HANDBOOK

FOR

FOSTER AND ADOPTIVE PARENTS

Family Foster Care

Therapeutic Foster Care

Kinship Foster Care

Adoption

Success Coach

Intensive In-Home

Lake Waccamaw, NC

Kinston, NC

Fayetteville, NC

www.boysandgirlshomes.org

www.facebook.com/bghnc.cbs

Mission Statement: Boys & Girls Homes of North Carolina, Inc. is dedicated to providing a comprehensive array of residential and community-based services to meet the needs of vulnerable children by addressing their physical, emotional, social, educational, and spiritual development.

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INTRODUCTION

Foster Care: Welcome to the Team!

Being a foster/adoptive parent can be rewarding; it can also be difficult and discouraging; but don't worry! You and the staff at Boys & Girls Homes are in this together, WE ARE A TEAM!

As with any team activity, foster care takes practice, commitment, and perseverance. We will cheer you on and coach you the entire way.

PRACTICE

Practice really does make perfect as you attend our trainings which equip you with the opportunity to polish your parenting skills and even learn new ones. Our training sessions are designed to fulfill your hourly requirements for state licensure as a foster/adoptive parent. The session topics can also be requested by YOU! Just let your licensing worker know what topics interest you. A successful team communicates the needs of the entire group and addresses them together.

COMMITMENT

No team has ever succeeded without commitment. You not only commit to the child or children in your care but also to the program you are a part of. We also are committed to you. We are here to provide you with what you need and when you need it. You are available to the children under your care 24 hours a day, seven days a week. We are available to you 24 hours a day, seven days a week. A successful team is made up of individuals who join in and play their part.

PERSEVERANCE

It takes perseverance to win as a foster parent. To take a child into your home and to teach them and to model for them the skills necessary to succeed takes more than unconditional love. It takes patience, confidence, and humility. There will be days when you feel you are losing, but making it through those days with a child is exactly how you win. You win the child's trust and their respect. You win for yourself the knowledge that you are making a difference for a child. A successful team sticks with it through thick and thin.

This handbook is a resource to help you succeed as a foster/adoptive parent. Boys & Girls Homes of North Carolina thanks you for joining our team!!

How Do You Get Help?

Important Phone Numbers and Addresses:

Boys & Girls Homes of North Carolina, Inc. (Main Office)
PO Box 127
400 Flemington Dr.
Lake Waccamaw, NC 28450
Phone: (910) 646-3083
Fax: (910) 356-4067

Boys & Girls Homes of North Carolina, Inc. (Kinston Office)
668 Stratford Blvd
Kinston, NC 28504
Phone: (252) 520-6727
Fax: (252) 520-6739

Boys & Girls Homes of North Carolina, Inc. (Fayetteville Office) 351 Wagoner Dr, Ste. 125
Fayetteville, NC 28303
Phone: (910) 703-8777
Fax: (910) 703-8778

Emergency/After-Hours: Family: (910)770-1474
Therapeutic: (910) 770-0083

FOSTER PARENT REMINDERS

When a child comes into your home, an initial physical must be scheduled within 3 days, ideally within 24 hours of placement. While making the physical appointments, keep in mind that children over the age of 1 year must be seen by the dentist within 6 weeks of placement. A school age child who has not been to the eye doctor should obtain an appointment and then be seen yearly thereafter. Please make sure to provide a copy of the physical forms (initial/30 days and well child) along with a provider report to your BGH Social Worker.

When getting a placement, it is important to make sure that your home and car have the necessary items to meet the needs of the child. Example: If a child needs a car seat or booster seat, or a crib. BGH Social Workers will ask DSS if the child has their own seat, however, it is best practice to be prepared in the event that they do not. Your home also needs to be "baby proofed" if applicable. A BGH Social Worker will make every effort to be at your home at the time of placement and if unable, they will make a visit within 24 hours.

Start taking pictures of the children placed in your home from day one so you can start a Lifebook. If you need some suggestions on how to start a Lifebook, please ask your Boys & Girls Homes Social Worker.

Keep track of all your paperwork regarding the placement (you will need to refer to it frequently). Ask either the DSS Social Worker or your Boys & Girls Homes Social Worker if the child is on any medication, does he/she have any previously scheduled appointments coming up or visits. Start filling out your MAR forms from day one with the child's information and any medications prescribed at the time of placement. The MAR forms are to be filled out daily and turned in the following month (EX. March will be turned in at your April home visit). These forms are to be completed whether the child takes any medications or not, if not simply put an X through the form and say No Meds. MARs are extremely important to stay on top of, especially if your child takes daily medications. The Service Log is to be completed monthly, please include any services on the form, not just medical. If you take a child to a parent or sibling visit, if you attend court or an evaluation, include it all on the service log. If there is ever a question about medications, appointments or visits, it will be documented. A copy of the service log is to be turned into your Boys & Girls Homes Social Worker.

Make time to attend court hearings, meetings with DSS, therapy sessions and school meetings. Try to go and introduce yourself to your child's teachers. Let the school personnel see you and get to know you. Remember you are an advocate for the kids when they are in your home. Please make sure your Boys & Girls Homes Social Worker gets a copy of each child's report cards and lets them know about any meetings or school issues.

As a foster parent you are obligated to report if you suspect any abuse or neglect. Call your Boys & Girls Homes Social Worker if a child discloses anything to you and they can walk you through the process of how to make a report. Reports can be made anonymously if you prefer but talk with us and we can help you with the process of contacting your local DSS.

When you receive a placement, within the first 24 hours tell the child, if of age, your house rules. Take

the time to sit with them and let them know what you expect from them and what they can expect from you. It will be easier for you both if they know upfront rather than letting them guess what they can/can't do, remember they have not grown up in your home and what may have been allowed at their previous home may not be allowed in your and vice versa.

If a child is three and under a referral must be made to CDSA (Child Development). Ask your Boys & Girls Homes Social Worker to help you if needed. If the child is older, they may be referred to More at 4 or a pre-K program.

If a child is 13, then you along with your consultant need to get the child into a LINKS program if offered by your county.

If you have a child that is sexually active, birth control should be discussed with the DSS social worker, your Boys & Girls Homes social worker and the child. Please also talk with your social worker assigned to your home if you feel the child or you need information on STD's and treatment of them.

DO NOT CUT YOUR CHILD'S HAIR UNLESS YOU HAVE PERMISSION FROM THE PARENT OF THE CHILD OR THE DSS SOCIAL WORKER ASSIGNED TO THE CHILD. THERE IS NO EXCUSE IF YOU CUT THE CHILD'S HAIR.

DO NOT USE ANY TYPE OF PHYSICAL DISCIPLINE. IF YOU HAVE A QUESTION ABOUT A DISCIPLINE TECHNIQUE, DO NOT USE IT UNTIL YOU HAVE TALKED WITH YOUR BOYS & GIRLS HOMES SOCIAL WORKER!!!! PHYSICAL DISCIPLINE IS NOT ALLOWED UNDER ANY CIRCUMSTANCES!!!!!

These are just some reminders when you receive a placement. We understand that when a new child comes into your home it gets hectic. If you have any questions whatsoever, please reach out to your Boys & Girls Homes Social Worker.

Donna Yalch, Chief of Community Based Services, Boys and Girls Homes of NC, Inc.

BGH Social Workers and DSS Social Workers

BGH Social Worker

Each foster home has a social worker assigned to them who is employed by Boys & Girls Homes. This person is your number one support system and she will deal with any challenges you may encounter about the foster child in your home. Your BGH social worker works with you in assisting your foster child to adjust, to develop youth treatment plans, arrange home visits, and to evaluate youth performance, progress and any problem areas that need addressing.

You also will be assigned a licensing social worker that will assist you with questions regarding your license, trainings, and will handle any changes that may occur in your home during your licensure.

Your BGH social worker is the first person to contact when you have questions, concerns, problems and emergencies. It is very important you share with your BGH social worker information about your child's adjustment in your family, development, or any problems that may arise. Please contact your BGH social worker no matter how small a problem may seem.

If there are any changes of household composition (members), employment, address, phone number or any major sickness or hospitalization of someone in your home please notify your social worker. Also notify your social worker if a child becomes sick or is involved in an accident, you plan any vacation or out of town overnight trips, if any contact is made by the birth family unannounced or unplanned, or if any problems arise with your child at home, school or in the community, please notify your social worker immediately. **YOUR SOCIAL WORKER OR A MEMBER OF THE BGH TEAM IS AVAILABLE 24 HOURS A DAY THROUGH THE ON-CALL SYSTEM.**

DSS SOCIAL WORKERS

All children who are placed in your home will have a social worker assigned to them from the DSS that holds custody. DSS also works with the child's biological family. Your DSS social worker visits your home once per month and talks with you and your family. DSS social workers are also invited to join in the treatment planning and they will sometimes help with transportation for your child to and from visits. Your child's DSS social worker is a valuable team player in our foster care program.

Procedures, Policy, & Information

Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-2025
Subject: Monthly Stipend Format

When you provide foster care for a child, you will receive a stipend check the following month. Include with the check is a spreadsheet that breaks down the payment information. The sheet will show you the "placement history", the "rate per day", the number of "nights of care", and the total stipend amount.

The **"rate per day" will change depending if there are 30 or 31 nights in the month. However, the monthly amount will stay the same.** For example if you have a child who is 4 years old, the monthly rate is $702. On your spreadsheet if it is a 31 day month the "rate per day" will be $22.65. If you multiple this by 31 nights it equals $702. If it is a 30 night month, "the rate per day" will be $23.4. If you multiply this by 30 nights it too equals $702. So you are getting the same monthly rate, the "rate per day" is all that is changing. Below you will see the current stipend breakdown, which you are already familiar with:

Amount Per Family Foster Care Child:

Age: 0-5	Age: 6-12	Age: 13-20
$702/Month	$742/Month	$810/Month

Amount Per Therapeutic Foster Care Child:

Age: 0-5	Age: 6-12	Age: 13-20
$60/Day	$70/Day	$80/Day

Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-2025
Subject: Respite Care & Stipend

Boys & Girls Homes of NC, Inc. offers respite care for any of our foster parents. If you need respite care for any reason, please contact your BGH Social Worker two weeks in advance and we will find a home for the children to go to temporarily.

When you provide respite for a family foster care child you will get paid $20 a night as long as it does not exceed 5 days. If you are going to provide respite for a family foster care child and it will go longer than 5 days then you will get the regular board rate according to the age of the child. It will not be $20 a day for 5 days and then board rate for the remaining time. It will be board rate the entire time. If we did it any other way we would be paying out more for the child to stay in respite than we receive from DSS.

When you provide respite for a therapeutic foster care child you will get the normal therapeutic rate per night based on that child's age.

Foster care and respite care are paid according to the actual number of nights the child spends with the foster or respite family. This is how DSS pays us.

You should receive your stipend by the 15th of every month. If you do not receive payment by the 15th of the month please contact the office at that time. Please do not call the office regarding your stipends until after the 15th.

If you have any questions about this, please contact the office or your BGH Social Worker.

Financial Information

MONTHLY STIPEND

A monthly stipend, or board rate, is set for each child depending upon their age. The monthly stipend is expected to cover all expenses of the child in the home except for medical expenses (Medicaid). The stipend is sent to the foster home by the 15th of each month if the check is to be mailed. Our most common and preferred method of getting the stipend to you is by means of direct deposit. Ask your licensing worker or consultant if you need a direct deposit form.

The payment is sent for the month prior. For example, if a child is placed in your home April 1, you will receive a stipend for that child in May. By the same token, if a child leaves your home April 16, you will receive a check in May for the days the child was in your home in the month of April (overnights).

MEDICAL EXPENSES

Most children whom BGH will place with you are eligible for medical coverage through Medicaid. Each child will have a Medicaid card and will cover medical appointments, hospitalizations, eye care, dental care, physician services, and most prescriptions.

TAX INFORMATION

"The tax benefits of keeping foster children are often overlooked by foster parents, resulting in a loss of tax savings to which they are entitled. Both the US Internal Revenue Service and the NC Department of Revenue make provisions for foster children. Depending on certain factors, they may be counted as dependents, or foster parents' expenses may be deductible as charitable contributions. It is usually more beneficial to the foster parents to claim expenses as charitable contributions, but because every situation is unique, foster parents are urged to consult an accountant or an attorney for tax advice."

A foster child must be placed in your home for at least 6 months + 1 day to file them on your taxes.

DONATIONS

We have donations of clothing, school supplies, luggage, etc. If you find you need these items, please ask your BGH Social Worker and they will try to help you find what you need.

Post Office Box 127 • 400 Flemington Drive
Lake Waccamaw, North Carolina 28450

DIRECT DEPOSIT ENROLLMENT FORM
FOR DEPOSIT OF MONTHLY STIPEND PAYMENTS

Printed Name(s):_____

_____

Bank Name_____

ABA/Routing #_____

Account #_____

Checking _____ or Savings _____ (mark one)

I hereby authorize Boys & Girls Homes of North Carolina and the bank listed above to deposit the stipend payment into the account listed above each month.

If funds to which I am not entitled are deposited into my account in error, I hereby authorize Boys & Girls Homes of North Carolina to direct the bank to return said funds.

Signature_____ date_____

Signature_____date_____

PLEASE ATTACHED A COPY OF A VOIDED CHECK OR DEPOSIT TICKET TO THE SIGNED FORM AND RETURN TO YOUR B&GH CONSULTANT OR OTHER POINT OF CONTACT AT THE AGENCY.

Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

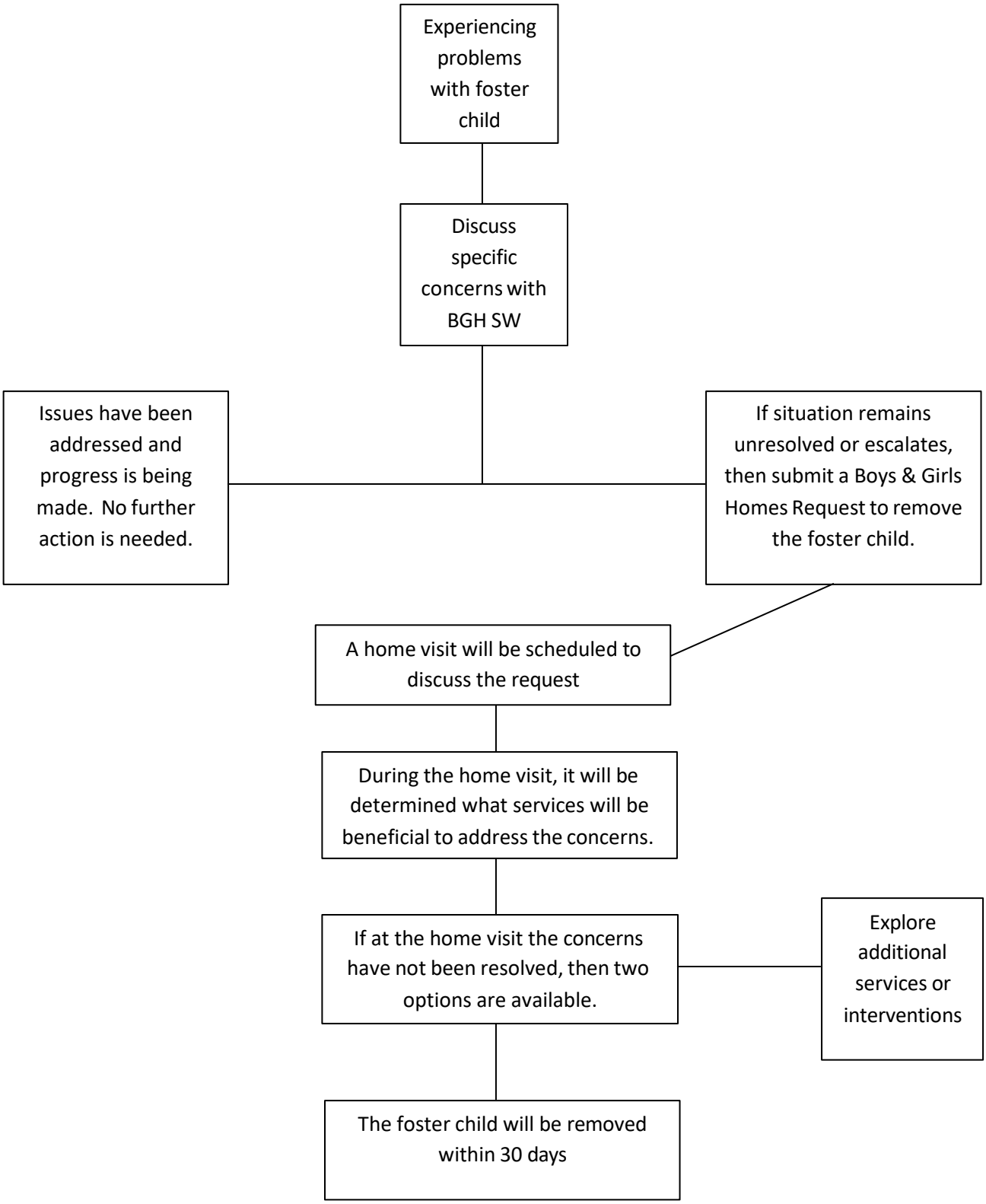
To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-25
Subject: Placement Disruptions

According to Boys & Girls Home of North Carolina Foster Care and Adoption's policy, if you feel that a foster child's behavior is escalating, changing, or becoming unmanageable, you should first speak with your designated BGH Social Worker. Once a plan for change is put in place with the child and you still feel the behavior warrants the removal of the child, you must put the request in writing to Boys & Girls Homes Foster Care and Adoption program. In the request you should explain in detail what the behaviors or concerns are and what strategies or services you have put in place to help assist the child. Once your request is received, your BGH Social Worker along with your licensing worker may schedule a home visit to discuss the situation. If after the visit you still feel the child must be moved from your home, Boys & Girls Homes of NC will have up to thirty days to move the child.

Your BGH Social Worker will work jointly with DSS to ensure a placement is secure within the allotted 30-day time frame.

Procedure to Request for Removal of Foster Child



Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-25
Subject: Medications

Return to the legal custodian or BGH Social Worker any medications when youth are discharged from the foster/adoptive home or if any prescription medications are discontinued. The legal custodian will then dispose of the medication.

Please contact me at (910) 646-3083 ext. 218 if you should have questions.

Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-25
Subject: Emergencies

If a child in your home injures themselves and you need to seek medical treatment, please let your BGH Social Worker know immediately.

If the child runs-away, call 911 and your BGH Social Worker immediately. If it is after hours, call the emergency on-call number if you are unable to reach your BGH Social Worker along with 911.

If there is a fire or natural disaster in your home, please get yourselves, your family and any children in your home to a safe place. Once you are safe, call your BGH Social Worker or the emergency on-call and let them know what has happened. Number and let them know what has happened.

If there is a human caused disaster, i.e. shooting, bombing, etc., please follow the emergency responders and/or police procedures. Please contact your BGH Social Worker immediately and let the consultant know what the situation is.

You will need to fill out a critical incident report if a child is injured or runs away. This report should be given to the BGH Social Worker as soon as possible.

Should an emergency arise, your BGH Social Worker can help facilitate the contacting of supervisors, DSS and/or any other person or entity that should be made aware of an emergency.

Please contact me at (910) 646-3083 ext. 218 if you should have questions.

Boys & Girls Homes of North Carolina, INC.
PO Box 127
Lake Waccamaw, NC 28450

To: All Foster Parents
From: Donna Yalch, Chief of Community Based Services

Date: 4-01-25
Subject: In the event of a hurricane

Hurricanes can usually be forecast sufficiently in advance for emergency action to be taken before such a condition can seriously affect individual foster homes. In the event of a hurricane Boys & Girls Homes will be in contact with each home in order to alert you of the possibility of it affecting your area.

If there is a mandatory evacuation for the area you live in, you must evacuate. If you choose not to evacuate then Boys & Girls Homes reserves the right to move the foster child(ren) for their safety. You must inform your BGH Social Worker of your evacuation plans and if you are planning to leave the state, then you must get written permission from the DSS social worker. If you have special circumstances and feel you cannot evacuate, please contact your BGH Social Worker immediately. If there is not a mandatory evacuation for your area then please follow the guidelines listed below.

1. Check supplies of canned food, water, medicine, and batteries for radios and flashlights in advance. This is particularly important in regard to prescription medication needs.
2. In the event of evacuating the area please notify Boys & Girls Homes staff of the arrangements and how you can be reached. Foster children are expected to remain with their foster families during emergencies.
3. At home you should secure any trash cans, flowerpots, or anything that could become a missile and be blown around.
4. At no time allow children outside during a hurricane unless you have been notified by the appropriate authorities that the hurricane has passed.
5. Children should not go outside after a hurricane unless you have first given your authorization. Teach children to avoid downed power lines, fallen trees, standing or moving water, debris, and injured or confused animals.

By following these guidelines and planning ahead, your home and family will be better prepared in the event of a hurricane.

Please contact me at (910) 646-3083 ext. 218 if you should have any questions.

Reasons for Termination

If you violate any of the policies your foster home could be terminated or revoked.

If your home receives a CPS report and it is substantiated then your license will be revoked and you cannot get licensed for at least five years. This is not an agency policy, this is according to the State Licensing Agency.

If you get a criminal charge while licensed, depending on the charge and circumstances, your license may be terminated or revoked. Please let us know so we can discuss the charges.

Licenses terminate at the end of the two-year license period unless all re-licensing materials have been received by the licensing agency in a timely manner.

The licensing agency can terminate a license before the end of the two-year license period if requested by the foster parents. Both foster parents are required to sign a termination letter if /when needed.

The licensing agency may revoke or deny licensure to an applicant who has a finding that will place the applicant on the following:

(1) Health Care Personnel Registry
(2) North Carolina Sex Offender and Public Protection Registry
(3) North Carolina Public Offender

How to Report Child Abuse/Neglect

Children are the most vulnerable citizens of our society. Because of this, they are at risk for abuse and/or neglect. The effects of child abuse and neglect can be traumatic and long lasting; in some cases, it results in death of the child.

Any person or institution who has cause to suspect that a child is being abused or neglected is required by law to report it. As foster/adoptive parents, you are required to report if you suspect abuse or neglect. Failure to report a suspected case of child abuse can be punished as a misdemeanor. You can make a report of child abuse or neglect by calling, writing, or visiting the Social Services in your county, Child Protective Services Division. A social worker will listen to you and take the information you give. It is helpful if you can share the following:

The name, address, and age of child

Name and address of the child's parent, guardian, or caretaker

The child's condition, including the nature and extent of the injury

Any information regarding the presence of weapons in the home, alcohol/drug abuse, or other factors affecting a social worker's safety are helpful.

When a child tells you that he/she has been abused, the child may be feeling scared, guilty, ashamed, angry, and powerless. You may feel a sense of outrage, disgust, sadness, anger, and sometimes disbelief. It is important, however, for you to remain calm and in control of your feelings in order to reassure the child that something will be done to keep him or her safe. You can show your care and concern by:listening carefully to what the child is saying, telling the child you believe him or her, telling the child the abuse was not their fault, and letting the child know that you will make a report to help stop the abuse. You will NOT be helping the child if you: make promises you cannot keep or discuss what the child told you with others who are not directly involved with helping the child.

So remember, in our hurried and busy lives, there may be a child that needs your help; take the appropriate steps to help protect that child.

CPS Procedures

All North Carolina foster parents should understand CPS policies and procedures. Below is a brief overview, but we encourage you to learn more by talking to your licensing worker.

Steps/Issues in a CPS Investigation

- The report must meet the state's legal definitions of abuse, neglect, or dependency. If it does not, no investigation occurs.
- For reports of abuse, an investigative assessment must be initiated by the county receiving the report within 24 hours; for cases of neglect or dependency, the county must initiate an investigation within 72 hours. Initiation includes face-to-face contact with all children living in the home.
- CPS must interview people thought to know about the alleged maltreatment.
- After information-gathering, CPS decides whether the foster family harmed the child through their action or inaction. This is where a case decision is made whether to substantiate the allegation.
- CPS reports the outcome of the investigation to the Central Registry and, in the case of a substantiation, other parties.
- If the decision is made to substantiate, the licensing worker and CPS worker visit the foster parent to explain the decision.

If You Are Investigated by CPS:

The DSS of the county you live in will conduct the investigation. If the child is from the county you live in, then a neighboring county will do the CPS investigation.

Cooperate with both the Boys & Girls Homes and the investigating agency to complete the investigation and resolve issues of concern.

- Ask about the allegations and the process of the investigation until you understand to your satisfaction. It may help to write down answers to your questions.
- Ensure you and all children living in your home are interviewed by CPS. These interviews are required, since all children living in a residence are considered alleged victim children. This includes your own children. Interviews may be held in private.
- Allow CPS to visit your home. Law, policy, and administrative code require this.
- Make any records or documentation you have kept concerning the child available to social workers.
- Do not attempt to have the child examined by a doctor or other professional without the agency's authorization.
- Do not "investigate" the allegations on your own by questioning the child.
- Provide a list of collateral contacts and witnesses the social worker may interview to gather all relevant information about your situation or the alleged incident of maltreatment.

Know and exert your rights as you deem necessary.

- Consult an attorney.
- Document or record interviews and conversations with CPS workers.
- Have a witness present during every contact with the investigating social worker. It may be helpful if this witness is well-respected in your community.
- Request copies of safety, risk, and strengths and needs assessments completed by the social worker.

Take care of yourself and your family.

- Call for support from your local, state, or national foster parent association.
- Join a support group or seek the emotional support of others (including professional counselors) as needed.
- Use your licensing social worker as a source of support and information.

Remember this is not a "win-lose" situation and DSS is not your adversary. Together you can partner to maintain foster children in a safe, nurturing, permanent home.

Notification of Boys & Girls Homes Client Confidentiality Policy

The information that our children and their families and legal custodians provide us during the application, admission, and foster care process are to be considered confidential by all Boys & Girls Homes employees. This information is to be shared and discussed only with members of that child's Boys & Girls Homes care team (Foster Parents, Consultant/Trainer, Therapist, Childcare Administrative Assistant, Director, Chief of Community Based Services, and the President of Boys & Girls Homes of NC,) who are directly involved in the care and documentation of care for that child. Under the following specific conditions, release of information is permitted and/or required by law and professional ethics:

1. When Boys & Girls Homes has received an authorization for release of information signed by the legal custodian. Such a release must specify which documents are to be released, for what purpose, to whom, and for what period of time. Such releases may be revoked by the legal custodian at any time except to the extent that action based upon the consent has already been taken.

2. The child presents a threat of physical harm to either themselves or to other persons and disclosure is made to avert the potential for physical harm.

3. When Boys & Girls Homes is required by law to report abuse, neglect, or exploitation of children.

4. When in response to a court order or in cooperation with a commitment proceeding as allowed by law.

5. When Boys & Girls Homes records are being audited by State licensing or accreditation bodies. Such audits are done on site and are designed to assure the presence of certain documents and pieces of information rather than to review the specifics of a case record. Legal custodians sign a release of information for these purposes at the time of the child's admission.

Whenever a child's information is to be disclosed, permission for disclosure must be given by the Director or Chief of Community Based Services. Only necessary, relevant and verifiable information is to be released and then only to appropriate professional workers or public authorities.

All the paper materials that make up a child's case record are to be kept in a child's file which is organized for ease of retrieval and kept in secure conditions (e.g. in a locked file cabinet).

Foster children and their parents/legal custodian may have access to their records on the premises in the presence of Foster Care Staff. Any request for this must be cleared through the Program Director. Any information not to be shared because of its perceived harmful nature for the child will be removed from the file prior to the child or families viewing of the file. A written statement noting which pieces of material were not made available and what shall be entered into the file. Additionally, viewing of the file shall be done in a manner that protects the confidentiality of other family members or other individuals referenced in the record.

Foster Parents agree to also refrain from posting pictures and/or status updates on any social media sites regarding the foster children in the home and to refrain from having a foster child's picture placed in a newspaper or other public announcement except when approved by the parents/legal guardian and Boys & Girls Homes of NC.

Employees who release children's records or discuss children's information other than according to the above guidelines may be subject to dismissal.

