closet or pantry.
- E. Foster children in care at the family foster care home shall not discipline other foster children.
- F. A family foster care home shall prohibit all cruel and unusual discipline including, but not limited to, the following:
 1. Any type of physical hitting or any type of physical punishment inflicted in any manner upon the body of the foster child, such as spanking, striking, swatting, punching, shaking, biting, hair pulling, roughly handling a foster child, striking with an inanimate object, or any humiliating or frightening method of discipline to control the actions of any foster child or group of foster children.
 2. Discipline that is designed to, or likely to, cause physical pain.

3. Physical exercises such as running laps, push-ups, or carrying heavy rocks, bricks, or lumber when used solely as a means of punishment.
4. Assignment of physically strenuous or harsh work that could result in harm to the foster child.
5. Requiring or forcing a foster child to take an uncomfortable position such as squatting or bending, or requiring a foster child to stay in a position for an extended length of time such as standing with nose to the wall, holding hands over head, or sitting in a cross-legged position on the floor, or requiring or forcing a foster child to repeat physical movements when used solely as a means of punishment.
6. Verbal abuse or derogatory remarks about the foster child, his/her family, his/her race, religion, or cultural background.
7. Denial of any essential/basic program service solely for disciplinary purposes.
8. Deprivation of meals or snacks, although scheduled meals or snacks may be provided individually.
9. Denial of visiting or communication privileges with family, clergy, attorney, or caseworker solely as a means of punishment.
10. Releasing noxious, toxic, or otherwise unpleasant sprays, mists, or aerosol substances in proximity to the foster child's face.
11. Denial of sleep.
12. Requiring the foster child to remain silent for a period of time inconsistent with the foster child's age, developmental level, or medical condition.
13. Denial of shelter, clothing or bedding.
14. Withholding of emotional response or stimulation.
15. Discipline associated with toileting, toileting accidents or lapses in toilet training.
16. Sending a foster child to bed as punishment. This does not prohibit a family foster care home from setting individual bed times for foster children.
17. Force feeding a foster child.
18. Isolating a foster child in a locked room for discipline.
19. Use of physical or mechanical restraint as discipline for a foster child, including, but not limited to, the use of handcuffs, shackles, straight jackets, posey vests, ankle and wrist restraints, craig beds, vail beds, hospital cribs, and chest restraints.

7.708.36 Physical Restraint [Rev. eff. 1/1/07]

If a family foster care home uses physical restraint with a foster child(ren) in care in an emergency situation when the foster child is a danger to himself/herself or others, the family foster care home must be pre-approved by the certifying authority to conduct restraints and must be in compliance with all the rules concerning physical restraint as found at Sections 7.714.53 - 7.714.536. The family foster care home must notify the placing caseworker when a child is restrained.

7.708.37 Religion [Eff. 2/1/02]

- A. The family foster care home shall demonstrate consideration for, and sensitivity to, the religious backgrounds of foster children in care. The family foster care home shall assist a foster child's involvement in religious activities appropriate to the foster child's religious background and based upon the needs and interests of the foster child.
- B. Foster children in care at the family foster care home shall be allowed and encouraged to celebrate their religious holidays.

C. Opportunity and assistance shall be provided for each foster child to practice the chosen/preferred religious beliefs and faith of his/her family. If the family has no preference, the individual preference of the foster child shall be respected. This includes, but is not limited to, making necessary arrangements for attendance of foster children at the appropriate religious institution or at a study group for religious instruction.

D. A foster child may be invited to participate in religious activities of the family foster care home.

E. A foster child shall not be coerced or forced to participate in the religious activities of the family foster care home or to attend religious services.

F. Any form of religious intervention used by the family foster care home to control or change a foster child's behavior, or treat or heal a medical condition, must be approved, in writing, by the legal guardian(s) of the foster child prior to the use of the intervention.

G. A family foster care home cannot deny medical care to a foster child because of religious beliefs.

H. The foster child's family and/or guardian must be consulted prior to any planned change in religious affiliation made by the foster child while he/she is in care at the family foster care home.

