ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 97 ADM-15

DIVISION: Services and Community Development

TO: Commissioners of Social Services
Executive Directors of Voluntary Authorized Agencies

DATE: July 24, 1997

SUBJECT: Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure

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ATTACHMENTS: Listed in Table of Contents where those available on-line are so indicated

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 ADM-21 91 ADM-36	94 LCM-64	18 NYCRR Parts 357 428 441 507	SSL 20 34 373-a 398 PHL Article 27-F	Standards of Payment Chap.VIII (B)	

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I. PURPOSE

The purpose of this directive is to provide guidance and set best practice standards for implementing New York State Department of Social Services regulations and policies requiring assessment of risk for human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) in foster children. Included in this directive are guidelines for determining a foster child's capacity to consent and for obtaining legal consent for HIV testing when risk is identified.

Regulations requiring these actions were adopted and effective on August 23, 1995, amending sections 428.3, 441.22, and 507.2 of Title 18 NYCRR. New York State statutes related to these regulations include Public Health Law, Article 27-F, which establishes criteria for HIV-related testing and confidentiality; Section 373-a of the Social Services Law (SSL) which specifies the persons and entities to whom the medical history of the foster child must be provided; and Section 398(6) of the SSL, which requires local commissioners of social services to provide for expert mental and physical examinations of any foster child reasonably suspected of having a mental or physical disability or disease and to provide necessary medical or surgical care for any child needing such care. In addition, standards of care and treatment applying to residential programs for children must be provided according to SSL, Section 462.

II. BACKGROUND

As the number of HIV/AIDS infection and mortality cases continues to increase nationwide, the number of New York families and children infected and affected by the epidemic also continues to rise. While the highest statistics are reported by New York City, no area of the state is exempt from mounting numbers of cases of HIV infection. No vaccine and no cure for the disease has been developed as of the issuance of this directive. However, continuing research has resulted in development of new treatments and medications being used by the medical community to prolong life and maintain the quality of life for those infected. More effective early treatment makes the identification of children at risk more urgent and has resulted in the determination of the State Department of Social Services to develop this major policy initiative for the benefit of the children in foster care. The regulations emphasize the importance of preventive measures, counseling and education of youth and risk reduction, as well as testing when risk is identified, and medical care as needed.

The 1995 regulations were an important addition to previous requirements set forth in the Department's earlier Administrative Directive (91 ADM-36) issued September 16, 1991: "Foster Care and Adoption: HIV-Related Issues and Responsibilities." That directive focused on confidentiality and disclosure issues, documentation, and required training and information for staff involved in HIV-related issues, HIV counseling and testing.

The addition of the HIV assessment, counseling and testing regulatory requirements discussed in this directive continues the Department's efforts to address a health care crisis affecting families and children of all ages, with particular focus on children in foster care.

Chapter 220 of the Laws of 1996, which became effective February 1, 1997, required that all infants born in hospitals or birthing centers be tested for HIV. No parental consent for this additional component of the prior existing Newborn Screening Program is required. For a discussion of the significance of this testing in relation to an authorized agency's responsibilities, see page 10 of this directive.

III. PROGRAM IMPLICATIONS

The regulatory requirement for assessment of HIV risk for each child placed in foster care, regardless of age, provides a higher standard of awareness and medical services related to the HIV epidemic affecting children and families in New York. Practice and program implications of this mandate will include development of new agency procedures for designation of informed staff to conduct assessments, obtain legal consents, arrange for HIV testing, provide follow-up services and ongoing counseling.

A. DESIGNATION OF STAFF TO MAKE ASSESSMENTS

Designation of staff to make the assessments of capacity to consent and HIV risk is an important internal administrative decision for each authorized agency. Such designations must include serious consideration of staff information and training on HIV/AIDS issues as required by Department regulations, as well as staff experience with particular age groups. Counseling and the ability to discuss prevention and risk reduction are skills needed by designated staff working with older children. When medical staff or a clinical social worker is available within the agency, such persons may be able to undertake the assessments with a minimum of additional preparation and training. Designated staff will need to use flexibility, cultural sensitivity, and their own experience and judgment in implementing assessment procedures, and modify those procedures based on the age, developmental stage and cognitive abilities of the foster child.

Staff designated to make the assessments should take advantage of further training opportunities offered through Department contractors, or through other agency, community or medical training providers, as discussed on page 20 of this directive. (Please also see pages 24 and 25 of 91 ADM-36 for agency requirements to provide HIV-related information and training for staff initially and annually.)

In addition to understanding the basic medical/physical development and impact of the disease, designated staff making the assessments of capacity to consent and HIV risk will need to learn the legal standard for capacity to consent as defined on page 5, as well as the rules regarding HIV-related confidentiality and the penalties for breaking such rules (see page 30 and Appendix A). The ability to relate to children in different stages of development and growth will be important in making the assessments, requiring sensitivity to the developmental and emotional status of each child. Ability to counsel adolescents will be a particularly important skill needed by staff designated to work with this age group.

B. FIRST STEP IN ASSESSMENT: DETERMINATION OF CAPACITY TO CONSENT

Determination of the foster child's capacity to consent is the first step for designated staff to take in meeting the requirements for assessment of HIV risk. No HIV testing, even after identification of risk, may take place unless written consent has been given by a person authorized to give consent according to Public Health Law, Article 27-F. A person with capacity to consent is the only person who may provide the required written informed consent before HIV testing may take place. For a child without such capacity, written consent for HIV testing must be obtained from a person authorized by law to give such consent (see pages 15-17 of this release).

An assessment of a child's capacity to consent is required by Department regulations within five business days of each child's entry into foster care. For each child who entered foster care prior to September 1, 1995, an assessment of capacity to consent was to have been made 60 days prior to the child's next medical examination or to the next service plan review occurring after August 23, 1995, whichever was earlier.

1. Alternatives and definitions

Staff designated to determine the child's capacity to consent are required to consider in their initial five day assessment which of the following two alternatives applies to the child: (1) there is NO POSSIBILITY that the child has the capacity to consent, or (2) there may be A POSSIBILITY that the child has the capacity to consent. In the case of the second category, staff have 30 days to make a final determination regarding the child's capacity to consent. The determination regarding which

category applies to the child must be made without specific regard to the child's age, and the decision must be based on the definition of capacity to consent provided in Article 27 F of the Public Health Law and included in Department regulations at section 441.22 (b)(1) as follows:

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CAPACITY TO CONSENT

Capacity to consent means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

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Decisions regarding capacity to consent are to be made on a case-by-case basis, with consideration given to the developmental stage and cognitive abilities of the child.

"Cognitive abilities" refers to a child's level of perception, memory, judgment, and understanding as these characteristics relate to HIV risk factors, risk behavior reduction, HIV testing, counseling on the nature and consequences of the disease, and the disclosure of HIV-related testing information.

In cases where a designated staff person has difficulty making a satisfactory determination regarding an individual child's capacity to consent, supervisory assistance is recommended. In rare instances when the decision is not resolved with supervisory assistance, consultation with a third professional may be necessary.