HIPPA

HIPAA (Health Insurance Portability and Accountability Act of 1996) is a set of national standards for the protection of health information. The goal is to assure that an individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care to protect the public's health and well-being. The rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

All of an individual's health information is protected. This includes common identifiers such as name, address, birth date and social security number.
disclosure of information is required:

- To individual (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and
- To DHHS (Division of Human and Health Services) when it is undertaking a compliance investigation or review or enforcement action.

Situations where disclosure may be permitted without consent:

- To provide health care treatment
- Obtain payment for services
- Training programs
- Internal Quality Review
- Research
- To report abuse, neglect or domestic violence
- Court Order and Subpoena
- Emergency Medical Services
- Committing of a crime
- Reporting communicable diseases

It is always best practice to ask the individual to sign a Consent to Release if possible before disclosing without consent. And, we like to ensure that the client understands the need for the releasing of information. This is referred to as "Informed Consent."

In order to ensure client confidentiality we should always adhere to the following:

- Keep the door to medical records closed at all time
- Keep your office door closed at all times so that clients in the hall do not hear you on the phone
- Do not leave charts in your office so that clients may be privy to these
- Lock your office door when leaving your office if charts are inside
- Do not discuss any information with anyone outside of the agency- "**what happen here-stays here"**
- Any client identifying information that is not maintained in the medical record should be shredded-never tear up and put in trash can
- Do not discuss clients in hallways with others-discuss only behind closed doors

Examples of HIPAA violations:

- Releasing information without client consent when consent is required
- Talking about client's information in the hallways of the agency or any other location.
- Not closing office doors when checking phone messages
- Discussing information with anyone outside of the agency who does not have a "need to know"
- Exercising caution when bringing up client information on computer screens to ensure you have correct client information before making the screen privy to the client
- Ensuring that any client information taken outside of the center is secured in a security bag and secured safely in the vehicle

_____ _____

Foster/Therapeutic Parent Signature Date

_____

Print Name

_____ _____

Supervisor/Witness of Signature Date

_____

Print Name

It is the policy of Boys and Girls Homes of NC to strengthen and preserve the family unit, as well as protect the welfare of children. This will not only enhance the quality of services that children in foster care receive, but also ensure that these children are protected from further violations of their safety, permanency, and well-being. These rights were made into law so as to preserve the mission and values of child welfare services.

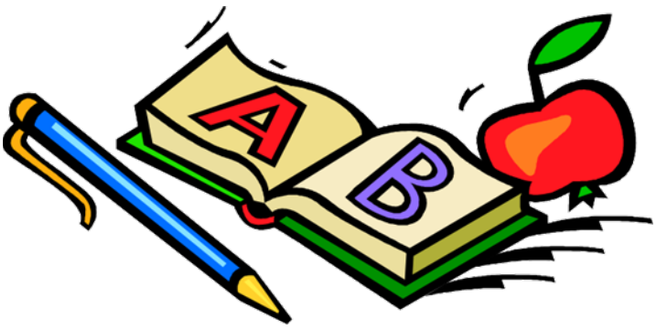
Session law 2013-326 FOSTER CARE CHILDREN'S BILL OF RIGHTS

1. A safe home free of violence, abuse, neglect, and danger.
2. First priority regarding placement in a home with siblings.
3. The ability to communicate with the assigned social worker or case worker overseeing the child's case and have calls made to the social worker or case worker returned within a reasonable period of time.
4. Allowing the child to remain enrolled in the school the child attended before being placed in foster care, if at all possible.
5. Having a social worker, when a child is removed from the home, to immediately begin conducting an investigation to identify and locate all grandparents, adult siblings, and other adult relatives of the child to provide those persons with specific information and explanation of various options to participate in placement of a child.
6. Participation in school extracurricular activities, community events, and religious practices.
7. Communication with the biological parents if the child placed in foster care receives any immunizations and whether any additional immunizations are needed if the child will be transitioning back into a home with his or her biological parents.
8. Establishing and having access to a bank or savings account in accordance with State laws and federal regulations.
9. Obtaining identification and permanent documents, including birth certificate, social security card, and health records by the age of 16, to the extent allowed by federal and State law.
10. The use of appropriate communication measures to maintain contact with siblings if the child placed in foster care is separated from his or her siblings.
11. Meaningful participation in a transition plan for those phasing out of foster care, including participation in family team, treatment team, court, and school meetings.

SCHOOL ENROLLMENT

It is your responsibility to enroll your foster child in the school district where you live. All of the necessary school and immunization records should be obtained from your child's social worker. If your child is in need of special classes, either your Boys & Girls Homes Social Worker or the child's DSS Social Worker will assist you.

As you can imagine, a new school can be a stressful experience for your child. All foster parents should visit the school with their child and become involved in school activities to ease that transition. Get to know their schedule, teachers and the administrative staff. School staff are a vital part of our team approach to foster parenting!



SCHOOL EXPENSES AND FREE LUNCH

Your monthly stipend is expected to cover all monthly school expenses.

All foster children are eligible for the school's free lunch and breakfast program. You should obtain and complete the necessary forms from the school where your child will be attending. If you prefer not to participate in the free lunch program, the cost of the lunches should come out of the monthly stipend.

SCHOOL FIELD TRIPS/EXTRACURRICULAR ACTIVITIES

Extracurricular activities are crucial to healthy and normal child development therefore, foster parents are responsible for applying and paying for school field trips and extracurricular activities for the children placed in their home. The monthly stipend should be used for this purpose. If you need assistance please contact your consultant who can help find other services that might help with cost and/or activities.

IMPORTANT DEFINITIONS

- **ABANDONMENT:** When the parents leave their children for a long period of time and do not tell anyone where they can be contacted and do not arrange for the care of the children. Examples include leaving a newborn child in a hospital or on a doorstep, or arranging for temporary care of a child through a friend or relative and not returning.

- **ADOPTION:** The assurance of a family for a child is intended to last a lifetime. This assures a child a family where he/she will be safe and nurtured.

- **ATTACHMENT/BOND:** The affectionate and emotional ties between two people that continue indefinitely over time and last even when people are geographically apart. Foster and adoptive parents should always be sensitive to children who become part of their families because these children often feel painfully separated from people to whom they feel bonded.

- **BIRTH FAMILY/FAMILY OF ORIGIN:** The family to whom the child was born. Also called biological family.

- **CASE PLAN:** Based on the information the agency has gathered about a family, this describes the specific steps that will be carried out to reunite the family. Its goals are set to lessen the risk that led to the child's removal from his or her birth family. It describes 1) what the birth parents will do to develop strengths and meet needs, 2) what the agency worker will do to help the birth parents and child, 3) what others, including foster parents, will do to help the birth parents and child, and 4) when the goals will be met.

- **CHILD & FAMILY TEAM MEETINGS (CFT):** Child and family team meetings are events during which family members and their community supports come together to create a plan for the child that builds on the family's strengths, desires, and dreams and addresses the needs identified during the CPS assessment. CFT meetings always have a clear but open-ended purpose. They always involve options or decisions for the family to make and they always involve the family in developing specific safety plans and in lining up services and supports.

- **CHILD PROTECTIVE SERVICES (CPS):** The legal intervention of child welfare agencies, through the judicial (court) system, to protect children and families.

- **CULTURE:** A particular group's knowledge, beliefs, and behaviors that members of the group learn and pass on through generations. For example, in the African American culture, family members, friends, and neighbors will often foster or adopt children without going through formal procedures. This informal fostering and adopting is not something all African American families do, but it occurs often enough that it is recognized as part of their culture.

- **CUSTODY:** Responsibility for a child's physical care, such as food, shelter, and necessary transportation.

IMPORTANT DEFINITIONS

- **DEVELOPMENTALLY DELAYED:** As defined by state law, usually indicated by a combination of behavioral indicators, including speech disorder; lags in physical development; failure to thrive; hyperactive/disruptive behavior; sallow, empty facial appearance; habit disorder (sucking, biting, rocking); conduct/learning disorders; neurotic traits (sleep disorder, inhibition of play, unusual fearfulness); behavioral extremes; overly adaptive behavior (inappropriately adult or infantile); developmental lags, attempted suicide.

- **DISRUPTION:** When a foster or adoptive family decides they are unable to continue caring for a particular child and that the child must leave their home. This term can also be used when a child's behavior or circumstances lead to the child being moved from a current placement.

- **FAMILY ASSESSMENT:** A meeting between a family and an agency worker. In these, the agency worker and a prospective foster or adoptive family will take time to discuss progress, solve problems, and meet the family's needs so the family can make an informed decision as to whether they will foster or adopt.

- **FAMILY PROFILE:** Written description of your family written by you on forms given to you by an agency. You will complete these as you complete MAPP.

- **FETAL ALCOHOL SYNDROME (FAS):** A condition caused when a child is exposed to alcohol before being born because the pregnant mother uses alcohol. It affects a child's intelligence, development and physical growth and affects facial features.

- **FOSTER CARE:** A protective service for families. Usually means families helping families. Children who have been physically abused, sexually abused, neglected or emotionally maltreated are given a family life experience in an agency approved, certified or licensed home for a planned, temporary period of time. The primary goal of this is to reunite children with their families.

- **GRIEF CYCLE:** Repeated grieving for past losses. Children can be reminded of past losses at important steps in their growth and grieve those losses again. This is a natural process that continues as individuals mature and experience life.

- **GUARDIAN AD LITEM (GAL):** When a child in foster care must appear in court, the court often provides the child with a special helper. The role of this helper is to advocate for the child's interests in court. This person may be a lawyer or a volunteer from the community who has had special training.

- **GUARDIANSHIP:** The right to make major decisions for a child, such as deciding a child's religion or providing permission to marry or serve in the military. Also includes the legal right to be in contact with the child.

- **IDENTITY:** Who an individual is. It is based on a person's connections. These connections include family, race, culture, and occupation. It may change throughout a person's lifetime.

IMPORTANT DEFINITIONS

- **INDEPENDENT LIVING SKILLS:** Older youth in foster care who do not return to their birth family or are not provided with a permanent family through adoption receive this preparation. Agency staff and foster parents prepare these youth to assume the rights and responsibilities of adults in society.

- **IN-SERVICE TRAINING:** Continuing education classes/trainings needed to keep foster care license up to date. The topics for trainings can be provided by the agency or another outside agency. Topics to count for in-service hours must be related to children, families, safety, and culture.

- **LIFEBOOK:** A combination of a story, diary, and scrapbook that has information about a child's life experiences. This can be started when a child first comes into care. They are best developed in partnership by the foster parents, birth parents, agency staff, and child. The children take these with them when they return home, are adopted, or go into independent living. It may include pictures, report cards, souvenirs, medical records, etc.

- **MATURATIONAL LOSSES:** Expected, predictable losses all people experience in the course of maturing and developing. These losses help people move forward in their development and, thus, help people experience new gains. For example, when a child learns to walk, he/she loses security of being held constantly.

- **MUTUAL HOME ASSESSMENT:** The agency's collection of all written information about a prospective foster/adoptive family. This is available to the family.

- **NEEDS:** Underlying conditions that must be met before a person can achieve a goal. They are not a problem, they are usually the cause of the problem. For example, Tommy wets the bed. His foster parents have noticed that he usually wets the bed after visiting with his birth parents. So, one of his needs may be help in understanding why he cannot live with his birth parents at this time.

- **NEGLECT:** When parents fail to meet children's basic needs for shelter, food, clothing, schooling, or medical attention. Examples include letting children go hungry or keeping a home so dirty or unsafe for children that they might become sick or be hurt accidently.

- **PERMANENCY PLAN:** What child welfare agencies do to protect children's right to grow up in permanent families. Agencies develop these plans to place children in living situations that will meet their needs and give them stability for the longest period of time.

- **PERMANENCY PLANNING ACTION TEAM (PPAT):** A regular panel review of how each case of a child in foster care is progressing. The purpose of this is to ensure that a child's case is not ignored or given less than appropriate attention. It is also meant to make sure that a child does not drift for an inappropriate amount of time in foster care but, rather, that some permanency plan is arranged for the child through the child's returning to his or her birth family or through

IMPORTANT DEFINITIONS

the child's being freed for adoption. Procedures may differ from agency to agency, but this must occur every six months, and the 18 month one must occur in a courtroom setting.

- **PHYSICAL ABUSE:** As defined by state law, usually indicated by unexplained bruises, welts, burns, fractures/dislocations and lacerations or abrasions. Other behavioral indicators include a child who feels deserving of punishment, is wary of adult contact, is apprehensive when other

  children cry, is aggressive, withdraws, is frightened by his/her parents, is afraid to go home, reports injury by parents, often has vacant or frozen stares, lies very still while surveying surrounding (infant), responds to questions in monosyllable, demonstrates inappropriate or precocious maturity or indiscriminately seeks affection.

- **RACE:** A way of classifying groups of people, based on common physical characteristics or appearance. These characteristics include skin color, shape and color of eyes, facial features and hair texture.

- **RESPITE:** Provides temporary care for children when the children's parents need a break from parenting responsibilities.

- **RISK:** The likelihood of any degree of future harm or maltreatment.

- **REUNIFICATION:** One of the primary goals of the child welfare field. Child welfare professionals work hard to keep birth families together because they believe that children do best when they can grow up with their own birth families.

- **SELF ESTEEM:** How an individual feels about who he/she is.

- **TERMINATION OF PARENTAL RIGHTS (TPR):** A way of meeting the developmental needs of a child by legally transferring ongoing parental responsibilities for that child from the parents to adoptive parents; and, in the process, creating a new kinship network that forever links the birth family and the adoptive family through the child who is shared by both.

Information on Independent Living

- Foster parents need to provide mentoring, information, and institutional and business resources in the community that can promote self-sufficiency, informed decision making, and readiness to assume responsibility for:
    - Activities of daily living
    - Obtaining housing and household management
    - Obtaining and keeping employment
    - Budgeting, saving, and investing
    - Money management including, high costs associated with loans and buying on credit and debt counseling
    - Use of community resources
    - Use of information about when and why public assistance is available
    - Serving as a resource to the community
    - Affect interpersonal communication and conflict resolution.