7.708.38 Education [Rev. eff. 9/1/02]

A. Foster children shall attend educational/vocational programs in the most appropriate and least restrictive educational setting for the foster child, including, but not limited to, attending regular classes conducted in accredited elementary, middle, and secondary schools within the community.

B. Regular school attendance or an educational plan is required for each foster child according to school attendance laws; a suitable, quiet, well-lighted place for study shall be provided together with necessary books, papers, pencils and other equipment which are reasonably required by school-age children. Foster parents shall review grade reports and other information received from teachers or school authorities with foster children in care and shall counsel and assist foster children regarding adequate classroom performance. The parent, guardian or authority with responsibility for the foster child shall be advised of school performance. Reasonable efforts shall be made to involve a foster child in extracurricular activities. The foster parents shall attend school staffings, conferences, and Individualized Educational Plan meetings when possible.

C. Foster children attending school shall be permitted to participate in school extracurricular activities to the extent of their interests and abilities and in accordance with each individual foster child's plan.

D. In order to ensure that all students who may have disabilities are provided an appropriate education, the family foster care home, in cooperation with the certifying authority, shall ensure that adequate "Child Find" procedures are utilized. Such procedures shall be developed cooperatively with Local Education Agencies (LEA) in accordance with Exceptional Foster Children's Educational Act rules and regulations and LEA procedures. Child Find includes a process for screening, referring, assessing and staffing students suspected of having a disabling condition.

7.708.39 Community Participation [Rev. eff. 1/1/04]

A. Participation in community activities shall be encouraged, supported, and a vital part of each foster child's life and choice.

B. The family foster care home shall reflect consideration for, and sensitivity to, the racial, cultural, ethnic and/or religious backgrounds of foster children in care. The family foster care home shall involve a foster child in cultural and/or ethnic activities appropriate to his/her cultural and/or ethnic background. Other factors should include, but are not limited to, consideration of the child's family, community, neighborhood, faith or religious beliefs, school activities, friends, and child's and family's primary language.

- C. The family foster care home shall utilize available services, facilities, and activity programs of the community, and foster children shall be given opportunities to participate as individuals or as a group in agency-sponsored recreational and cultural programs.
- D. With the approval of the certifying authority, the family foster care home may deduct reasonable sums from a foster child's allowance as restitution for damages done by the foster child. Restitution must be negotiated with the foster child and based on the foster child's ability to pay. A written record of damages and any restitution paid by a foster child must be maintained by the family foster care home and certifying authority.
- E. Chores at the family foster care home are considered part of the participatory responsibility of living together. They shall provide constructive experiences in accordance with the age and ability of the foster child.
- F. All chores shall be scheduled so as not to conflict with other essential scheduled activities.
- G. The family foster care home shall comply with all child labor laws and regulations in making work assignments, with consideration for agricultural work assignments in those communities.
- H. Paid or voluntary work assignments outside of the family foster care home shall be approved by foster parent(s) and the county designee for the foster child, who shall know the employer, the specific type of work, and the conditions of employment.
- I. A foster child shall not be exploited. A foster child may not participate in solicitation on behalf of the family foster care home or certifying authority for a fund-raising activity without the written permission of the parent(s) or guardian(s) for each specific activity, and the foster child must be willing to participate in the activity.

7.708.4 PERSONAL CARE AND SAFETY OF THE FOSTER CHILD

7.708.41 Medical and Health Services [Eff. 2/1/02]

- A. A general medical examination for each foster child must be completed or scheduled with a physician or a nurse practitioner prior to or within fourteen (14) calendar days following placement at the family foster care home. A statement from the examiner shall be retained in the foster child's file. This exam shall include the following:
1. An examination for physical injury and disease.
 2. Vision and hearing screening.
 3. A current assessment of the foster child's health, including immunizations.
- B. Whenever indicated, a foster child shall be referred to an appropriate specialist for either further assessment or treatment.
- C. Subsequent physical and other examinations shall be done annually or as directed, in writing, by the physician or other qualified health professional.
- D. Dental examinations, appropriate to the age of the foster child, must have been completed within four months prior to placement or scheduled or completed within eight (8) weeks following placement. The family foster care home or governing body shall ensure that each foster child receives a dental examination every six months or as required in writing by a dentist.
- E. At all times there shall be first aid supplies readily available at the family foster care home. Each foster parent must be certified in first aid, or the equivalent, and CPR for all ages of foster children in care.
- F. The family foster care home, in conjunction with the parent(s) or guardian(s), shall make every effort to ensure that a foster child needing corrective devices such as glasses, hearing aids, etc., is provided with the necessary equipment. The placing authority for the foster child shall assist with obtaining resources as necessary to fulfill this requirement.
- G. The family foster care home has the right to request a statement regarding the foster child's general health from a medical examiner. In a potentially life-threatening situation, the family foster care home