2. Assessment Categories

While the definition of capacity to consent prohibits determination based on specific age, the application of the definition to children in foster care requires an assessment based on realistic levels of development and cognitive abilities. The following assessment categories provide best practice guidelines for making the determination:

a. Infants and pre-school children

Infants and pre-school children entering foster care would clearly have NO possibility of capacity to consent, based on the legal definition given above. In such cases,

designated staff are to proceed immediately with the assessment of risk for HIV infection described in Section III. C. beginning on page 7. For those children with NO possibility of capacity to consent, the HIV risk assessment, based on medical or psychosocial information available at the time, must also be completed within the first five business days of entry into care. Children in this category who entered foster care prior to September 1, 1995 were to have an assessment of capacity to consent and HIV risk 60 days prior to their next periodic medical examination or service plan review, whichever came earlier.

In cases where an infant or pre-school child has already been tested through the Department of Health mandated universal newborn testing program effective February 1, 1997, and the results of such test are made available to the authorized agency, documentation of any known risk and results of the HIV testing at birth are to be included in the child's uniform case record. This information will need to be shared with the child's medical provider at the time of the comprehensive physical examination required within 30 days of the child's entry into foster care.

b. Elementary school children

A foster child in this category would generally have NO possibility of capacity to consent, particularly if the child is in the lower elementary grades. It is unlikely that a child under the age of puberty would be fully able to understand and appreciate the nature of this complex disease or to make an informed decision regarding testing and disclosure. Only in exceptional cases might such a child be considered to have A possibility of capacity to consent. (The fact that a child is assessed to have no capacity to consent does not eliminate consideration of informing and counseling an elementary school child regarding prevention and risk reduction at a level appropriate for the age and development of the child.)

Further, since capacity to consent is to be determined on a case-by-case basis, if there may be A possibility of such capacity, staff may take up to 30 days after the child's entry into care to make a firm decision and to complete the HIV risk assessment. For elementary school children who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of risk for HIV infection were required no later than 60 days before the child's next periodic medical examination or service plan review, whichever came earlier.

c. Pre-adolescent, early adolescent middle school children

Foster children attending middle school or junior high school are more likely to have the capacity to consent

based on the legal definition. However, the broad range in individual physical, mental and emotional development in children at this stage of growth requires a case-by-case determination of such capacity within the 30 day timeframe allowed by the regulations when there may be A possibility of capacity to consent. In this developmental stage, supervisory review of the determination of capacity is suggested, and where a question remains, consultation with a third party may be necessary.

d. High school and post-high school youth

Young people in these categories will generally have the capacity to consent to HIV testing and disclosure, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, through the required information and counseling process within the 30 day timeframe for determination of capacity and assessment of risk, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and to make an informed decision regarding the recommended testing when risk is identified.

Unresolved questions regarding capacity to consent in this stage of development should be referred to a supervisor and may suggest the need for consultation with other appropriate professional staff, such as a psychologist or clinical social worker.

When a youth in foster care is determined by staff on the basis of developmental stage and cognitive abilities to have the capacity to consent, that young person has the right to make his or her own decision on whether to be tested for HIV infection.

C. SECOND STEP: RISK ASSESSMENT FOR HIV INFECTION

1. Required timeframes for HIV risk assessment

The second step in the requirements for HIV assessment and testing involving children in foster care is the determination of HIV risk factors in the child's medical and psychosocial history, based on the information available. For children with NO possibility of capacity to consent, the assessment of HIV risk must be completed within the first five business days of entry into care. If agency staff determine that a child may have A possibility of capacity to consent, the timeframe for both the determination of capacity to consent and the HIV risk assessment is extended to 30 days from entry into care.

For each child who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of HIV risk were to be completed 60 days prior to the child's next

service plan review or next scheduled medical examination, whichever came earlier.

2. HIV risk factors

Three groups of HIV risk factors for use during the assessment process are provided in the Department's regulations (section 441.22(b) of 18 NYCRR) and in Section IV.D. (pages 23-24) of this directive. Developed with the cooperation of the medical community and the AIDS Institute of the Department of Health, the listed factors are to be used by designated staff in reviewing the health/medical and psychosocial history and other written records regarding the child, as well as for guidance in discussions as appropriate with a child, youth or child's parents. The risk factors should never be used as an oral checklist with children, but are intended primarily for internal use by staff in making the assessments.

The first group of risk factors is relevant for an assessment of infants and pre-school children, with the factors related to perinatal transmission from the mother to the infant during pregnancy, at birth or through breast-feeding. The second group, a list of family psychosocial/health factors which also may result in perinatal HIV transmission, is primarily related to infants and pre-school children, but has been identified as a latent source of transmission to some elementary and middle school children as well.

The third group provides a list of factors primarily used for assessment of older children, based on the child's behavior and/or other means of direct transmission. (See further discussion on pages 23-24.) It is this third group which may be helpful in counseling and discussions on prevention and risk reduction with older youth who may be able to understand the serious issues involved in transmission of HIV/AIDS.

3. Assessment of HIV risk through written records

For all age groups, the health/medical and psychosocial family history of the child, to the extent available, is the foundation for the assessment of HIV risk. Therefore, a review of any written information/records concerning the child is essential. Information regarding the child or child's family may be available through the following:

a. any medical or psychosocial records available at the time of placement or that become available at any time while the child is in foster care;

b. any relevant information recorded as a result of contacts and discussions with the child's family, foster family, or medical providers;

c. child protective services investigative reports on the Preliminary Assessment of Safety form (DSS 4337) or other written record.

When a child is identified through such available information as having one or more of the HIV risk factors listed on pages 23 and 24 of this directive, the risk factor(s) and basis for the determination are to be documented in the uniform case record of the child. Authorized agencies must keep all HIV-related information in the medical history file of the child which is technically part of the uniform case record, but is often kept in a separate location in order to limit access to specified persons.

When a review of the information available is insufficient to determine whether a child is at risk, staff will need to make a reassessment when new information becomes available. In all cases, staff will need to review any additional relevant information at each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(6) of Department regulations.

4. Assessment of HIV risk indicating direct, person-to-person discussion/contact

The following guidelines for assessment of HIV risk involving person-to-person contacts, discussion and counseling, as appropriate, are provided in the same four categories as those used above to determine capacity to consent:

a. Infants and pre-school children

Available written records of the child in this category will generally be sufficient to make an assessment of HIV risk. However, if relevant information is lacking, designated staff may wish to make reasonable efforts to contact the parents of the child, other staff, medical or community services providers who are known to have knowledge of the child and/or the child's family.

It is this category of child for whom early intervention and medical treatment have been determined through scientific studies to be extremely important in maintaining the quality of life and prolonging life. The identification and medical care of infants and pre-school children who may be HIV-infected are therefore urgent goals of the Department's assessment and testing policy and regulations. If one or more risk factors are identified for a child in this category, immediate efforts should be

made to obtain necessary legal consent for testing or re-testing as necessary and to arrange for the test so that early treatment and services may be provided if the child tests positive.