- Prior to discharge a child should receive assistance to maintain or obtain:
    - Health insurance
    - Health records
    - Medical, dental, developmental, mental health, and substance abuse treatment services
    - Needed medication

- Foster parents should help prepare a youth aging out of the foster care system for a successful transition by providing:
    - Information about rights and services to which the youth may have access as a result of a disability
    - Information on availability of affordable community based health care and counseling
    - Information about court and welfare systems
    - Information to maintain an ongoing relationship with their tribe and tribal community members as applicable
    - Information about child care services if needed
    - Support through community volunteers or individuals who have made a successful transition if needed
    - Range of living situations
    - Evaluation of the risks of various housing options
    - Access to one committed caring adult
    - Access to cultural supports
    - Access to positive peer support

- Foster Parents should assist the youth in obtaining or compiling documents necessary to function as an independent adult including:
    - An identification card
    - A social security or social insurance number
    - A resume, when work experience can be described
    - A driver's license, when the ability to drive is a goal
    - An original copy of the youth's birth certificate
    - Religious documents and information
    - Documentation of immigration, citizenship, or naturalization, when applicable
    - Documentation of tribal eligibility or membership
    - Death certificates when parents are deceased
    - A life book or a compilation of personal history and photographs, as appropriate
    - A list of known relatives, with relationships, addresses, telephone numbers, and permissions for contacting involved parties
    - Previous placement information
    - Educational records, such as high school diploma or general equivalency diploma, and a list of schools attended, when age-appropriate.

INFO ON SEXUAL ABUSE

- **What is sexual abuse?** Child sexual abuse is unwanted sexual contact with a child under 16 years of age.

- **What are some examples of sexual abuse?** Some examples of sexual abuse are: being touched in private parts, molested, raped, being asked to touch private parts of the other person.

- **Who usually commits sexual abuse?** Girls are more likely to be abused within the family and boys are more likely to be abused outside the family. Some are abused both by relatives and strangers. The first experience of abuse may make them at risk of future abuse.

- **How often does sexual abuse usually happen?** Sexual abuse can happen one time or go on for years. Abuse that occurs outside the family is usually of shorter duration because the abuser has less opportunity of contact with child.

- **How does sexual abuse usually happen?** Most sexual abuse does not involve force but it does involve some form of manipulation. Force and violence are sometimes used to threaten the child into obeying. Sometimes, the abuser may use threats of harm, rejection, or abandonment, or use tricks or blackmail.

- **Why are children more vulnerable?** Children are dependent on adults and are not yet mature – they are easily influenced. Children are also accessible (easy to find) for adults, especially to family members.

- **What are some reactions to sexual abuse?** Each person reacts in a different way. It depends on many factors relating to the abuse, how strong or weak family relationships are, and other life experiences, whether they had positive relationships with other people, inside and outside family.

- **How do families react to sexual abuse?** The family often tries to deny that the sexual abuse happened and to keep it a secret from relatives and outsiders. When sexual abuse happens outside the family, the family is more likely to help and protect the child.

- **How can you recover from sexual abuse?** To recover from sexual abuse, many survivors benefit from individual counseling and group therapy.

INFO ON SEXUAL ABUSE

MYTHS ABOUT SEXUAL ABUSE

- It is not sexual abuse if you were not touched. (For example, a male relative checks "how your breasts are developing," someone insists they have the right to watch you using the toilet, or someone insists on coming in when you are using the shower).

- It is not sexual abuse if the acts were done by someone you love.

- If it only happens once, it is not really sexual abuse. You should just ignore it.

- It is not sexual abuse if you were not physically forced.

- It is not sexual abuse if you became sexually aroused or if you had an orgasm during the incident.

- Sexual abuse is committed by crazy strangers.

REASONABLE AND PRUDENT PARENTING ACTIVITIES GUIDE DRAFT

The Reasonable & Prudent Parenting Standard is a requirement for IV-E agencies per Federal Law PL 113-183 and it became SL 2015-135 in North Carolina. The reasonable and prudent parent standard means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of North Carolina to participate in extracurricular, enrichment, cultural, and social activities. Normal childhood activities include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for a period of over 24 hours and up to 72 hours.

This tool is a guide to identify what activities caregivers have the authority (includes signing permissions/waivers) to give permission for a child or youth's participation without the prior approval of their local child welfare agency or licensing agency. The first column in the table shows a category of activities, the second column identifies specific activities within that category that a caregiver has the authority to give permission (or sign whatever might be a part of the activity) without obtaining the agency's approval. The third column identifies those activities that do require the agency's or court's approval.

It is important to realize this is simply a guide as to who has the authority to provide permission. It does not automatically mean that every foster child or youth can participate in any of these activities. It does mean that a reasonable & prudent parent standard is applied in making the decision. The standard is applied to each child and youth individually, based on the totality of their situation. One tool that can be used by caregivers to help apply critical thinking in making these decisions is the Applying the Reasonable & Prudent Parent Standard.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples ofchildhood activities the local child welfare agency or licensing agency must approveorobtainacourt order
(Local child welfare agency or licensing agency approval ornewcourt orderisneededanytimeanactivityisinconflictwithanycourt orderor supervision/safety plan)		
1. Family Recreation	• Movies • Community Events such as concert, fair, food truck rodeo • Family Events • Camping • Hiking • Biking using a helmet • Other sporting activities using appropriate protective gear • Amusement park • Fishing (must follow NC General Statute Chapter 113: Any one over age 16 must have a license)	• Any of these events or activities lasting over 72 hours • Target Practice (gun, bow and arrow, cross bow at either formal range or private property) must have local child welfare agency approval and be supervised by adult age 18 or over, abiding by all laws.
2. Water Activities (Children must be closely supervised and use appropriate safety equipment for water activities)	• Structured water activities with trained professional guides and /or lifeguards: river tubing, river rafting, water amusement park, swimming at community recreation pool. • Unstructured water activities with adult supervision: boating wearing a life jacket, swimming	• Any of these events or activities lasting over 72 hours

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
3. Hunting (using gun, bow and arrow)		Must have local child welfare agency approval, should have biological parent approval and would require the following: • Child/youth must take the NC Hunter's Safety Class • Supervision by a person at least 18 years old or over, who has also taken the above safety course • Documentation that the requirements are met are provided to the local child welfare agency in advance
4. Social/Extra-curricular activities	• Camps • Field Trips • School related activities such as football games, dances • Church activities that are social • Youth Organization activities such as Scouts • Attending sports activities • Community activities • Social activities with peers such as dating, skateboarding, playing in a garage band, etc • Spending the night away from the caregiver's home	• Any of these events or activities lasting more than 72 hours • Target Practice (gun, bow and arrow, cross bow at either formal range or private property) must have local child welfare agency approval and be supervised by adult age 18 or over, abiding by all laws. • Playing on a sports team such as school football would require both the birth parents' approval and the local child welfare agency approval

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples ofchildhood activities the local child welfare agency or licensing agency must approveorobtainacourt order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
5. Motorized Activities	Children and caregivers must comply with all laws and use appropriate protective/safety gear. Any safety courses that are required or available to operate any of the vehicles/equipment listed must be taken. Children riding in a motorized vehicle with an adult properly licensed if required including but not limited to: • Snowmobile • All-terrain vehicle • Jet ski • Tractor • Golf cart • Scooter • Go-carts • Utility vehicle • Motorcycle State laws must be followed regarding operating motorized equipment or vehicle including but not limited to: • Snowmobile	• Children may not be a passenger on a lawnmower.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
	• All-terrain vehicle (must be 8 years of age to operate and anyone less than 12 years of age may not operate an engine capacity of 70 cubic centimeter displacement or greater; no one less than 16 may operate an engine capacity of 90 cubic centimeter displacement or greater and NO ONE under 16 may operate unless they are under the continuous visual supervision of a person 18 years or older per NC § 20-171.15) • Jet ski (may be 14 years of age with boating safety certification, otherwise must be 16 or older- NC § 75A-13.3) • Tractor (must be 15 to operate NC § 20-10) • Golf cart (must be 16 to operate NC § 153A-245) • Scooter/Moped (No one under age 16 may operate a moped and no license is required NC § 20-10.1)	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
	• Go-carts • Utility vehicle • Lawn mower may not be operated by anyone below age 12 • Motorcycle (No one under 16 may acquire a license or learner's permit. No one less than 18 may drive a motorcycle with a passenger. NC § 20-7)	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
6. Driving	The following persons can be the required second signature for a youth's permit or license: • Youth's parent or guardian • A person approved by the parent or guardian • A person approved by the Division • Specifically for children in custody: Guardian ad litem or attorney advocate; a case worker; or someone else identified by the court of jurisdiction The youth who is 16 or older may acquire insurance and is responsible for the premium and any damages caused by the youth's negligence. This does not preclude a foster parent from adding a youth to their insurance. A driver's permit is required to "practice" driving in NC and cannot be obtained prior to age 15.	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
7. Travel	All travel within the United States less than 72 hours	• All travel more than 72 hours • All travel outside the country
8. Employment/Babysitting	Youth 14 years and older and following NC § 95-25.5. • Interview for employment • Continuation of current employment • Does not interfere with school *Sexually aggressive and physically assaultive youth may not babysit other children	Youth is 13 years or younger
9. Religious Participation	Attend or Not attend a religious service of the child's choice	Notify worker when the child and the biological parent and/or foster parent choices are in conflict.
10. Cell Phone		This is a collaborative decision between the placement provider, the local child welfare agency worker, and the youth.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
11. Child's Appearance	• Interventions requiring medical treatment for lice and ring worm	• When the child and biological parent choices are in conflict such as with perms, color, style, relaxers, etc. • Ear piercings must include biological parent in decision • Permanent or significant changes including but not limited to: ○ Piercing (Per NC § 14-400 it is illegal for anyone under 18 to receive a piercing (other than the ears) without consent of custodial parent or guardian. ○ Tattoos (Per NC § 14-400 it is illegal for anyone under 18 to receive a tattoo.)
12. Leaving child home alone		• The issue of being left alone (in any situation) needs to be discussed and agreed upon in CFT.

*Adapted from Washington State Caregiver Guidelines for Foster Childhood Activities

Therapeutic Foster Care

Program Description and Mission Statement

Service Definition

TFC Parent Responsibilities

Boys and Girls Homes of North Carolina, Inc.
Therapeutic Foster Care

Program Description

Boys and Girls Homes of North Carolina Therapeutic Foster Care Program is a private non-profit agency that provides foster care for at-risk children that have special emotional, behavioral, developmental, and educational needs. Our foster homes provide safe, secure, and loving environments for children between the ages of birth to eighteen. The BGHNC therapeutic foster care program allows children who need to be placed out of home to receive day-to-day services by licensed therapeutic foster parents and other community services until the child can be reunited with his or her family, with other family members, permanently placed with adoptive parents, or emancipated. Clinicians, case managers, therapeutic foster care consultants, therapeutic foster parents, and other treatment team members work together with the child to define treatment needs and assist the child in making progress towards his or her treatment goals.

Mission Statement

Our goal is to provide treatment home-based foster care to a diverse population of at-risk children. Boys and Girls Homes of North Carolina Therapeutic Foster Care program utilizes a person centered multidisciplinary approach to treatment in order to meet the needs of each client individually. Our vision is that each child and his or her family will develop the necessary skills, attributes, and maturity to reach his or her full potential in life.

THERAPEUTIC FOSTER PARENT RESPONSIBILITIES

Therapeutic Foster Parents serve as both caregivers of children with treatment needs (the fostering role) and as active agents of planned change (the treatment role).

*TFC parents must be present for all Child and Family Team Meetings. TFC parents contribute vital input in treatment planning from their observations of the child in the treatment home and community.

*TFC parents have the responsibility of implementing all in-home treatment strategies in the treatment plans.

*TFC parents must have available time to meet with the TFC consultant on a weekly basis for consultation, support, guidance, intervention suggestions, and treatment updates.

*TFC parents keep a daily record of the child's behavior and progress towards goals. TFC will also keep daily medication administration records (MAR).
TFC parents are expected to turn in their paperwork in a timely manner each month to their consultant.

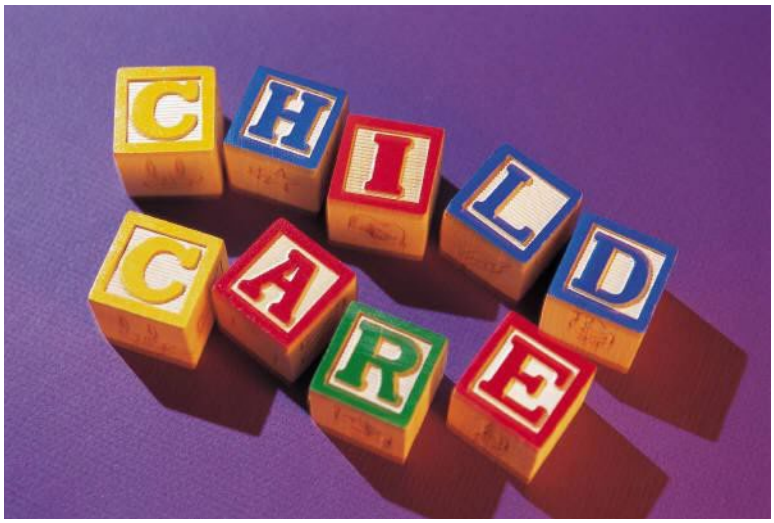
*TFC parents are responsible for scheduling appointments, transporting children to appointments, and participating in appointments as the active caregiver of the child. This includes medical, dental, educational, and mental health appointments.

*TFC parents assist the child in maintaining contact with his/her family and work to support and enhance these relationships, unless contraindicated by treatment plan.

*TFC parents shall develop and maintain positive working relationships with all service providers of the child (doctors, therapists, social service agencies, and other resources).

*TFC parents shall assume the primary responsibility of ongoing relationships with teacher and administrators at the child's school. It is the TFC parents' responsibility to monitor attendance, homework, and academic achievement. TFC parents must also attend all IEP meetings.

*TFC parents shall provide 30 days notice to TFC consultant when requesting the move of a child. This will allow for the least disruptive transition.