shall refer the foster child's care to the appropriate medical and legal authority. If a foster child wishes an exemption from a medical examination or medical treatment due to religious beliefs, the foster child shall submit a written statement signed by his/her parent(s) or guardian(s) which states the reasons for such an exemption. The family foster care home has the right to refuse admission to a foster child whose parent(s) or guardian(s) refuses medical treatment or examination based upon religious convictions.

H. Foster parents shall be aware of and shall observe foster children for signs of illness or disease and shall respond to and care for a foster child suffering from illness, accident or injury. If contagious, the foster child affected should be isolated from other children in the home and made as comfortable as possible. First aid care shall be provided as required. If additional care, medical attention or removal from the home is indicated, the appropriate person with responsibility for the foster child shall be contacted and medical assistance shall be obtained without undue delay. A written record of any illness or injury to a foster child shall be retained in each foster child's individual record.

I. The family foster care home shall regularly maintain and update a foster child's Human Services Health Passport, or a document containing all the information listed in the Health Passport, for foster children placed by a county department of social services. This document is to be photocopied regularly and submitted to the foster child's caseworker. The original of the document shall be given to the caseworker upon the foster child's discharge so that it can be given to the family foster care home where the foster child is being admitted or to the foster child's parent(s), guardian(s), or family member(s) with whom the foster child is placed.

J. Medications shall be administered and stored in the following manner:

1. When a foster child first goes into care, the family foster care home shall ascertain all medication the foster child is currently taking.
2. All medication must be kept in a clean storage area inaccessible to foster children and stored according to pharmacy instructions.
3. All prescriptive medications shall be administered only upon the written prescription of a physician. The family foster care home shall also obtain written authorization from the prescribing physician to administer any non-prescriptive medication.
4. In an emergency situation, non-prescriptive medication may be administered on the verbal authorization of a physician. Written confirmation must then be obtained for the verbal authorization.
5. The family foster care home shall maintain for each foster child a cumulative record of all medication, both prescriptive and non-prescriptive, dispensed to that foster child, including:
 - a. The name of the foster child.
 - b. The name and dosage of medication.
 - c. The time and date the medication was dispensed.
 - d. The name or initials of the person administering the medication.

7.708.42 Food and Nutrition

A. The family foster care home shall provide nutritious foods in the variety and amounts as appropriate for the age, appetite, and activity of each foster child in care.

B. At least three nourishing, wholesome, well-balanced meals a day shall be offered at regular intervals except when foster children receive their morning and/or noon meal(s) at school. No more than fourteen (14) hours shall elapse between the evening and morning meals. Nourishing snacks shall be part of the daily food provided.

C. Family meals including all children and adults present in the home shall be provided whenever possible.

D. Foster children shall be encouraged to eat a variety of the food served but shall not be subjected to undue coercion, including forced feeding, or punished for refusal to eat.

- E. All food shall be from sources approved or considered satisfactory by the health authority. All foods shall be stored, prepared, and served in such a manner as to be clean, wholesome, free from spoilage, and safe for human consumption. Only pasteurized milk shall be served. Home pressure-canned fruits and vegetables and canned meats cannot be served because of the possible severe health concerns for foster children from botulism in unsafe canned foods. Fruits, vegetables and meats may be frozen.
- F. There shall be a record made of the special diets prescribed and prepared for a foster child.
- G. Foster children must not be given foods that are contrary to their religious beliefs, or of their family, or are known to cause an allergic reaction or a health hazard.
- H. Water shall be readily accessible to foster children.
- I. Common drinking cups shall not be permitted.