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Virtually all children born in the State since February 1, 1997 are tested for HIV antibodies shortly after birth as part of the State's Newborn Screening Program (NSP). The authorized agency should not retest a child under the age of twelve months unless the child tests negative at birth but there are risk factors that are present after birth (i.e., the infant has been breast fed); the authorized agency is unable to obtain the NSP test results; or the child's NSP test was positive necessitating follow-up PCR or viral culture testing discussed below. Additionally, given the availability of the test results, as described below, authorized agencies should seek the test results for all foster children born on or after 2/1/97, up to the age of 12 months, regardless of whether or not there are risk factors present. The test results should be available approximately ten days after the child's birth.

There are two possible methods for obtaining the test results, both of which require obtaining one of the following identifiers: a) the Newborn Screening Program Blood Collection form identification number (available from the birth hospital through the Newborn Screening Designee; however, after a couple weeks following birth may only be available through the hospital's medical records office which, depending upon the hospital, may take too long a period to be made available to be viable); or b) the mother's social security number.

A physician caring for the foster child can access the newborn test results through the NSP's Voice Response System (VRS) at Wadsworth Laboratory, using one of the two identifiers described above. (Note: All physicians must register with the NSP at (518) 473-7552 if they have not used the system before.) If the authorized agency does not find this method of obtaining the test results practicable for a particular child, the agency can instead contact the ACS Pediatric AIDS Unit (212) 266-3304, if the child is in ACS' custody, or Carol Shortsleeves from this Department at (518) 474-9594. If you choose to use the ACS or NYSDSS contact person, it will still be necessary to have one of the two identifiers listed in the preceding paragraph. The ACS and NYSDSS will then contact the State Department of Health (SDOH) Laboratory to obtain the test result. (SDOH will be evaluating the volume of requests it receives for test results from ACS and NYSDSS to determine its ongoing

capacity to provide results for foster children up to the age of 12 months.)

The newborn's antibody test results reflect the HIV status of the mother. A negative result means the mother and newborn are most likely not infected. A positive result means the mother is infected and the newborn may or may not be infected. To determine if the newborn is infected, a child must be retested using a more sophisticated "PCR" test (or viral culture). All infants will need at least two PCR tests. The optimal time for the first PCR is at the first pediatric visit or by one month of age. HIV infection can be reasonably ruled out for infants who have had two negative PCR tests after one month of age, with one test coming after 4-6 months of age. (The SDOH does HIV PCR testing on all HIV positive infants less than 18 months of age for free.) The SDOH requires the birth hospital to notify the physician responsible for the baby's care of the antibody test results. If the result is positive, the physician must administer the follow-up PCR test(s) and provide or arrange for post-test counseling for the infant's mother. Any PCR test required to be administered to an HIV-antibody positive infant up to the age of 12 months born on or after 2/1/97 does not require the obtaining of legal consent.

The SDOH requires birth hospitals to ensure that an infant who tests HIV-antibody positive on the Newborn Screening test is located and has a definitive diagnosis by PCR (or viral culture). The hospital is also required to obtain the results of the PCR test (or viral culture). It is important to determine those infants who are infected so they can receive early care, including drugs to prevent PCP (a serious form of pneumonia to which very young HIV-infected infants are particularly susceptible).

There may be occasions when a child tests HIV-antibody positive, enters foster care shortly after birth, and the birth hospital (or the SDOH, if the hospital asks for assistance) is trying to locate either or both the infant and the mother. In relation to the infant, the authorized agency should provide the following information, upon request, to the birth hospital or the SDOH:

(1) the location of the infant;
(2) the name and phone number of the physician/clinic caring for the infant;
(3) whether a PCR (or viral culture) is scheduled for the infant or has been done; and
(4) the results of such testing.

If the birth hospital or the SDOH asks for assistance in locating the infant's mother, it is for the purpose of informing her of the test result, providing counseling, and

encouraging her to receive appropriate medical care, especially if she was previously unaware of her HIV positive status. If the case planner knows the whereabouts of the infant's mother or is in contact with her, he/she should tell the infant's mother that they have been asked to inform her that she should contact the birth hospital to obtain important medical information about herself. After making such contact as soon as practicable, the case planner should inform the entity trying to locate the infant's mother that the message was conveyed.

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b. Elementary school children

Written records and reports should serve as the foundation for the assessment of HIV risk in this category of children. Relevant risk factors will be found primarily in the first two groups of factors listed on pages 23 and 24, involving perinatal transmission of HIV.

However, staff should be aware that some items in the third group (e.g., sexual abuse), may also be applicable to elementary school (and pre-school) children. After checking the written records available, a designated staff person with experience and ability in relating to this category of children may wish to initiate a discussion with the child as appropriate about HIV risk behavior and the reasons for the assessment and possible testing.

The approach used in such discussions will depend on the developmental and emotional status of the child and the ability of the child to understand such explanations. For example, a child may be among those children who have already been involved in substance abuse or in sexual activity. If there is any indication of such risk behavior, and if the child appears able to engage in a discussion of prevention issues, the staff should begin such a discussion and provide opportunities to continue on other occasions.

In many cases in this category, designated staff may be able to discuss with the child who has one or more risk factors the importance of the HIV test in order to provide any necessary medical care. It should be explained to the child that the test will probably involve drawing blood, but will be no more painful than, for example, the types of required injections the child has experienced to protect against disease -- the required pre-school vaccinations.

While the older child in this category may be determined to have capacity to consent as defined in section III.C., most of these children will probably not meet the standard. Therefore, if one or more HIV risk factors are identified, and the child is determined not to have the capacity to

consent, staff will need to obtain the necessary legal consent for HIV testing from someone other than the child and arrange for the test according to procedures described in paragraph III.D. below.

c. Pre-adolescent, early adolescent middle school children

Many children in this category may meet the standards of development and cognitive ability leading to a determination of capacity to consent. HIV risk assessments involving children at this level should be made by staff who are well-informed regarding HIV/AIDS issues and have training and experience in working with children in this category.

While a review of written records will again serve as the basis for an initial assessment of risk, staff must initiate a person-to-person discussion with each youth within the first 30 days of entry into foster care in order to complete a determination of capacity to consent and a valid assessment of HIV risk.

Staff should take care to ensure that the initial and subsequent meetings of staff with the child regarding HIV risk be non-confrontational and non-threatening. Again, the risk factors listed in Section IV. D. of this directive should not be used as an oral checklist in assessment and counseling meetings with children and youth. The list is intended as a guide for staff in reviewing records and discussing prevention, risk reduction, and transmission of the disease with children and youth as appropriate for their level of understanding.

Risk factors particularly relevant to this category of child will be those in the third group on page 24 related to direct transmission of HIV through personal contact involving blood or semen, although perinatal transmission has been documented as the risk factor in some cases. Discussion of the third group of factors can form the basis for providing important information and counseling to the child. The initial meeting will be important in helping the child understand the reasons for the required assessment of HIV risk in order to offer support services and medical care if needed. Continuing opportunities for sharing information should be offered. If risk is identified, other issues for discussion will include required information on confidentiality and disclosure as discussed on page 30 of this directive.

d. High school and post-high school youth

As with the middle school category above, the initial meeting with high school youth will be important in helping the youth understand that the required HIV risk assessment

and discussion are meant to offer opportunities for sharing information on prevention and reduction of risk behavior, as well as to provide a recommendation for testing if risk is identified.