ACRONYMS & WORDS TO KNOW

ACRONYMS & TERMS

A

AAMR - American Association on Mental Retardation
ADA - American Disabilities Act
ADATC - Alcohol and Drug Abuse Treatment Center
ADD - Attention Deficit Disorder
ADETS - Alcohol and Drug Education Traffic School
ADHD - Attention Deficit Hyperactive Disorder
AG - Academically Gifted
AHEC - Area Health Education Center
AOC - Administrative Office of the Courts
AMI - Alliance for the Mentally Ill
ARC - Association for Retarded Citizens
ASAM - American Society of Addictive Medicine

B

BED - Behavioral/Emotional Disorder (public schools)

C

CAP - Community Alternatives Program
CAP- MR/DD - Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities
CASSP - Child and Adolescent Service System Program
CC - Community Collaborative
CCSW - Certified Clinical Social Worker
CDSA - Children's Development Services Agency
CEC - Council for Exceptional Children
CFAC - Consumer and Family Advisory Committee
CFP - Child and Family Plan
CFT - Child and Family Team
CHIP - Children's Health Insurance Program
CJO - Criminal Justice Offender - Child or Adult Population
CMH - Child Mental Health
CMS - Centers for Medicare/Medicaid Services
CSAT - Center for Substance Abuse Treatment

D

DCD - Division of Child Development
DD - Developmental Disabilities
DHHS - Department of Health and Human Services
DJJDP - Department of Juvenile Justice and Delinquency Prevention
DMA - Division of Medical Assistance
DMH/DD/SA - Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DOC - Department of Correction (State)
DOH - Department of Health (County)
DPH - Department of Public Health
DPI - Department of Public Instruction (State)
DSDHH - Division of Services for the Death and Hard of Hearing (State)
DSM-IV - Diagnostic and Statistics Manual
DSS - Division of Social Services (State)
DWCH - Division of Women's and Children's Health (changed from Maternal and Child Health, 1997) (State)
DWI - Driving While Impaired

E

EBD - Emotionally or Behaviorally Disturbed
EBP - Evidence Based Practice
ECAC - Exceptional Children's Assistance Center
ED - Emotionally Disturbed
ELT - Executive Leadership Team of the Division of MH/DD/SAS
EMH - Educable Mentally Handicapped (sometimes
EMR -Educable Mentally Retarded) EOC - End of Course (DPI)
EOG - End of Grade (DPI)
EPSDT - Early Periodic Screening, Diagnosis and Treatment
ESEA - Elementary and Secondary Education Act
ESL - English as a Second Language

F

FAPE - Free and Appropriate Public Education
FFCMH - Federation Families Children's Mental Health
FES - Family Empowerment Scale
FFK - Families for Kids

FSN - Family Support Network

G

G.S. - General Statute
GAF - Global Assessment of Functioning

H

HC - Health Check
HC - Health Choice
HCBS - Home and Community Based Services
HIPAA - Health Insurance Portability and Accountability Act of 1996
HMO - Health Maintenance Organization
HOM - Homeless Child or Adult Substance Abuse Population
HUD - Housing and Urban Development

I

ICC - Interagency Coordinating Council
ICD - International Classification of Diseases codes
ICF - Intermediate Care Facility
ICF-MR - Intermediate Care Facility - Mentally Retarded
IDEA - Individuals with Disabilities Education Act
IEP - Individualized Education Program
IFSP - Individual Family Services Plan
IPRS - Integrated Payment and Reporting System
IT - Information Technology

J

JCAHO - Joint Commission for Accreditation of Healthcare Organizations

L

LDA - Learning Disability Association (was ACLD)
LEA - Local Education Agency (Local Public School Systems)
LEP - Limited English Proficient
LME - Local Management Entity
LOC - Legislative Oversight Committee
LOC - Level of Care
LRE - Least Restrictive Environment

M

MAJORS - Managing Access for Juvenile Offender Resources and Services

MED - Seriously Emotionally Disturbed - Child Population

MHA/NC - Mental Health Association in North Carolina

MHTF - Mental Health Trust Fund

MMIS - Medicaid Management Information System

MOA - Memorandum of Agreement

MOU - Memorandum of Understanding

MR - Mental Retardation

N

NAMI-CAN - National Alliance for the Mentally Ill - Child Adolescent Network

N.C. - North Carolina

NCAMI - North Carolina Alliance for the Mentally Ill

NCAMI-CAN - North Carolina Alliance for the Mentally Ill, Children & Adolescent Network

NC Families United - North Carolina Families United

NCHC - North Carolina Health Choice

NC TOPPS - North Carolina Treatment Outcomes and Program Performance System

NC WISE - North Carolina Window of Information on Student Education

NIMH - National Institute of Mental Health

NMHA National Mental Health Association

O

ODD - Oppositional Defiant Disorder

OHI - Other Health Impaired

OT - Occupational Therapy

p

PCP - Person Centered Plan

PEP - Personal Education Plan (Public Schools)

PT - Physical Therapy

PTO - Parent and Teachers Organization

PTSD - Post Traumatic Stress Disorder

PYFU - Powerful Youth Friends United (Powerful Youth)

Q

QA - Quality Assurance

QI - Quality Improvement
QM - Quality Management

R

RFA - Request for application
RFI - Request for information
RFP - Request for Proposal
RRC - Regional Resource Centers (Special Education)

S

SAD - Substance Abuse Disorder - Child
SAMHSA - Substance Abuse and Mental health Services Administration
SBI - State Bureau of Investigation
SCFAC - State Consumer and Family Advisory Committee
SCS - Standard Course of Study (DPI)
SED - Seriously Emotionally Disturbed
SIP - School Improvement Plan
SIMS - Student Information Management System (DPI)
SMHRCY - State Mental Health Representatives for Children and Youth
SNAP - Support Needs Assessment Profile
SIS - Supports Intensity Scale
SOC - System of Care
SOS - State Operated Services
SPMI - Sever and Persistent Mental Illness
SS - Social Security
SSI - Supplemental Security Income

T

TEACCH - Treatment and Education of Autistic and Related Communication Handicapped Children
TMH - Trainable Mentally Handicapped (also TMR)
TTY - Text Telephones

U

UM - Utilization Management

V

VI - Visually Impaired (also VH)

VR - Vocational Rehabilitation

W

WIC - Special Supplemental Food Program for Women, Infants, and Children

WORDS TO KNOW

Access

An array of treatments, services and supports is available: consumers know how and where to obtain them, and there are no system barriers or obstacles to getting what they need, when they need it.

Achievement Test

A test that measures what a child has learned. Scores are reported in age or grade equivalents.

Acting Out

Feelings/emotions that may be expressed by self-abusive, aggressive, violent and/or disruptive behavior.

Adaptive Behavior

A wide range of skills used by a child to meet his/her everyday needs.

Advance Directive

A legal document that allows consumers to plan their own mental health care in the event the individual loses the capacity to effectively make decisions.

Advocacy

The process of actively supporting the cause of an individual (case advocacy) or group (class advocacy), speaking or writing in favor of, or being intercessor or defender.

Affective Disorder

A disorder of mood (feeling, emotion). Refers to a disturbance of mood and other symptoms that occur together for a minimal duration of time and are not due to other physical or mental illness.

Aftercare

Supervision or treatment provided to individual for a limited time after release from a treatment program.

American Society of Addiction Medicine (ASAM)

An international organization of physicians dedicated to improving the treat of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use.

Anxiety Disorder

Exaggerated or inappropriate responses to the perception of internal or external dangers.

Appeals Panel

The State MH/DD/SA appeals panel established under NC G.S. 371 and G.S. 122c-151.4

Appropriate Education

An individual education program specially designed to meet the unique needs of a child who has a disability

Architectural Barrier

Any part of a building or grounds that keeps a handicapped person from having normal, easy access.

Assessment/Evaluation

All activities (tests, interviews, observations) to gather information leading up to writing a plan and identifying services or interventions that for a child and family.

Attachment Disorder

An attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships

Attention Deficit Disorder

Symptoms are inattentiveness and impulsiveness. In some cases hyperactivity is also a symptom (ADHD).

Autism

A developmental disorder that affects communication and behavior.

Behavior Modification

A method of changing behaviors by teaching and reinforcing new behaviors. Behavior modification is done by setting goals and using a specific plan to reach those goals.

Behavioral Objectives

Steps to reach goals. Describes what a child will be able to do and how he will learn to do it. Behavioral objectives also state how the learning will be measured and the criteria for success.

Behaviorally-Emotionally Handicapped (Public School)

A handicap that involves how a person behaves and acts towards others. Some common symptoms are: cannot make or keep friends; does not act his age or in ways that fit the

activity or situation; has general and ongoing moods of sadness or depression; has difficulty learning; has other personal or school-related problems.

Bipolar Disorder

A mood disorder with elevated mood often accompanied by major depressive episodes.

Block Grant

funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose.

Case Management

A service that helps individuals and families get and coordinate community resources such as health, behavioral health (mental health, substance abuse, etc.), income assistance, education, housing, and medical care.

Centers for Medicare and Medicaid Services (CMS)

The federal agency responsible for overseeing the Medicare and Medicaid programs

Child and Family Plan (CFP)

A comprehensive service and support plan for children with multiple and complex challenges and needs, and their families. The plan is based on family strengths, the goals and needs of the family. (Note: different agencies may have more specific plans related to their own mandates or funding requirements. See Person-Centered-Plan or Individual Education Plan for examples.)

Child and Family Team (CFT)

A group of selected people that meets with a child and family to set goals and plan services. The CFT is built around the family to make sure the family's unique strengths are promoted and their needs are met. Team members, including the family, work together to write a Child and Family Plan that is based on what the family wants and needs.

Collaboration

A helping relationship between a family member and a professional in which the family and professional share power and responsibility.

Community-Based Services

The practice of having services as well as management and decision-making responsibility at the community level.

Conduct Disorder

Repetitive and persistent patterns of behavior that violate either the rights of others or age-appropriate social norms or rules.

Confidentiality

Keeping information private. Allowing records or information to be seen or used only by those with legal rights or permission.

Consent

Giving approval or agreeing to something. For example, in education, a parent must give consent before a child can be evaluated or placed in a special program.

Consumer and Family Advisory Committee (CFAC)

A committee of ordinary people who get help from the LME or whose loved ones do. They advise the LME in the design of the local system.

Cross-Categorical

Special Education in which students receive services or are in the same classroom with students who have different types of disabilities.

Cultural Competence

A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies that enable individuals and groups to interact appropriately, showing acceptance and understanding of others.

Delinquency

Violation of law by a child or youth (usually under 18).

Depression

A type of mood disorder characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time.

Developmental Disorders

Disorders that have predominant disturbances in normal development of language, motor, cognitive and/or motor skills.

Developmental Disorders

Disorders that have predominant disturbances in normal development of language, cognitive and/or motor skills.

Dual Diagnosis

A diagnosis of an emotional disorder and another disorder such as developmental delay, drug and/or alcohol use or a mental illness.

Due Process Hearing

A formal legal proceeding presided over by an impartial public official who listens to both sides of the dispute and renders a decision based upon the law.

Early Periodic Screening, Diagnostic and Treatment Services (EPSDT)

Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

Emotional Disorder (or Disability)

Behavior, emotional, and/or social impairment exhibited by a child or adolescent that disrupts his/her academic and/or developmental progress, family, and/or interpersonal relationships.

End of Course Tests

Test that are designed to assess the competencies defined by the NC Standard Course of Study for each of the following courses: Algebra I, Algebra II, English I, Biology, Chemistry, Geometry, Physical Science, Physics, Civics and Economics, and US History. Tests are taken during the last 10 days of school or the equivalent for alternative schedules.

End of Grade Tests

Tests in reading and mathematics are taken by students in grades 3-8 during the last three weeks of the school year.

Enhanced Benefits

Mental health, developmental disabilities, and/or substance abuse services that may be provided for those individuals meeting Target Population eligibility for services through NC Mental Health Reform.

Evaluation

More in-depth than an assessment, examination of specific needs or problems by professionals using specific evaluation tools.

Evidence Based Practices

Evidence Based Practice (EBP) refers to growing scientific knowledge about treatment practices and their impact on children with emotional or behavioral challenges. Defined by the Institute of Medicine **(IOM)** as "the integration of best research with clinical expertise and patient values".

Exceptional Children (public schools)

All children who because of permanent or temporary mental, physical, or emotional handicaps need special education and related services to get an appropriate education in the public schools.

Family Advocate

A community resident and/or a family member who provides support to families who enter the service delivery system. This support may be emotional support, education about services, assistance linking to and working directly with service providers, and advocacy within the service system to help families build on their unique strengths and meet their individualized needs.

Family Support

Persons identified by the consumer as either family members or significant others who provide the necessary support for furthering quality of life, reaching personal life goals or recovery.

Free Appropriate Public Education (FAPE)

A legal guarantee that no child can be denied a public education because of a disability. The public education must be at no cost to parents, be based on the child's needs, and meet the standards of the state education agency.

Family Support Program

Programs available in the community that help children and their families so that children can remain in their homes, and all members of the family can live balanced, healthy lives.

Health Choice

The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other funds.

Health Insurance Portability and Accountability Act (HIPAA)

A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current service consumer are not discriminated against based on health status. Protects privacy of consumer health information.

Inclusion

An educational option for students with disabilities to be educated in a regular classroom in their neighborhood school with all necessary supports provided so that the student can participate fully.

Individualized Education Program (IEP)

A written plan for a child with special education needs. The plan is based on results from an evaluation and is developed by a team that includes the child's parents, teachers, other school representatives, specialists, and the child when appropriate.

Informed consent

When you give permission for a service and it has been explained to you in a language/way you can understand.

Intelligence Quotient (I.Q.)

A score from a standardized test of mental ability. I.Q. is found by relating the person's test score to his age.

Least Restrictive Environment

An educational, treatment or living situation that provides appropriate services or programs for a child with disabilities while imposing as few limitations or constraints as possible.

Local Management Entity (LME)

Formerly known as Area Mental Health, Developmental Disability, and Substance Abuse Authorities, these public entities oversee and manage all public mental health, developmental disability and substance abuse services through contracts and other arrangements with their local Provider Community (private organizations that deliver direct services). Required by NC Mental Health Reform.

Mainstreaming

Placement of a child with a disability in the regular classroom for part of the school day

Mental Illness

General term for severe emotional problems or psychiatric disorders of adults.