7.708.43 Personal Hygiene and Daily Routine

- A. The family foster care home shall ensure that foster children receive training in good habits of personal care, hygiene, and grooming appropriate to their age, gender, race and culture.
 - 1. There shall be supervision by foster parents to provide for proper grooming and physical cleanliness of the foster children.
 - 2. The family foster care home shall ensure that foster children are provided with necessary and appropriate toiletry items, including clean, individual towels and washcloths, toothbrush, toothpaste, comb, and shampoo.
 - 3. Foster children shall be encouraged or assisted to maintain cleanliness or good hygiene; teeth shall be brushed each day and more frequently when possible.
- B. The family foster care home shall have basic daily routines for foster children in care.
 - 1. Daily routines shall not be allowed to conflict with the implementation of a foster child's family services plan.
 - 2. Daily routines shall be established for mealtimes, waking, and bedtimes.
 - 3. Opportunity for physical exercise shall be planned for each foster child.

7.708.44 Clothing and Personal Belongings

- A. The family foster care home shall allow a foster child in care to bring his/her personal belongings to the program, as defined by the family foster care home policy, and to acquire belongings of his/her own. However, the family foster care home shall, as necessary, limit or supervise the use of these items while the foster child is in care. Where extraordinary limitations are imposed, the foster child shall be informed of the reasons, in a language or manner of communication the foster child can understand.
- B. The family foster care home shall ensure that each foster child in care has adequate clean, proper-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being and as appropriate to age, gender, individual needs, culture, and ethnicity.
 - 1. Each foster child's clothing shall be distinguished as his/her own.
 - 2. A foster child's clothing shall be kept clean and in good repair. The foster child shall be involved, as appropriate, in the care and maintenance of his/her clothing. As appropriate, laundering, ironing, and sewing facilities shall be accessible to the foster child.
- C. The family foster care home in conjunction with the placing authority shall ensure that discharge plans make provisions for clothing needs at time of discharge. The wardrobe for each foster child shall go with him/her at time of discharge.

7.708.45 Emergency Drills

- A. There shall be a plan for foster parent(s) and foster children to follow in case of emergency or disaster. The plan shall include provisions for roles and responsibilities during an emergency, evacuation of the family foster care home, and the assignment of a central meeting place where each individual may be accounted for.
- B. Fire exit drills must be held often enough so that all occupants are familiar with the drill procedure and their conduct during a drill is a matter of established routine.
- C. Drills must be held at unexpected times and under varying conditions to simulate the conditions of an actual fire.
- D. Drills must emphasize orderly evacuation under proper discipline rather than speed. Running or horseplay shall not be permitted.
- E. Drills must include suitable procedures for ensuring that all persons in the family foster care home actually participate.
- F. A record of fire drills must be recorded by the family foster care home.
- G. Smoke alarm devices shall be regularly used in the conduct of drills.
- H. The family foster care home shall make special provisions for the evacuation of any foster child with a disability in the family foster care home.
- I. The family foster care home shall take special care to help emotionally disturbed or perceptually handicapped foster children understand the nature of such drills.
- J. If appropriate to the location of the family foster care home, tornado drills must be held often enough so that all occupants are familiar with the drill procedure and conduct during a drill is a matter of established routine. A record of tornado drills must be recorded by the family foster care home.

7.708.46 Transportation

- A. A family foster care home or certifying authority shall ensure that each foster child is provided with the transportation necessary for implementing the foster child's family service plan.
- B. A family foster care home shall have means of transporting foster children in cases of emergency.
- C. Any vehicle used by the family foster care home in transporting foster children in care, whether such vehicle is operated by a foster parent or any other person acting on behalf of the family foster care home, shall be properly licensed, and the vehicle shall be maintained in accordance with Colorado law.
- D. Any foster parent or other person acting on behalf of the family foster care home operating a vehicle for purpose of transporting foster children shall be properly licensed to operate the class of vehicle in accordance with Colorado law.
- E. Foster children under 16 years of age must be properly fastened into a restraint system that conforms to all applicable Federal Motor Vehicle Safety Standards and pursuant to Colorado law.
- F. A family foster care home shall not allow the number of persons in any vehicle used to transport foster children to exceed the number of available seats in the vehicle.
- G. The vehicle shall be enclosed and provided with door locks.
- H. A family foster care home shall ascertain the nature of any need or problem of a foster child which might cause difficulty during transportation, such as seizures or a tendency toward motion sickness. The family foster care home shall communicate this information to the driver of any vehicle transporting foster children in care.