As is true for the pre-adolescent children, staff working with this category of youth will need to be sensitive and flexible in providing opportunities for such counseling and discussion and to understand that the young person may be both emotionally and physically exhausted by the events which have led to placement in foster care. At no time should such meetings become threatening, confrontational, or coercive.

The risk factors particularly relevant to high school and post-high school youth are those on page 24 related to direct transmission of HIV from another person, generally through the youth's own behavior, particularly related to sexual activity or drug abuse. Other possible risk factors are sexual abuse and, very rarely today, contaminated blood transfusions. Prior to discussions and counseling sessions with the youth, staff will need to review any information available through CPS, medical history, or other documentation related to possible HIV risk.

If the youth has the capacity to consent and is identified through the HIV risk assessment as having one or more risk factors, staff will recommend testing and discuss with the youth the reasons why such a test is important in order to obtain medical and other services if the result is positive. In addition to a discussion of the identified risk and the recommendation for testing, staff will need to forthrightly discuss the issues of confidentiality and disclosure as they apply to foster children (see page 30), as well as explaining to the youth the two types of testing available -- confidential and anonymous -- and the differences between the two. The youth with capacity to consent then has the absolute right to make his or her own decision regarding whether to undergo HIV testing and, if so, the type of testing.

In confidential testing of children in foster care, the name of the child and the authorized social services agency with responsibility for the child are recorded by the test site, and the results of the test are to be provided to the agency, as well as to others specifically permitted by law to be given such information as discussed on pages 30-32.

Anonymous testing is available in certain locations only to persons with capacity to consent. The person tested is identified only by an ID number. Results of the test can be given only to that person, regardless of foster care

status. However, a recent Department of Health policy change allows the person who chooses the anonymous type of testing to request a conversion from anonymous to confidential status at the time the results are provided. This makes possible the transmission of the results to a medical or social services provider in order to obtain needed treatment or services.

As in all categories, documentation in the case record will be necessary on the assessment of capacity to consent, assessment of HIV risk, counseling provided, and in the case of youth with capacity to consent, the decision regarding testing and arrangements made for the test if consent is obtained.

D. THIRD STEP: OBTAINING LEGAL CONSENT FOR TESTING

When HIV risk has been identified, designated staff will need to obtain legal written consent from an individual with legal authority to consent before the child can be tested.

1. Child with capacity to consent

As indicated on the preceding page, the child or youth who has been determined to have capacity to consent is the only person who can make a decision regarding testing and provide legal written consent for his or her HIV test.

If the youth agrees to be tested, he or she will be asked to sign a brief dated statement of consent (see model form in Appendix D) to be retained in the case file. (Please note that this brief statement is for the social services agency record; at the testing site, the youth will be asked to sign the Department of Health official informed consent form (see Appendix E for official form).) Staff will then proceed to make arrangements for the test within the next 30 days.

2. Child without capacity to consent

When a foster child does not have capacity to consent, there are three possible sources, all with specific limitations, for the necessary legal consent for the HIV testing of the child:

O - the parent or legal guardian of the child; or

O - the local social services commissioner or designated representative on an administrative level; or

O - a court order in cases of urgent medical necessity as defined on page 16-17.

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FOSTER PARENTS OR PROSPECTIVE ADOPTIVE PARENTS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD. CASEWORKERS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD.

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a. Consent by the parent or legal guardian of the child

(1) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into custody under Article 10 as an abused or maltreated child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, it is necessary to discuss with the parent or guardian the child's risk and the need for testing. Staff need to ask the parent/guardian for permission to test the child and to ask for a written response within 10 days of the request. If the parent agrees to provide legal consent for the test and is able to be present at the test site with the child to sign the required Department of Health pre-test consent form, staff should schedule the appointment and make other arrangements, including transportation as necessary.

If the parent refuses or is unable to provide written permission for testing the child identified as being at risk for HIV after reasonable efforts have been made to contact and discuss the importance of testing, it will be the responsibility of the commissioner or designated representative to provide the legal consent for testing in Article 10 cases.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been placed in foster care voluntarily by the parent/guardian, or has been placed in foster care as a Person in Need of Supervision (PINS) or as a Juvenile Delinquent (JD), written parental consent is required in order to test the child. If the parent refuses to provide such consent, staff are encouraged to meet with the parent to discuss the importance of early treatment and care for children who may be HIV-infected. If the parent continues to refuse, the authorized agency's only alternative in such cases is to determine whether to ask for a court order, pursuant to FCA 233, based on urgent medical necessity as defined below.

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Urgent medical necessity, for the purpose of this directive, means a determination that:

(1) a child entering care has previously tested positive and/or has symptoms related to HIV infection requiring immediate medical attention; or
(2) the infant or pre-school child has been abandoned; or
(3) the child's parent has HIV/AIDS or has died from HIV/ AIDS.

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b. Consent by the local social services commissioner or designated representative.

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"Designated representative" refers to designation by the local social services commissioner of specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases; for example, a deputy commissioner, director of services, or the executive director of a voluntary child caring agency.

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(1) When HIV risk has been identified for a child without capacity to consent, and the parents of the child have surrendered guardianship and custody of the child or parental rights have been terminated, the local social services commissioner or designated representative must provide the necessary written consent for testing the child. Designated staff will need to obtain the signed consent and make arrangements for the test.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into or kept in protective custody pursuant to Article 10 of the FCA or section 417 of the SSL, and the parents are unavailable or have refused to provide consent for the child to be tested, the local social services commissioner or designated representative will provide the necessary written consent, as explained in a. above.

E. FOURTH STEP: HIV COUNSELING

1. Counseling required by Public Health Law

Article 27-F of the Public Health Law requires that the person who provides written consent for the HIV test must receive pre- and post-test counseling and information regarding the test at the test site. This rule is applicable to the child with capacity to consent and to the parent or guardian who accompanies the child without capacity to consent to the test site.

However, such a rule would not be applicable to a physician who provides consent in an emergency situation, nor to the social services commissioner with custody of the child, nor to the commissioner's designated representative with the legal right to sign the required consent form prior to an HIV test for foster children without capacity to consent. Again, caseworkers or foster parents who accompany a child to a test site may not sign consent for the child's testing, but should carry with them the required consent form signed by the appropriate person. They may be asked by site personnel to receive such pre- and post-test counseling as is appropriate.

Counseling and information provided at the test site are governed by the requirements of the New York State Department of Health, and will include an overview of the following as appropriate for the child to be tested and/or the adults present:

a. the HIV test, including its purpose, the meaning of the results, and the benefits of early diagnosis and medical intervention;

b. the procedures to be followed, including that the test is voluntary for persons with capacity to consent; that consent may be withdrawn at any time by a person with capacity to consent; and that anonymous testing is available for persons with capacity to consent;

c. the persons entitled to disclosure of HIV-related information according to Public Health Law;

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(Please note that this information may be confusing unless the foster child, parent or guardian, foster parent, or caseworker present at the testing site has been previously informed regarding confidentiality and disclosure issues under Social Services Law and regulations, which differ from and add to the basic requirements in Public Health Law.)