NC WISE

North Carolina Window of Information on Student Education. This secure web-based tool provides educators with direct and immediate access to a full spectrum of data on a student's entire career in the NC public school system. (permanent record)

Objectives

See Behavioral Objectives.

Person-Centered-Plan

Individualized and comprehensive plan that specifies all services and supports to be delivered to the individual eligible for mental health and/or developmental disability and/or substance abuse services according to NC Mental Health Reform requirements.

Positive Behavioral Interventions and Supports (PSIS)

A research-based model of school-wide systems of support that include proactive strategies for defining, teaching, and supporting appropriate student behaviors to create positive school environments. Instead of using a patchwork of individual behavioral management plans, a continuum of positive behavior support for all students within a school is implemented in areas including the classroom and non-classroom settings (such as hallways, restrooms).

Related Services

Supports needed to help a child get the most from his special education. Related services are paid for by the public school. They include services such as speech and language therapy, transportation, physical therapy, and counseling.

School Improvement Plan

A plan that includes strategies for improving student performance, how and when improvements will be implemented, use of state funds, requests for waivers, etc. Plans are in effect for no more than three years.

Service Provider

Any person or agency giving some type of service to children or their families. Part of the Provider Community under Mental Health Reform.

Strengths Inventory

A set of questions to help people think and talk about their strengths such as what they like to do and what they do well.

Support Services

Transportation, financial help, support groups, homemaker services, respite services, and other specific services to children and families.

System of Care

The process of different human service systems and community supports working together with families to provide a coordinated continuum of care driven by values and principles of the System of Care model.

System of Care Model

Nationally recognized, research-based, best practice framework to build on strengths to meet the multiple and changing needs of children with complex challenges and their families, including a wide range of services and supports organized into a coordinated local network within local communities. A core set of values and principles underlie all planning, implementation and evaluation activities.

Target Populations

Those individuals who meet eligibility requirements to receive Enhanced Benefits (see Enhanced Benefits definition) for mental health, developmental disabilities, or substance abuse conditions according to the NC State Plan for Mental Health Reform. In general, individuals who meet Target Population eligibility are those with the most serious or severe unmet challenges and needs.

Title I DPI

A federal funding program for schools to help students who are behind academically or at risk of falling behind. Funding is based on the number of low-income children in a school, generally those eligible for the free lunch program. Title I money supplements state and district funds.

Title III DPI

Title III is the section of No Child Left Behind that provides funding and addresses English language acquisition and standards and accountability requirements for limited English proficient students.

Title IX DPI

Title IX of the Educational Amendments of 1972 bans sex discrimination in schools receiving federal funds, whether it is in academics or athletics.

Title XIX - Medicaid: Medical services funded through Title XIX of the Social Security Act, which matches approximately 54 percent of state funds. Benefits are outlined annually in a Medicaid State Plan and include many different health related services.

Transition

The change from using children's services to using adult services, moving from one program to another, starting or leaving school, or other important life changes.

Wraparound

Planning, coordination, and delivery of services and supports to children and their families that is individually tailored to each family with the goal of keeping the family together in the community and keeping the child in a regular school setting.

504 Plan

A 504 plan is a legal document falling under the provisions of the Rehabilitation Act of 1973. It is designed to plan a program of instructional services to assist students with special needs who are in a regular education setting. A 504 plan is not an Individualized Education Program (IEP) as is required for Special Education students. However, a student moving from a Special Education to a regular education placement could be placed under a 504 plan.

{Some of the information in this glossary is taken from the text of *Taking Charge.)*

Childhood Mental Health Diagnoses

Brief descriptions, signs, and symptoms of common childhood mental health diagnoses

ANXIETY

Anxiety is a natural human emotion; everyone feels anxious or worried at times. We are all familiar with preschoolers who are frightened by the dark, have a variety of bedtime rituals and can get anxious at times of separation from a parent. However, a youngster who experiences anxiety more strongly and more readily than others and worries excessively to a degree that interferes with his or her life may have an Anxiety Disorder. Anxiety in children and teenagers can arise because of separation, fears, something catastrophic happening, being judged, worrying about things before they happen, getting a perfect score on a test, being in school or in social situations. Anxiety Disorders are among the most common mental health problems affecting children and teenagers and are among the most effectively treated.

Forms of Anxiety

Anxiety is a complex emotion, and its signs and symptoms may be manifested in different ways. The following are brief descriptions of the forms of anxiety that may occur in children and teenagers. Detailed descriptions, signs and symptoms, causes, treatment and related information can be found by linking to each disorder.

- **Separation Anxiety Disorder** — Children with separation anxiety disorder (SAD) have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. The child may cling to parents, refuse to go to school, or be afraid to sleep alone. Separation Anxiety Disorder (SAD) is characterized by an extreme fear and significant distress about being away from home or caregivers that affect a child's ability to function socially and academically. These children have a great need to stay home or be close to their parents and may worry excessively when they are apart. Unlike the occasional mild worries a child may feel at times of separation, separation anxiety disorder affects the child's ability to engage in ordinary activities.
- **Generalized Anxiety Disorder** — Children with generalized anxiety disorder (GAD) have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense, or easily tired, and they may have trouble concentrating or sleeping. Children with GAD are usually eager to please others and may be "perfectionists," dissatisfied with their own less-than-perfect performance.
- **Social Phobia** — Social anxiety disorder or social phobia is an excessive fear of being negatively evaluated, rejected, humiliated or embarrassed in front of others. Therefore ,children and adolescents with social phobia fear a wide range of situations such as giving oral reports, participating in gym class, speaking to adults or peers, starting or joining in conversations, eating in public, and taking tests. They may fear unfamiliar persons, and therefore have difficulty making friends or meeting new people. Children and teenagers with social phobia typically respond to these feelings by avoiding the feared situation. They may stay home from school or avoid parties. Social phobia can be limited to specific situations, the adolescent may fear dating and recreational events but be confident in academic and work situations. While studies have reported cases of social phobia in children as young as 8 years, it is more frequently diagnosed in adolescents.
- **Obsessive-Compulsive Disorder** — Children with OCD have frequent and uncontrollable thoughts (called "obsessions") and may perform routines or rituals (called "compulsions") in an attempt to eliminate the thoughts. These children and teenagers often repeat behaviors to avoid some imagined consequence. For example, a common compulsion is excessive hand washing due to a fear of germs. Other common compulsions include counting, repeating words silently, and rechecking completed tasks. In the case of OCD, these obsessions and compulsions take up so much time that they interfere with daily living and cause a great deal of anxiety. Unlike adults, children do not always have the

necessary cognitive skills or life experience to recognize that the obsessions or compulsions are excessive or unreasonable. When obsessive thoughts become so frequent or intense or rituals become so extensive that they interfere with functioning, the diagnosis of Obsessive Compulsive Disorder (OCD) is considered.

- **Post-Traumatic Stress Disorder** — Children who experience a physical or emotional trauma such as witnessing a shooting or disaster, surviving physical or sexual abuse, or being in a car accident may develop post-traumatic stress disorder (PTSD). A child may "re-experience" the trauma through nightmares, constant thoughts about what happened, or reenacting the event while playing. A child with PTSD may experience symptoms of general anxiety, including irritability or trouble sleeping and eating. A child with Posttraumatic Stress Disorder develops symptoms such as intense fear, disorganized and agitated behavior, emotional numbness, anxiety or depression, after being directly exposed to or witnessing an extreme traumatic situation involving threatened death or serious injury or hearing about such an event involving a family member. Victims of repeated abuse or children who live in violent environments or war zones may experience PTSD. Treatment includes community and family support and psychotherapy.
- **Acute Stress Disorder** — Unlike most psychiatric disorders both Acute Stress Disorder and Post- Traumatic Stress Disorder are triggered by a specific event. Acute Stress Disorder refers to a reaction occurring within 4 weeks and lasting from 2 days to 4 weeks after an individual was exposed to a trauma. The person responded with intense fear, helplessness or horror to an event or events that involved actual or threatened death or serious injury, or a threat to the one's physical integrity. Examples are rape, mugging, combat, natural disasters, etc. Acute stress disorder is a diagnostic category introduced in 1994 to differentiate time-limited reactions to trauma from post-traumatic stress disorder (PTSD). Not all individuals exposed to trauma will experience a disorder. The impact of a traumatic event on a child, depends on the severity of the event and the child's previous level of functioning.
- **Panic Disorder (with or without Agoraphobia)** — Panic Disorder (PD) with or without Agoraphobia is recognizable by shortness of breath, pounding heart, tingling and numbing sensations, hot or cold flushes, and terror when in certain situations or places. During a panic attack the person feels intense fear or discomfort, a sense of impending doom or sensations of unreality. Panic attacks may or may not accompany agoraphobia, the fear of being stuck in a situation where help or escape is unavailable. While severe anxiety may trigger a panic attack, people with Panic Disorder will often have symptoms of panic without any apparent trigger. Panic disorder often begins during adolescence, although it may start during childhood, and sometimes runs in families. Unlike the occasional, mild worries that children often experience, panic disorder may dramatically affect a child's life by interrupting his or her normal activities when an episode occurs or when the child becomes preoccupied with worry about possible future panic attacks.
- **Agoraphobia** — Agoraphobia, a type of anxiety which involves intense fear, may start in childhood or late adolescence. Individuals with agoraphobia worry about having a panic attack in a public place. Because of these fears they avoid any place or situation where escape might be difficult or help unavailable if the individual should develop sudden panic-like symptoms. In the event that they cannot avoid the feared place or situation, they show significant distress. Common fears are crowds, elevators, public transportation, and shopping malls. Some may find it extremely difficult to pursue normal activities, such as leaving home, attending entertainment or sports events, pursuing education or a career.
- **Specific Phobia** — refers to an intense, unreasonable fear of a specific object or situation. Some common phobias are animals, flying, lightning.
- **Selective Mutism** — Selective mutism refers to selective silence in a child who speaks freely in very familiar situations. Children who demonstrate this condition appear comfortable and talkative with

close family members. However, whenever people other than the closest family members are present, the child is quiet and shy. Some children avoid eye contact and do not communicate in any form with others. They refrain from the use of gestures or changes in facial expression. Children who are selectively mute show wide variations in their social actions. Some children enjoy contact with others and will play easily, but remain silent. Some have a close friend who often speaks for them by interpreting gestures. Others find all aspects of social situations uncomfortable and do not participate at all. Whatever form selective mutism takes, it can persist. There are children in the 2nd, 3rd, and 4th grades who have never spoken in school. There are students in high school who have not uttered any or no more than a few words in a school setting. As you can imagine, the condition can have dramatically negative effects on social functioning.

- **School Refusal Behavior** — refers to children who are entirely absent or truant from school or leave during the day. Although not a disorder listed in the Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV), it can be associated with Social Anxiety Disorder, Separation Anxiety Disorder, Social Phobia, and Conduct Disorder.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Although all individuals are restless and inattentive occasionally, these qualities are more severe, persistent, and impairing in children with Attention-Deficit/Hyperactivity Disorder (ADHD). For a child to be diagnosed with ADHD, these behaviors must cause difficulty in multiple areas such as at home, in school, or with friends. ADHD is more prevalent in boys than girls.

ADHD is a behavioral disorder with three major symptoms:

- Inattention—The child may have difficulty sustaining attention, listening, and attending to detail. Organization and study skills may be poor, and the child may be distractible and forgetful.
- Impulsivity—The child may blurt out answers, often interrupt or intrude, or have difficulty waiting in school and in play situations. These characteristics frequently impede social relationships.
- Hyperactivity—The child may seem to be in constant motion, fidget or squirm, often run or climb, talk excessively.

There are three major types of ADHD:

- **Combined Type.** This is the most common subtype and involves inattentive, hyperactive, and impulsive symptoms.
- **Predominantly Inattentive Type.** These children often lose things, forget their homework, daydream, and have trouble managing their time, planning, and organizing their things.
- **Predominantly Hyperactive-Impulsive Type.** This is the least common type and is characterized by restlessness and fidgetiness, but few or no problems with attention or concentration.

BIPOLAR DISORDER

Bipolar Disorder, also known as manic depression, is characterized by intense, persistent mood swings between the poles of depression and mania. These moods are greatly intensified or clearly different from the youngster's usual personality and are far out of proportion to events in the environment in intensity and/or duration. The youngster experiences the typical signs of depression – helplessness, hopelessness, and worthlessness – and the signs of mania – grandiosity and exuberance. The disorder may be genetic and caused by a chemical imbalance in the brain. Medication is successful in moderating the symptoms.

The defining features of Bipolar Disorder are intense and wild mood swings between the two poles that cause serious disruption to one's life. When depressed, the youngsters will feel unhappy and hopeless; during

the manic phase of the illness, they may believe they are better than anyone else and even feel invincible. A youngster can experience either phase of the disorder, the depression or the mania, anywhere from several days to several months. The main symptoms include:

- **Depression** - In the depressed phase of the disorder a youngster has the typical signs of depression; she may feel worthless and hopeless. She can be passive, lethargic, have difficulty sleeping or eating, be uncaring about her physical state, or even be agitated.
- **Mania** - At least once, the youngster easily and unpredictably switched to being manic, as evidenced by elevated mood, grandiosity, seemingly unlimited energy despite a lack of sleep, risky behavior, lack of awareness of usual human limits, possible delusions and hallucinations, and losing touch with reality.
- **Flight of ideas** - A rapid sequencing of thoughts that at first may seem illogical, but are actually related to one another.

For some youngsters, periods of time when they are functioning quite well and have 'normal moods' are interspersed with periods of time when they are manic or depressed. Mixed presentations are most common for pre-pubertal children. Teens show discrete manic and depressive episodes. Less common are youngsters who cycle rapidly, four times a year, or day to day, alternating between depression and mania.

CONDUCT DISORDER

The child with a Conduct Disorder does not respect authority, has little regard for the basic rights of others and breaks major societal rules; he or she demonstrates aggressive conduct that threatens physical harm or property damage, deceitfulness, theft, truancy or running away from home. The child with a Conduct Disorder is often vengeful, irascible, and has a chip on his shoulder. The cause of Conduct Disorder is believed to be a combination of genetic vulnerability and environmental factors. Treatment plans might include behavior therapy with the child and parents and pharmacotherapy.