7.708.5 RECORDS AND REPORTS

7.708.51 Records [Rev. eff. 3/2/05]

- A. The family foster care home, in conjunction with the certifying authority, shall maintain complete records as required for the licensing or certification of the family foster care home in accordance with the rules regulating family foster care homes.
- B. Records for foster children shall be retained for at least three years. Retention of records for a longer period may be desirable when they reflect an accident, injury or other unusual circumstance.
- C. A record of admission shall be completed for each foster child in care prior to or at the time of placement. The admission record shall be maintained at the family foster care home where the foster child resides and shall contain:
1. Foster child's name, date and place of birth (verified by a birth certificate when possible), gender, race, religious preferences of parent(s) or foster child, date and reason for placement.
 2. Foster child's address and telephone number, parent(s) or guardian(s) address and telephone number if different from the foster child.
 3. Name, address, day and nighttime telephone number of individual or agency placing the foster child with the name of individual arranging the placement.
 4. Any documents pertaining to the foster child's legal status such as court orders, including the appointment of a Guardian ad litem, legal guardianship, or custody agreements.
 5. A copy of the placement agreement pursuant to 7.708.61, K.
 6. Health records including a health history, chronic medical problems of the foster child, illnesses the foster child has had during the last six months and a complete list of all medications the foster child is taking.
- D. Each foster child's file shall also include:
1. Current medical and dental reports, accident, injury, or illness reports, record of medication administered and necessary medical care provided to the foster child while in placement.
 2. Copies of educational records and reports of school work, including scholastic performance, certificates of achievement or award, copies of school pictures, extracurricular interests.
 3. The foster child's Family Services Plan, a summary of the periodic evaluations of the foster child's progress and resultant changes in the Family Services Plan.
 4. Psychiatric and psychological reports, when available.
 5. Summary recording of significant contacts with parent(s), guardian(s) and other involved agencies.
 6. If requested by the provider, a written notice to employees of the Department of Human Services and of county departments or other individuals with a need to know, if the foster parents do not want personally identifiable information provided to adult members of the foster child's family. Written notice may be subsequently provided to the parties aforementioned for release of personally identifiable information to the foster child's family which shall include the consent to release information, the foster parent's signature, and the date.

7.708.52 Reports [Eff. 2/1/02]

- A. The family foster care home shall immediately notify the foster child's parent(s), guardian(s), and/or the responsible agency of any serious illness or serious injury resulting in medical treatment away from the family foster care home, hospitalization or death involving a foster child in care.
- B. The family foster care home shall notify the parent(s), guardian(s), or placing authority as soon as possible upon discovery that a foster child has run away.
- C. A report about a death must include:
1. The foster child's name, birth date, address, and telephone number.
 2. The names of the foster child's parent(s) or guardian(s) and their address and telephone number if different from that of the foster child.
 3. Date of the fatality.
 4. Brief description of the incident or illness leading to the death.

5. Names and addresses of witnesses or persons who were with the foster child at the time of death.

6. Name and address of police department or authority to whom the report was made.

D. The family foster care home shall notify the certifying authority of any change in the status of the family foster care home, police intervention or moving traffic violations that could affect care and safety of foster children.

CSFPA - *Colorado State Foster Parent Association*

Membership Form

Print this page and fill it out.

Mail the form and a check or money order to CSFPA.

CSFPA

7651 West 41st Ave, Suite 90

Wheat Ridge, CO 80033

303-463-7989

800-426-3281

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City, zip: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Licensing Agency: _____

Circle Membership Type:

\$10 - Initial Membership

\$30 - Renewal Membership

\$75 - Agency Membership

\$20 - Group Member Rate

Circle Foster Parent Type:

- Foster

- Receiving

- Group

- Other