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d. the nature of AIDS and HIV-related illness, information about discrimination problems and the legal protections against such discrimination, and information about risk behavior for transmission/contraction of HIV infection;

e. referral to an anonymous testing site upon request of a child with capacity to consent.

These Public Health Law requirements in no way replace the responsibility for authorized agencies providing foster care to

meet the assessment and counseling requirements set forth in Department regulations and this directive.

2. Counseling required by social services policy and regulations

Social services agency staff need to ensure that foster children and youth, parents or legal guardian, foster and prospective adoptive parents, as applicable, are prepared and informed prior to the child's testing site visit. When the test is conducted in-house, qualified and licensed medical employees of the authorized agency may be designated by the administration to provide the information and counseling needed to meet both Public Health Law and social services requirements. However, if the testing site is external to the agency, the staff there will provide standard information as required, but may have no familiarity with the child's background or medical history and no reason to develop a continuing relationship with the child. Therefore, the PHL counseling procedure will not negate the foster care agency's responsibility to maintain a counseling relationship with the child, especially with adolescents.

One of the most difficult and critical challenges of the HIV assessment and testing policy is the need for staff to provide information and counseling to pre-adolescent and adolescent foster youth on HIV prevention and risk reduction as required by section 441.22(b)(4)(i)(h) of Department regulations and this directive. Department-contracted training for staff on "Adolescents and AIDS" is available to prepare staff for this responsibility, as are a variety of materials from the Department of Health and community organizations. Any combination of individual and group discussions, booklets, pamphlets and other print materials, videos, peer support groups, peer theater productions or other means of communication, as well as directed counseling, may be useful in gaining the young person's attention regarding the importance of HIV prevention and risk reduction. Medical centers and youth-serving organizations in urban areas are often resources for this essential service.

In all cases, the youth with capacity to consent must be informed by designated staff of any risk factors identified for him or her, and the importance of being tested in order to receive medical care and services if HIV-infected. In addition to being offered the choice of confidential or anonymous testing as described on pages 14 and 15, the youth should be fully informed as to the confidentiality and disclosure rules required by Social Services Law; for example, the requirement that agencies inform the child's foster or prospective adoptive parents of all known medical issues, including HIV-related information concerning the child, as discussed on pages 31 and 32.

Along with discussion of the risk assessment and information regarding an HIV test, designated staff working with children

who have any possibility of capacity to consent should ensure that they have ongoing opportunities for access to further information and discussion.

F. TRAINING, INFORMATION AND SUPPORT FOR STAFF AND FAMILIES PROVIDING SERVICES RELATED TO HIV ASSESSMENT, TESTING AND CARE OF AT RISK FOSTER CHILDREN

Every authorized agency will need to develop a plan to provide or arrange for the training, information and support necessary for all persons involved in the HIV-related assessment, testing and care of at risk foster children.

1. Information and training for staff

All staff who are given access to confidential HIV-related information will need information and training within 45 days of employment on basic medical, legal and service issues related to the HIV risk assessment and testing of foster and adoptive children. In addition, annual updates on such issues will ensure that information is provided on continuing changes in medical care and legal procedures. Such information may be provided through any combination of formal training, informal discussion and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered.

Basic and advanced AIDS training for agency staff is provided by the Department under contract with qualified organizations. In addition, other state agencies, including the Department of Health, as well as many urban medical centers and community service providers, offer conferences, forums, and classes related to HIV/AIDS issues.

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Please refer to Administrative Directive 91 ADM-36, "Foster Care and Adoption: HIV-Related Issues and Responsibilities," pages 16, 24-25 for more detailed discussion of training issues. For additional resources, see Appendices attached to this directive for possible contacts, consult your agency's staff development coordinator, or contact your Regional Office for further information on available training.

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Some agencies working with HIV-affected children and families have found that support groups for staff have been effective in helping them cope with the emotional stress involved in providing services to this population. In many communities, networks of HIV/AIDS service providers offer mutual support activities. Appendices attached to this directive suggest contacts.

2. Foster parent support and training

Foster parents caring for HIV-infected children should also be

encouraged to take advantage of any educational opportunities provided by the agency or through the wider community to develop greater understanding of this complex disease and the skills necessary to support such children. Basic and advanced AIDS training for foster parents is provided by Department contractors.

If the child is designated as a "special" case, the foster parents must meet an annual training requirement of four hours in order to receive an enhanced (special) maintenance payment. If the child is designated as an "exceptional" case requiring a high level of care, foster parents must meet an annual training requirement of five hours in order to receive an exceptional maintenance payment. (See section 427.6 of Department regulations or the Standards of Payment Manual, Chapter VIII (B).)

IV. REQUIRED ACTION

Authorized agencies are required to take the following actions related to HIV risk assessment of all foster children and to HIV testing when appropriate:

A. DESIGNATION OF STAFF RESPONSIBLE FOR ASSESSMENTS OF CAPACITY TO CONSENT AND RISK OF HIV INFECTION

1. Each authorized agency must designate staff with appropriate background, training and experience to make the required assessment of each foster child's capacity to consent and risk of HIV infection. Such staff persons may be caseworkers, supervisors, clinical social workers, or medical personnel.

2. Qualifications of staff designated to make HIV risk assessments must include:

a. participation in HIV-related training; or
b. knowledge of HIV confidentiality requirements.

B. REQUIRED TIMEFRAMES FOR ASSESSMENTS OF CAPACITY TO CONSENT AND HIV RISK

1. Within five days of entering foster care, each child, regardless of age, must be assessed for capacity to consent as defined in Public Health Law and on page 5 of this directive.

A determination must be made and documented by designated staff within each authorized agency as to whether there is no possibility that the child has the capacity to consent or whether it is possible that the child may have the capacity to consent to HIV-related testing.

2. If a child is determined to have no possibility of capacity to consent, an assessment of risk for HIV infection must also be

determined within the first five days of entering care and documented as described beginning on page 7.

3. If it is determined that it is possible that a child may have the capacity to consent, an informed decision must be made and documented within 30 days of the child's entry into care regarding such capacity, and an assessment of risk for HIV infection must also be determined within the 30 day timeframe as described beginning on page 7.

4. For children entering care prior to September 1, 1995, all such children were required to be assessed for capacity to consent and risk of HIV infection at least 60 business days prior to the children's next scheduled periodic medical examination, as indicated in section 421.22 of Department regulations, or at least 60 business days prior to the children's next required service plan review, whichever occurred first.

C. BASIS FOR ASSESSMENT OF HIV RISK

1. For the child determined within five days of entry into foster care to have no capacity to consent, the child must, within the same five day period, immediately be assessed for risk of HIV infection based on the available medical and psychosocial history of the child, whether documented in a Child Protective Services (CPS) report, preventive services or other records, or provided orally by the child, parent, caseworker, or medical provider.