The behaviors of a child or adolescent who has a Conduct Disorder fall into four main groupings:

Aggression to people and animals
-bullies, threatens or intimidates others
-often initiates physical fights
-has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
-is physically cruel to people or animals
-steals from a victim while confronting them (e.g. assault)
-forces someone into sexual activity
Destruction of property
-deliberately engaged in fire setting with the intention to cause damage
-deliberately destroys other's property
Deceitfulness, lying, or stealing
-has broken into someone else's building, house, or car
-lies to obtain goods, or favors or to avoid obligations
-steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)
Serious violations of rules
-often stays out at night despite parental objections
-runs away from home
-often truant from school

The behavioral disturbances can cause deficits in social, academic or occupational functioning. The behavior usually occurs in a variety of settings, such as home, school and community.

DEPRESSION

Depression in children and teenagers is different from the feelings of sadness and other everyday emotions that most children experience. Depressed children are sorrowful beyond the range of normal sadness.
Depressed children do not necessarily have the same signs and symptoms as adults. They are often bored by everything. They may be under stress at school, be upset about something that happened with their friends, sleep or eat more than usual, or just want to be alone because they don't have fun when they are out.
Depressed children can be irritable, impossible to please, and moody, swinging from great sadness to sudden anger. If a child or teenager's symptoms become persistent, disruptive, and interfere with social activities, interests, schoolwork and family life, he or she may be depressed. Depression is most likely due to an inherited predisposition to a chemical imbalance in the brain. Effective treatments include medication and cognitive behavior therapy.

Signs & Symptoms

- -Frequent crying, sadness, tearfulness
- -Depressed or irritable mood
- -Difficulty concentrating
- -Irritability and anger
- -Fatigue
- -Feelings of worthlessness
- -Sleep problems or appetite problems
- -Social withdrawal
- -Restlessness or slowing down
- -Decreased interest or pleasure in activities
- -Extreme sensitivity to failure
- -Poor concentration
- -Frequent absences and declining academic performance
- -Boredom, low energy
- -Low self-esteem and guilt
- -Thoughts of death

There are two basic types of depression: ***major depression*** which lasts at least two weeks, and the milder but chronic ***dysthymia***, which is a less severe but longer lasting depressed mood that lasts for a year or longer and seems to characterize the child's temperament or personality.

EATING DISORDERS

The overall term Eating Disorders refers to several disorders, including Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder. The common feature of all these disorders is disordered eating behavior, often accompanied by a distorted body image, a compulsion to exercise, restriction of food, vomiting after meals, and a focus, but little pleasure in food. Anorexia Nervosa is diagnosed when a youngster's food restriction causes weight to drop 15% below what is normal. Bulimia Nervosa is characterized by attempts to binge and/or get rid of food already eaten. Binge Eating Disorder is also characterized by attempts to binge, but is not necessarily followed by attempts to get rid of food already eaten. Most recently neurochemicals have been implicated in the cause of eating disorders. Unhealthy eating behaviors can lead to serious medical problems. A combination of medication, cognitive behavior, individual and family therapy are the most common forms of treatment.

There are three types of eating disorders and the signs and symptoms may be manifested in different ways. Following are brief descriptions of the forms of eating disorders that may occur in children and teenagers.

Detailed descriptions, signs and symptoms, causes, treatment and related information can be found by linking to each disorder.

Anorexia Nervosa or self-starvation is diagnosed when a person weighs 15% less than expected according to growth charts. The youngster is obsessed with being thin, may exercise excessively, has fears about weight gain, an unrealistic image of her body, and possibly a loss or interruption of menstruation.

Bulimia Nervosa or binge eating and purging is not characterized by a specific weight loss, but rather by eating large amounts of food in a short time followed by behaviors to eliminate the food, such as vomiting, laxative use or excessive exercise. The behavior must occur at least twice a week for three months.

Binge Eating Disorder is characterized by recurrent episodes of binge eating, followed by periods of guilt, which occurs without the purging behavior.

OPPOSITIONAL DEFIANT DISORDER

Oppositional Defiant Disorder, a manifestation of Conduct Disorder, is characterized by a recurrent pattern of negativistic, defiant, disobedient and hostile behavior towards authority figures that seriously interferes with the youngster's day to day functioning. All children are oppositional from time to time, and oppositional behavior is often a normal part of development for two-to-three year olds and early adolescents. However, a diagnosis of Oppositional Defiant Disorder is considered when the behavior is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family, and academic life.

Signs & Symptoms

- frequent temper tantrums
- excessive arguing with adults
- active defiance and refusal to comply with adult requests and rules
- deliberate attempts to annoy or upset people
- blaming others for his or her mistakes or misbehavior
- often being touchy or easily annoyed by others
- frequent anger and resentment
- mean and hateful talking when upset
- seeking revenge

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school.

SCHIZOPHRENIA

Schizophrenia is characterized by the distorted thinking associated with delusions and hallucinations. Schizophrenia may have a gradual onset, with symptoms of withdrawal and disordered language evident over time, or it can have a sudden onset in adolescence. Evidence suggests that schizophrenia is due to an inherited biochemical abnormality in the brain. Treatment includes medication, such as neuroleptics, to alleviate the painful and intrusive thoughts, and structured programs and education for the youngster and family to improve daily functioning.

Schizophrenia is one of the most baffling, troubling, and potentially dangerous of the mental disorders because it seems so unbelievable. When a person has schizophrenia (psychosis), his brain is not processing information in the usual way, making it impossible for him to control his thinking or behavior. In the most severe stage, a person with schizophrenia has difficulty telling the difference between fantasy and reality and has thoughts of hurting himself or someone else. The main symptoms include:

- **Positive symptoms** including delusions, which are ideas which may seem real but are not based in reality. For example, someone may think she is being singled out by the government to join an elite military force or is convinced the answers to a television game show are secretly being sent to her through the cable wires. Hallucinations, another positive symptom, occur when a person sees, hears, or feels things that are not there. Hallucinations can seem so real to people with schizophrenia that they act in bizarre ways and do things that look strange to those around them.
- **Negative symptoms** refer to the absence of normal function. For example, teens may become distant, withdrawn, uninvolved with life, want to be alone, and have no energy for people or activities.
- **Disorganized speech** is evident in people with schizophrenia who often talk in a rapid but disjointed way. They either do not make sense or change topics so frequently that they are difficult to understand.
- **Disorganized or catatonic behavior**, such as suddenly becoming violent or walking around confused, or sitting and staring as if immobilized, may reflect a person's disordered thinking.

TOURETTES DISORDER and other TIC disorders

The child or adolescent with Tourette's Disorder has involuntary motor and one or more vocal tics, which occur at some time during the illness but not necessarily together. The tics vary; they wax and wane and change over time in frequency and complexity. They may involve different parts of the body (face, neck, shoulders, trunk, hands). The most common simple motor tics are blinking, shrugging, grimacing and nose- twitching. Some complex motor tics may appear purposeful, such as kissing, pinching, sticking out the tongue, touching, gyrating, making obscene gestures (called copropaxia). Simple vocal tics are meaningless sounds and noises, including grunting, tongue-clicking, hooting, and throat-clearing.

Other Tic Disorders
Transient Tic Disorder, a more common tic disorder, generally appears during the early school years. This disorder affects from 5 to 24% of all children. It differs from Tourette's Disorder in that the tics occur daily for at least two weeks but for no longer than one year. However, the child may have a series of transient tics over the course of years. Tics can be voluntarily suppressed for brief periods, and most are mild and hardly noticeable. In some cases tics are frequent and severe and may affect many aspects of a child's life.

Chronic Motor/Vocal Tic Disorder, another category of Tic Disorder, appears before age 21. It usually persists unchanged throughout a period of more than 1 year and involves either motor or vocal tics, but not both.

Psychiatric Medications for Children and Adolescents

STIMULANTS

Stimulants treat the core symptoms of Attention-Deficit Hyperactivity Disorder (ADHD) including impulsivity, hyperactivity, and inattention.

Possible Side Effects: loss of appetite, difficulty falling asleep, irritability and/or moodiness. Some children may develop tics while on the medicine while those with a tic disorder may find that the tics worsen. These medications can increase blood pressure and pulse slightly. (MONITOR WEIGHT AND GROWTH IF THE CHILD IS ON STIMULANT MEDICATION)

Medication Names

BRAND NAME	GENERIC NAME	NOTES
Ritalin	Methylphenidate	These are short acting—generally lasting 3-4 hours.
Focalin		
Methylin		
Methylin Chewable		
Methylin Liquid		
Concerta	Methylphenidate	These are long acting- generally lasting about 8-12 hours. Each one is formulated somewhat differently but there is generally no way to determine which will last the longest for any individual. Daytrana is the newest and uses a patch to deliver methylphenidate through the skin. The patch may cause some skin irritation.
Focalin XR		
Metadate CD		
Ritalin LA		
Daytrana Patch		
Dextrostat	Amphetamine	These are short acting- generally lasting about 3-6 hours. Each one is formulated somewhat differently but there is generally no way to determine which will last the longest for any individual. Adderall is a mixture of different forms of amphetamine (amphetamine salts).
Adderall		
Dexedrine		
Adderall XR	Amphetamine salts	Lasts 8-10 hours
Dexadrine Salts	amphetamine	Lasts 8-10 hours

NON-STIMULANT

Non-Stimulant medicat6ion treats the core symptoms of ADHD. May not have as strong of an effect on symptoms as the stimulants but may help individuals who have anxiety along with their ADHD.

Possible Side Effects: Decreased Appetite, nausea, insomnia or tiredness, dry mouth Medication

Names

Brand Name	Generic Name	Notes
Strattera	Atomoxetine	Has the potential to last 24 hours. Can often be given once a day although some patients require a second does in the late afternoon. Unlike most medication this one is dosed based on the patient's weight.

ANTIHYPERTENSIVE

Antihypertensive is historically used to control high blood pressure. It is often used as a first medical treatment for the tics of Tourette's Disorder. It can also be used to treat the hyperactive and impulsive symptoms of ADHD. IT can sometimes help with children who have aggressive behaviors.

Possible Side Effects: Dry mouth, sedation, or dizziness. On rare occasions it can trigger depressive symptoms.

Medication Names

Brand Name	Generic Name	Notes
Tenex	Guanafacine	The TTS is a patch that is changed every 3-4 days. It may cause local irritation.
Catapres, Catapres TTS patch	Clonidine	

SSRIs or SRIs (specific serotonin reuptake inhibitors)

SSRIs and SRIs are useful for depression, obsessive-compulsive disorder and anxiety disorders.

Possible Side Effects: Appetite changes, nausea, headache, sweating, insomnia and occasionally tiredness. Medication

Names

Brand Name	Generic Name	Notes
Prozac	Fluoxetine	Prozac was the first of this group of medications to be approved by the FDA. While there are some minor differences between these medications, they share more similarities than differences.
Serefam		
Zoloft	Sertraline	
Luvox	Fluvoxamine	
Paxil	Paroxetine	
Paxil Cr		In rare situations, during the early phases of the treatment for depression some individuals can have the onset or increase in suicidal thinking; therefore your physician will have guidelines on how frequently he/she needs to see the patient.
Pexeva		
Celexa	Citalopram	
Lexapro	Escitalopram	

TRICYCLIC ANTIDEPRESSANTS

Tricyclic antidepressants have been used to treat depression, ADHD, enuresis, and chronic pain. Unlike other tricyclics, Anafranil is used to treat Obsessive Compulsive Disorder (OCD).

Possible Side Effects: Sedation, weight gain, nausea, dry mouth, constipation. May cause changes in heart rhythm.

Brand Name	Generic Name	Notes
Tofranil	Imipramine	This group of medications is rarely used for the treatment of depression or ADHD because SRIs have replaced them for the treatment of depression and Strattera has replaced them for the treatment of ADHD.
Norpramin	Desipramine	
Elavil	Amitryptyline	
Pamelor	Nortriptyline	
Sinequan	Doxepin	

Anafranil	Clomipramine	First medications approved for the treatment of OCD.

OTHER ANTIDEPRESSANTS

These other antidepressants are used for depression and have been used to treat symptoms of ADHD. Some may be helpful for anxiety as well.

Possible Side Effects: dry mouth, decreased appetite

Medication Names

Brand Name	Generic Name	Notes
Wellbutrin	Bupropion	Wellbutrin is not useful for anxiety disorders
Wellbutrin SR		
Wellbutrin XL		
Effexor and Effexor XR	Venlafaxine	Has occasionally been used to treat ADHD.
Remeron	Mirtazapine	
Cymbalta	Duloxetine	

ANTIPSYCHOTICS

Antipsychotics treat psychosis, schizophrenia, bipolar disorder and impulsive/aggressive behavior.

Possible Side Effects: Weigh gain, sedation, dizziness, insulin resistance, and muscle stiffness.

Medication Names

Brand Name	Generic Name	Notes
Risperdal	Risperidone	Risperdal has been studied in the treatment of aggression and irritability in Autism.
Zyprexa	Olanzapine	
Seroquel	Quetiapine	
Geodon	Ziprasidone	
Abilify	Aripiprazole	
Clozaril	Clozapine	This is the most effective medication for treatment resistant psychotic condition. Patients must get weekly blood tests to monitor rare side effects.

MOOD STABILIZERS

Mood Stabilizers treat the symptoms of bipolar disorder.

Possible Side Effects: Excessive thirst, frequent urination, gastrointestinal symptoms, acne, and weight gain.

Medication Names

Brand Name	Generic Name	Notes
Lithium	Lithium	Requires frequent monitoring of lithium blood level, thyroid, and kidney functioning.
Lithobid		
Eskalith		

ANTI-CONVULSANTS

Anti-Convulsants are often used in the treatment of bipolar disorder and aggressive behavior.

Possible Side Effects: Sedation, tremor, gastrointestinal distress, weight gain

Medication Names

Brand Name	Generic Name	Notes
Depakote	Divalproex/Valproate	Both have been well studied for bipolar disorder. Has also been used for migraines.
Tegretol	Carbamazepine	
Carbatrol		
Trileptal	Oxcarbazepine	
Lamictal	Lamotrigine	Appears to be helpful in treating the depressive phase of bipolar disorder but is not as helpful in the manic phase.