2. When it is determined within five days of entry into care that a child may have capacity to consent, such determination of capacity to consent must be made within 30 days. The child also must be assessed for risk of HIV infection within that 30 day timeframe, using available medical and psychosocial history of the child as documented in reports and records, and through oral discussions with the child or medical provider as appropriate.

Oral assessments and counseling of the child must be conducted as appropriate for the age and development of the child, as discussed in Section III of this directive. Such discussions with the child must never be confrontational or threatening in any way. The second group of risk factors involving family members should not be used as an oral checklist with a child.

3. Assessments must be based on the risk factors listed on pages 23 and 24.

4. Results of the assessment must be documented in the child's medical record section of the uniform case record, with any risk factors identified. If no risk factors are identified, documentation in the uniform case record must specify that an assessment has been completed as required and must record the

date of the assessment. If the risk assessment for infants or very young children cannot be completed within required timeframes because of an emergency placement with no medical or social history of the child available, dated documentation in the case record must state that fact, along with a plan for obtaining such history. However, please note in the risk factors in section IV. D that abandonment is a valid risk factor, and also, as stated in C.1 above, a review of a CPS report or preventive services record may establish risk.

D. HIV RISK FACTORS

There are three groups of risk factors that must be used as the basis for determining whether the foster child or youth is at risk for HIV infection. The first two groups are primarily applicable to infants or young children who may have been infected at birth. The third group is primarily applicable based on the personal behavior of older children and adolescents, although there are important exceptions, such as sexual abuse. These risk factors include:

1. Risk factors associated with direct perinatal transmission of HIV infection from the mother during pregnancy, at birth, or through breast-feeding:

a. the child had a positive drug toxicology or drug withdrawal at birth;
b. the child had a positive test for syphilis at birth;
c. the child has symptoms consistent with HIV infection;
d. a sibling has a diagnosis of HIV infection, initially tested positive for HIV infection but later seroreverted to negative, or died due to an HIV-related illness or AIDS;
e. the child was abandoned at birth and no risk history is available.

2. Risk factors related to the medical and psychosocial history of the child's mother or father, or a sexual partner of the child's mother or father, generally relevant only to an infant or young child through perinatal transmission:

a. the individual has a diagnosis of HIV infection, or symptoms consistent with HIV infection, or death due to HIV-related illness or AIDS;
b. the individual has or had a male sexual partner who has had sex with another man;
c. the individual has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
d. the individual is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value prior to the child's birth;
e. the individual has a history of tuberculosis;
f. the individual is known or reported to inject illegal drugs or share needles, syringes, or other equipment

involved in drug use or body piercing;
g. the individual is known to use non-injection illegal drugs, such as crack cocaine;
h. the individual had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
i. the individual had a transfusion of blood or blood products in any other country at a time when the blood supply of that country was not screened for HIV infection.

3. Risk factors related to children and adolescents and associated with the child's behavior or with direct transmission from another person after the child's birth:

a. the child has symptoms consistent with HIV infection;
b. the child has been sexually abused;
c. the child has engaged in sexual activity;
d. the child has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
e. the child is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value;
f. the child has a history of tuberculosis
g. the child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
h. the child is known or reported to use non-injection illegal drugs, such as crack cocaine;
i. the child had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
j. the child had a transfusion of blood or blood products in any other country at a time when the blood supply was not screened for HIV infection.

E. OBTAINING LEGAL CONSENT FOR HIV TESTING WHEN RISK IS IDENTIFIED

If the required HIV risk assessment for a child in foster care identifies one or more risk factors for the child, the authorized agency must obtain legal consent from an appropriate individual before the child's HIV test can take place.

1. When a child lacks capacity to consent and is placed in foster care under Article 10 of the Family Court Act as an abused or neglected child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, and HIV risk is identified, designated staff must:

a. make a reasonable effort to inform the parent or guardian of the child of a positive HIV risk assessment and recommendation for testing;

b. request that the parent or guardian provide written permission within 10 business days for the testing of the child (see Appendix D for model form);

c. if permission signed and dated by the parent is received within the required timeframe, make an effort to discuss with the parent the parent's ability and willingness to accompany the child to the test site;

OR

explain to the parent that the agency will take responsibility for making arrangements for the testing, accompanying the child to the testing site, and providing the official consent signed by the commissioner or designated representative, keeping the parent informed of the procedures and results;

d. if there will be parental participation in the testing process, assist by arranging an appointment, providing transportation as needed, and informing the parent that staff at the testing site will provide pre- and post-test counseling and require the parent's signature on the official Department of Health informed consent form;

e. if the child's parent does not respond within the required timeframe, refuses to consent to the testing, or is unwilling or unable to participate in the testing procedures for the child, make arrangements for the HIV testing of the child and obtain the required written informed consent form (see Appendix C for the official form) signed by the commissioner or designated representative who must provide legal consent in such circumstances for the child's HIV test;

f. retain in the medical record section of the uniform case record a copy of the official Department of Health written consent form signed by the commissioner or designated representative and provided to the testing site.

2. When a child lacks capacity to consent, is placed in foster care as a result of parental surrender or termination of parental rights by the court, and HIV risk is identified, designated staff must:

a. make arrangements for the child to be tested;

b. obtain legal consent from the commissioner or designated representative who must provide the necessary signed official written informed consent on the Department of Health form (Appendix C);

c. retain a copy of the signed consent form provided to the testing site in the medical record section of the uniform case record.

3. When a child lacks capacity to consent, is placed in foster care voluntarily by his or her parents or by the court as a Person in Need of Supervision (PINS) or a Juvenile Delinquent (JD), and HIV risk is identified, designated staff must:

a. immediately inform the parent or guardian of the results of the assessment, and recommend testing;

b. explain testing procedures to the parent or guardian;

c. request written permission from the parent or guardian within 10 business days to make arrangements for HIV testing of the child (see model form in Appendix D);

d. if written permission is received, make arrangements for the test and for the parent or guardian to accompany the child to sign the official Department of Health written informed consent form at the test site;

e. if permission is denied by the parent or guardian, offer the parent/guardian the opportunity to meet with agency staff to discuss the assessment of risk factors and the importance of testing in order to provide medical care and services for any child who is HIV-infected;

f. if the parent/guardian continues to refuse permission, document that fact in the case record. Without parental consent, HIV testing of the child in this category cannot take place unless the agency secures a court order based on urgent medical necessity (as defined on pages 16-17 of this directive).

g. if the parent/guardian cannot be located, is incapacitated or deceased, seek a court order to allow for HIV testing.

4. When a foster child has been determined by the authorized agency to have the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions regarding an HIV test, the type of test, and a limited right to make certain decisions regarding disclosure of information related to an HIV test. Designated staff must respect these rights and must never use threats or coercion in an effort to persuade the child or youth to consent to testing.

In following required procedures to obtain consent from the child, the designated staff must:

a. inform the child of the results of the assessment of risk factors for HIV infection, including the specific risk factor(s) identified as the basis for the recommendation for HIV testing, and counsel the child regarding the benefits of being tested for HIV infection in order to receive medical care and services if an HIV infection is present;

b. inform the child that arrangements may be made for agency-supervised confidential HIV-related testing and that anonymous testing is available as an alternative;

c. provide information to the child of the requirements regarding the confidentiality of HIV-related information and the disclosures of confidential HIV-related information to certain persons and entities, as described in Section 441.22(b)(8) of Department regulations;

d. after providing the initial counseling and information to the child, ask the child whether he or she will agree to be referred for agency-supervised confidential HIV-related testing or anonymous testing;

e. if the child indicates that he or she will agree to be referred for agency-supervised confidential HIV-related testing, request that the child provide the authorized agency with written permission for such a referral and, within 30 business days of receiving such written permission, arrange for the HIV-related testing of the child including obtaining the necessary pre-test counseling for the child, written informed consent of the child and post-test counseling for the child in accordance with Article 27-F of the Public Health Law; OR

if the child indicates that he or she will agree to be referred for anonymous testing, offer to assist the child in obtaining access to an anonymous testing site; OR

if the child indicates that he or she will not agree to be referred for either form of testing, continue as part of the ongoing casework contacts with the child to discuss the importance of HIV related testing.

f. Regardless of whether a child who has the capacity to consent agrees to be referred for HIV-related testing, designated agency staff must continue to provide on-going counseling to the child regarding the importance of preventing and reducing behaviors that create a risk of HIV infection.

g. The child's decision pertaining to consenting or not consenting to HIV-related testing must be documented in the child's case record, and a copy of any signed written

agreement to be tested (see model form in Appendix E) also must be retained in the case record

h. Ensure that the child understands that, at any future time, the issues of HIV risk and testing may be reopened and discussed either at the request of the child or by agency staff.

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Authorized agencies must inform certified foster parents, approved relative foster parents, and prospective adoptive parents that they do not ever have legal authority to provide written consent at a testing site for HIV testing of children placed in their care.

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F. HIV TESTING OF CHILDREN IN FOSTER CARE

1. If a child in foster care is determined to have one or more of the risk factors listed in section IV. D of this directive, authorized agency staff must make arrangements for HIV testing to take place provided the required legal consent has been obtained:

a. within 30 business days of the child's entry into foster care if the initial assessment of the child indicated no possibility of capacity to consent (Please note that this timeframe is intended to correspond to the requirement for the child's initial comprehensive physical examination within 30 days of entry into care in accordance with section 421.22 of Department regulations and 90 ADM-21.);

b. within 60 business days of the child's entry into foster care if the initial assessment of the child indicated that there was a possibility that the child may have a capacity to consent, and the follow-up assessment completed within 30 days of entry resulted in a decision that the child did not have capacity to consent;

c. within 60 business days of the child's entry into foster care if the child was determined to have the capacity to consent and agreed to provide written consent to testing.

2. When a medical provider for the child in foster care recommends the HIV testing of the child based on medical/social history or symptoms, the authorized agency must begin immediately to initiate the procedures necessary to obtain legal consent before such testing can take place, unless the physician determines there is a medical emergency, in which case the physician may require the test be performed without consent. The child with capacity to consent retains the right in such situations to make his or her own decision regarding testing.

3. The HIV testing of a child or youth in foster care must be conducted:

a. under the direction of licensed medical personnel, who may be medical staff employed by the authorized agency or in designated testing centers or clinics;

b. at a designated testing center, medical facility or office.

4. Each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(2) of Department regulations must include an assessment by designated agency staff of whether HIV-related testing is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable. If it is determined that HIV testing is recommended, the authorized agency must initiate the process to obtain legal consent. If the written informed consent for the HIV-related testing of the child is obtained, the agency must arrange for testing within 30 business days of the recommendation.

G. SERVICES REQUIRED FOLLOWING HIV TESTING OF A CHILD IN FOSTER CARE

If a child in foster care tests positive for HIV infection, the authorized agency must:

1. provide or arrange for counseling of the child as needed and age appropriate in addition to any post-test counseling at the test site (see pages 17-20 for a discussion of practice issues involved in providing or arranging counseling for the child, for foster parents, prospective adoptive parents, or the parent/guardian of the child);

2. arrange for all follow-up medical services needed by the child as a result of the HIV test, including any additional tests recommended by the child's medical provider;

3. provide support services and counseling as needed to the child's parents and foster parents caring for a child who tests positive for HIV infection.

H. DOCUMENTATION RELATED TO THE ASSESSMENTS AND HIV TESTING OF A CHILD IN FOSTER CARE

Authorized agencies must document specific information related to the assessments and HIV testing of a foster child in the uniform case record. The authorized agency must document the following information in the medical record section of the uniform case record:

1. decision on the assessment of the child's capacity to consent, reason for the decision, and the date of the decision;

2. confirmation that the assessment of HIV risk factors was conducted within required timeframes;

3. identification of any risk factors listed on pages 23 and 24 of this directive;

4. information on any follow-up assessments;

5. a copy of the written consent for HIV testing provided by the parent or guardian of the child, the child with capacity to consent, or the commissioner or designated representative, as applicable;

6. documentation of the parent's or child's refusal to provide consent, as applicable;

7. date and location of any HIV testing of the child;

8. type of HIV test:

a. confidential or anonymous (anonymous is a choice available in foster care only to the child/youth with capacity to consent);

b. antibody (elisa, western blot) or viral (polymerase chain reaction (PCR));

9. results of the HIV test and any recommendations by the medical provider for follow-up tests or medical treatment for the child;

10. information and counseling sessions provided to an HIV-infected child;

11. information and counseling sessions provided to the parent of an HIV-infected child without capacity to consent who has a permanency planning goal of return home;

12. information and counseling sessions provided to the parent of an HIV-infected child with capacity to consent only if the child/youth has provided written consent to provide such HIV-related information concerning himself or herself to the parent;

13. information and counseling sessions provided to the foster parents or prospective adoptive parents caring for an HIV-infected child;

14. specific plans for training and support services for foster parents or prospective adoptive parents caring for an HIV-infected child.

I. CONFIDENTIALITY AND DISCLOSURE OF HIV-RELATED INFORMATION CONCERNING THE FOSTER CHILD

All person-specific HIV-related information must be maintained in a confidential manner, as required by Section 431.7 of Department regulations. In all cases when HIV-related information is made available as described in this section, a warning statement against further disclosure or redisclosure must be provided to those

receiving such information except those persons listed in paragraph 4 of this section. (For a copy of the warning statement, see Appendix A.)

1. Authorized agencies must insure that direct access to HIV-related information concerning a foster child is limited to:

a. an authorized agency responsible for the foster care or adoption of such child;

b. staff within that authorized agency who need to know such information in order to supervise, administer, monitor, or provide services for the specific HIV-infected child or child's family;

c. the child's medical care provider or medical facility;

d. the child with capacity to consent;

e. a person authorized by law to consent to health care for a foster child who lacks capacity to consent.

2. Authorized agencies must disclose HIV-related information concerning a specific foster child, whether or not the child has capacity to consent, to the following:

a. certified foster parents and approved relative foster parents caring for the HIV-infected child;

b. prospective adoptive parents and adoptive parents of the child freed for adoption;

c. another authorized agency when the child is transferred to that agency or agency facility for placement or treatment;

d. the law guardian of the child;

e. a foster child discharged to his or her own care; and

f. an adopted former foster child upon request.

3. Authorized agencies must disclose HIV-related information concerning a specific foster child to the following only under certain conditions:

a. the parent or guardian of the foster child if the foster child lacks capacity to consent;

b. the parent or guardian of the foster child with capacity to consent only if the child provides written consent to disclosure of the information to the parent or guardian;

c. in a court hearing related to the foster child only when directly ordered by a judge after a hearing on the issue of

disclosure (such information must not be provided in response to a subpoena, in accordance with Public Health Law, Article 27-F);

d. external services providers only when necessary to obtain essential health or social services for the foster child and only when the commissioner or designee has signed specific authorization for the release of such information, including the reason for the release, the warning statement against any redisclosure, the signature and date of signature from the person receiving such information. Examples: psychologist, home aide, day care or school staff (day care or school staff only when medication or other medical necessity directly related to HIV infection or AIDS is involved). (See model form in Appendix B.)

4. The right of a person in #2 or #3 to redisclose confidential HIV-related information concerning a foster child is limited to the following persons:

a. a prospective adoptive parent of a foster child freed for adoption, or an adoptive parent, without condition;

b. a certified foster parent or approved relative foster parent caring for the child, only when necessary for the care, treatment or supervision of the child;

c. the law guardian of the child when necessary to represent the child without capacity to consent in court proceedings;

d. the law guardian of the child when necessary to represent the child with capacity to consent in court proceedings only if the child with capacity to consent has provided written consent for such disclosure.

J. RECRUITMENT OF FAMILIES TO CARE FOR HIV-INFECTED CHILDREN IN FOSTER CARE

Authorized agencies operating foster boarding home and/or adoption home programs must include in their community relations efforts information regarding the need for foster and prospective adoptive families who may be able and willing to provide care for HIV-infected children identified by these HIV assessment and testing requirements.

V. REPORTING AND SYSTEMS IMPLICATIONS

Each authorized agency is required to document the HIV risk assessment and testing, as appropriate, for each child in foster care in accordance with Department regulations and this directive.

VI. ADDITIONAL INFORMATION

Additional information is provided through Appendices attached to this directive.

VII. EFFECTIVE DATE

The effective date of this Administrative Directive is August 15, 1997, retroactive to August 23, 1995 which was the effective date of Department regulations requiring authorized agencies to implement the HIV assessment and testing program for New York State children in foster care.

Rose M. Pandozy
Deputy Commissioner
Division of Services and
Community Development

APPENDIX A

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA

CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL

RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

MODEL FORM

APPENDIX B

Authorization for Redisclosure of Confidential HIV-Related Information

[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

Date _____

I hereby authorize redisclosure of confidential HIV-related information

by _____
(name of agency)

concerning _____
(child's name)

to _____
(person or agency)

for the following time period (check one):

____ specific dates: _____

____ while child remains in care of above-named person(s)

____ until services are completed

The purpose for authorizing redisclosure as permitted by Article 27-F of the Public Health Law and Department regulations:

_____

I am legally permitted to authorize redisclosure because I am:

____ the child named above

____ the birth parent or legal guardian of the child (where the child lacks capacity to consent)

____ the social services commissioner

____ the designated representative of the commissioner
(indicate title with signature)

Signature _____

Title (if appropriate) _____

Warning Statement on Redisclosure Except to Authorized Persons

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

Receipt of Confidential HIV-related Information

I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature_____Date_____
(person receiving confidential information in order to provide services)

Model Form

APPENDIX C

REQUEST FOR PARENTAL PERMISSION TO TEST CHILD FOR HIV INFECTION

(For a child without capacity to consent)

I have been informed that my child, _____, has been found by the agency where he/she has been placed in foster care, to be at risk for HIV infection. The agency recommends testing to determine whether the child is infected so that care and treatment can be given as necessary.

I understand that the agency is requesting my permission for the child to be tested, and that this form must be returned to the agency within 10 business days.

I understand that if I give my permission for my child to be tested, the agency will make arrangements for the test.

If the agency asks me to go to the HIV test site with my child and I agree to go, I understand that I would be asked to sign the Department of Health consent form and receive pre-test counseling at the test site.

I would need transportation to the testing site in order to take my child.

Yes___ No___

If my child was placed in foster care by the court for abuse or neglect, I understand that the agency may give consent and arrange for my child to be tested for HIV even if I do not sign and return this permission slip or if I refuse to give my permission for the test.

If my child was placed in foster care for reasons other than protective removal or placement (abuse or neglect), I understand that the agency may not give consent and arrange for my child to be tested for HIV. My child will not be tested unless I give permission or a court order is obtained. If I give permission, I understand that I must go with my child to the testing site.

I give my permission for my child placed in foster care to be tested for HIV infection.

Yes___ No___

I understand that the agency will inform me regarding the results of the HIV test.

Signed by _____ (parent)

Date_____

Received by agency staff_____ (signature)

Date _____

Model Form

APPENDIX D

DECISION REGARDING TEST FOR HIV INFECTION BY CHILD WITH CAPACITY TO CONSENT

I have been informed by agency staff that they believe I am at risk for HIV infection. Agency staff have explained the reason(s) why they believe I am at risk for HIV infection. I understand the importance of being tested in order to receive any necessary treatment and services.

I understand that if I agree to be tested, I will receive pre-test counseling at the testing site and will be asked to sign the official Department of Health written informed consent form.

I understand that if I agree to be tested, I may choose between confidential (agency-supervised) testing or anonymous testing (where I would be identified only by number).

I understand that I will be given the results of the test, whether confidential or anonymous. If I choose anonymous testing, no other person or agency will be given the results of the test. If I choose confidential testing, the agency will also receive the results of the confidential test, as will other persons required by law to be given the results. In either case, my parents could not be given the results without my written permission.

I understand that the agency will make arrangements for the test and for any necessary transportation to the test site.

I agree to be tested for HIV infection.

Yes _____ No_____

If I have checked "Yes," I choose:

Confidential testing _____
Anonymous testing _____

Signed_____

Date_____

Agency staff_____

Date_____

APPENDIX H

NEW YORK STATE INDEPENDENT LIVING TRAINING NETWORK WITH INFORMATION AND RESOURCES AVAILABLE ON ADOLESCENT ISSUES

Region 1:
Buffalo State College
Center for Development of
Human Services
Campus West
1300 Elmwood
Buffalo, NY 14222
(716) 882-1117

Region 2:
Buffalo State College
Center for Development of
Human Services
1210 Jefferson Road
Rochester, NY 14623
(716) 292-5010

Regions 3 and 4:
State University of New York
at Albany
Professional Development Program
135 Western Avenue
Albany, NY 12222
(518) 442-5700

Region 5:
State University of New York
at Stony Brook
School of Social Welfare
Stony Brook, NY 11794-8231
(516) 444-7565

Region 6:
South Bronx Human Development
Center
One Fordham Plaza, Suite 900
Bronx, NY 10458
(718) 295-5501