Behavior Management Policy, Strategies, and Suggestions

Therapeutic Foster Care Behavior Management Strategies

Boys and Girls Homes of North Carolina's policies and procedures clearly state that the use of ANY physical punishment or physical restraints when working with children in foster care or therapeutic foster care is prohibited. Violation of these policies and procedures may result in termination of your license as a foster parent. Consultants with BGHNC are available 24 hours a day, 7 days a week to support, assist, and give you suggestions for all challenging and crisis situations. However, if you feel that your safety, the child's safety, or another person's safety is at risk, call 9-1-1 immediately.

Children in therapeutic foster care may have many behavioral issues; however positive behavior management strategies and interventions have been shown to both increase a child's positive behavior and decrease a child's negative behavior when used consistently. Praising and rewarding a child for positive behaviors is just as important as providing consequences for a child as a result of negative behaviors. Some strategies and interventions are listed below:

- Social reinforcers/catching a child doing good (i.e. statements of thanks, praise, affection, high fives, pat on the back, thumbs up)
- Physical contact (hugs, sitting near a client, pat on the back, squeezing the shoulder)
- Undivided attention (leaning toward the client when talking, smiling, short conversation prompts to continue sharing details, one on one time, going out to do an activity)
- Natural and logical consequences
- Time out (unlocked, short term, separation from stimulation for the purpose of regaining self control)
- Loss of privileges stating clearly to the child what privilege they have lost, how long it is lost, the specific behavior that caused the loss and what they need to do to have the item returned.
- Providing allowances
- Use of a point system or sticker chart to track positive progress
- Behavioral contracts
- Redirecting a child
- Other strategies can be found within the Teaching Family Model Skills Curriculum and A to Z Behavior Skills for Younger Kids that were provided at the BGHNC pre-service trainings.

*** Always remember that your BGH Social Workers, DSS social workers, case managers, therapists, and doctors are here to support YOU as foster parents in hopes of promoting the best environment and strategies to benefit the child in your care!!

Therapeutic Foster Care Behavior Management and Discipline Agreement

I have received copies of the Boys and Girls Homes of North Carolina policies and procedures pertaining to Behavior Management and Discipline. I have also received a copy of suggested positive behavior management strategies.

I have read and understand the B&GH policies and procedures pertaining to Behavior Management and Discipline as well as a list of suggested positive behavior management strategies.

I understand that B&GH protects youth, staff, and foster parents by requiring strict adherence to this policy and procedure. I also understand and agree that it is my responsibility to support the established measures that safeguard youth in my care.

I understand that licensing regulations, the ethics code of B&GH, and the ethical codes of accreditation and certification entities of which B&GH is a member require that I ensure the safety of children in my care, ensure that a safe environment is provided for daily activities and all elements of treatment. I agree to follow all rules and regulations pertaining to the reporting of any violation of this policy.

As a Therapeutic Foster Parent, I understand that I should report any deviation from the identified procedures without fear of retribution or retaliation. I understand that violation of this behavior management and discipline agreement may result in disciplinary action that may include termination of my Foster Parent Service Agreement.

_____ _____

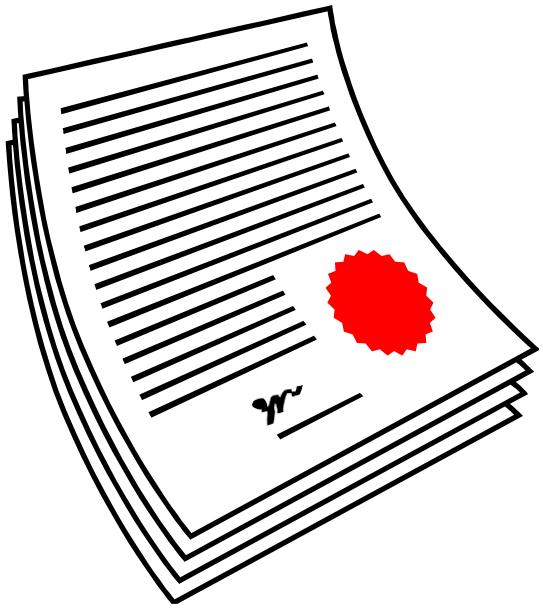
Foster Parent Signature Date

_____ _____

Foster Parent Signature Date

_____ _____

Therapeutic Foster Care Staff Witness Date Signature



LICENSING FORMS

Quarterly Licensing Visit Documentation

Foster Parent(s) Participating in the Licensing Visit:
Licensing Social Worker:
Date: Location:

Licensing Requirement	MET	NOT MET W/Comments	NOT APPLICABLE	Comments
Child placed in the home is treated as a member of the family and when advised by the agency is encouraged and supported to enhance the child's relationship with child's parents or guardian				
Foster parent has reported any changes in the composition of household, change of address, or change in employment status				
Foster parent provides child with supervision at all times unless other specified by treatment plan and/or team				
Foster parent's trainings such as CPR, First Aid, Universal Precautions, medication administration, and restrains (if applicable) are in compliance.				
New Therapeutic Foster Parent Training completed within first 2 years.				
HIV Training Completed for foster parents providing services for HIV consumers, if applicable.				
Substance Abuse Training completed for foster parents providing services for Substance Abusing consumers, if applicable				
Receiving continuing education training to meet 20 hour requirement for re-licensure.				
New criminal charges for any adult household member have been reported, if applicable.				
Physical(s) are current.				
Fire Inspection is current.				
Environmental Checklist is current.				

Discipline Agreement Up to Date				
Foster Parent Agreement Up to Date				
Operating Telephone				
Reports of Abuse or Neglect? What is the status?				
Reports of CIR's What is the status?				
Waiver(s); if applicable				

Describe the services and supports provided to the foster parents specific to enabling them to be successful in maintaining and improving the care of the children.

Licensing social worker discussed the following with the foster parents:

- □ Medication Administration Records for each child in their care. Comments:
- □ Lifebooks kept for each child in their care. Comments:
- □ Shared Parenting with birth parents of each child in their care. Comments:
- □ Respite requested / respite funds requested. Comments:

Document any other pertinent discussion between the foster parent and the licensing social worker; i.e. to address any foster home licensure compliance issues:

Licensing Worker's Comments:

Foster Parents' Comments:

_____ _____

Foster Parent Date

_____ _____

Foster Parent Date

_____ _____

Licensing Social Worker Date

Foster Parent(s) Name and Year: _____

FOSTER PARENT ANNUAL EVALUATION & ASSESSMENT OF 12 SKILLS

Has foster parent (s) completed in-service trainings with 10 hours per calendar year and at least 5 hours with BGH annually? **Y N**
5 points
TOTAL POINTS: _____

Does foster parent (s) speak in a positive manner when talking with DSS and other professionals? **1 point** **Y N**
Does foster parent (s) attend meetings and appointments for the foster child? **1 point** **Y N**
Is the foster parent willing to be a participant on a MAPP panel or has foster parent been on a MAPP panel this year? **1 point** **Y N**
TOTAL POINTS: _____

Is the child(ren)'s hair clean? (If there are not currently children in the home please refer to last placement. Only check N/A if foster parents have never taken a placement.) **Y N N/A**
1 point
Is the children's clothing clean and the appropriate size? **Y N N/A**
1 point
Are the children's bodies clean? **Y N N/A**
1 point
Do the foster parents get children involved in extra-curricular activities? **Y N N/A**
1 point
TOTAL POINTS: _____

Is the FP home and yard maintained without any environmental hazards or concerns? **Y N**
3 points
Do foster parents turn in paperwork to their social worker every month on time? **Y N**
10 points
TOTAL POINTS: _____

Is the home environmentally safe?	(1 point)	**Y**	**N**
Is the yard maintained?	(1 point)	**Y**	**N**
Is the yard free of safety hazards?	(1 point)	**Y**	**N**

TOTAL Points: _____

TOTAL OVERALL SCORE: _____

CPR/First Aid/Universal Precautions Expiration date: _____

Total Current Training Hours for the year: _____

1. **Document specific identified NEEDS of the foster parent(s) this year:**

2. **Document specific supports that have been provided for the foster parents this year:**

3. **Assessment of 12 skills-Please indicate how the FP(s) have applied the 12 skills to their current or a recent foster placement on the following page.**

FP Signature & Date: _____ **SW Signature & Date:** _____

FP Signature & Date: _____ **Licensing SW & Date:** _____

AGENCY/FOSTER PARENTS AGREEMENT

In consideration of mutual obligations and in order to promote a clear understanding of the factors involved in providing foster care, the following agreement is being entered into by **Foster Parent(s):** _____ and **Supervising Agency:** **Boys & Girls Homes of NC, Inc.**

THE FOSTER PARENTS AGREE:

- to allow the representative of the supervising agency to visit the home in conjunction with licensing procedures, foster care planning, and placement;
- to accept children into the home only through the supervising agency and not through other individuals, agencies, or institutions;
- to accept children into the home only through the supervising agency and not through other individuals, agencies, or institutions;
- to treat a child placed in the home as a member of the family and, when so advised by the supervising agency, support, encourage, and enhance the child's relationship with the child's parents or guardian;
- to maintain contact and exchange information with the supervising agency about matters affecting the adjustment of any child placed in the home. The foster parents shall agree to keep these matters confidential and to discuss them only with supervising agency staff members, or with other professionals designated by the agency;
- to obtain the permission of the supervising agency if the child is to be out of the home for a period exceeding 72 hours;
- to report to the supervising agency any change of address before it occurs and any change in the membership of the household, change in physical or mental health of any household member, criminal charges against any household member, and change in the financial resources or income of the household within 72 hours of its occurrence;
- to make no independent plans for a child to visit the home of the child's parents, guardian, or relatives without prior consent from the supervising agency;
- to adhere to the supervising agency's plan of medical care, both for routine care and treatment and for emergency care and hospitalization;
- to provide any child placed in the home with supervision that is appropriate for the child's age, intelligence, emotional make up, and past experiences and adhere to the supervision requirements specified in the out-of-home family services agreement or person-centered plan; and
- to comply with Title VI Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Multiethnic Placement Act, which are incorporated by reference including subsequent amendments and editions.

THE SUPERVISING AGENCY AGREES:

- to assume responsibility for the overall planning for the child and assist the foster parents in meeting their day-to-day responsibilities toward the child;

- to inform the foster parents concerning the agency's procedures and financial responsibilities for obtaining medica the foster parents' preferences in terms of sex, age range, and number of children placed in the home;

- to provide or arrange for training for the foster parents;

- to include foster parents as part of the decision-making team for a child;

- to allow foster parents to review and receive copies of their licensing record; and

- to notify foster parents of their right to obtain personal liability insurance in accordance with G.S. 58-36-44.

Other Provisions:

Signatures: We have read the foregoing statements and have retained a copy of this document.

Foster Parent (print): _____Foster Parent (sign): _____Date: _____

Foster Parent (print): _____Foster Parent (sign): _____Date: _____

Foster Parent (print): _____Foster Parent (sign): _____Date: _____

Foster Parent (print): _____Foster Parent (sign): _____Date: _____

Child Placing Agency Representative: _____ Date: _____

Signature and Title

FOSTER PARENT DISCIPLINE AGREEMENT

I, _____, foster parent for **Boys & Girls Homes of NC**, Inc. agree to the following conditions concerning the disciplining of any foster child placed in my home:

- I will not subject any child placed in my home to cruel or abusive punishment as established in G.S. 7B 101(1) and (15);

- I will not use any kind of physical discomfort such as marching, standing rigidly in one spot, depriving youth of sleep, etc.

- I will not use physical restraints as a means for behavior management.

- I will not subject any child placed in my home to corporal punishment, which includes, but is not limited to hitting, spanking, slapping, physical exercise as punishment, and inappropriate physical labor as punishment;

- I will not deprive any child placed in my home of a meal or contact with family as punishment;

- I will not place any child placed in my home in isolation time-out except when isolation time-out means the removal of a child to an unlocked room or area from which the child is not physically prevented from leaving. (The foster parent may use isolation time-out as a behavioral control measure when the foster parent provides it within hearing distance of a foster parent. The length of the isolation time-out shall be appropriate for the child's age, intelligence, emotional makeup, and past experiences);

- I will not subject any child placed in my home to verbal abuse, threats, or humiliating remarks about himself/herself or his/her family;

- I will not allow other children in your home to impose discipline on your foster/adoptive child.

- I will provide training and discipline that is appropriate for the child's age, intelligence, emotional makeup, and past experiences.

I understand that my relationship with the agency as a Foster Parent may be terminated and that my license may be revoked if I violate this agreement.

_____
Print Full Name

_____
Signature

_____
Date

This form must be signed by all licensed foster parents and adult members living in the household. A copy of this form is retained by the foster parents and a copy is retained by the agency

ADMINISTRATION OF MEDICATION

Foster/Adoptive Parents agree to abide the following procedures and guidelines:

1. Attend training through Boys & Girls Homes of NC, Inc. in the proper administration of prescription and non-prescription drugs.
2. To receive permission from youth's legal custodian to administer prescription and non-prescription drugs at the time of admission to Foster Care and Adoption Program. In addition, only administer prescription drugs to a child on the written order of a person authorized by law to prescribe drugs.
3. Allow prescription medications to be self-administered by children only when authorized in writing by the child's licensed medial provider.
4. (a) To maintain each foster child's prescription and non-prescription drugs in individual locked medication boxes accessible only to Foster/Adoptive Parents. To maintain the foster parent(s) and any member of the household's prescription and non-prescription drugs in a locked cabinet or locked medication box. (Foster parent and household members medications can be stored together.) The storage space must be in a clean, well-lit, well-ventilated room other than bathroom, kitchen, or utility room between 59 degrees F (15 degrees C) and 86 degrees F (30 degrees C).
   (b) To store medications in a refrigerator, if required, between 36 degrees F (2 degrees C) and 46 degrees F (8 degrees C). If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container within the refrigerator.
   (c) And to store prescription medications separately for each child.
5. To label prescription drugs with youth name, dosage and name of medication, name of prescribing physician, pharmacy, prescription number, and date prescription was filled, quantity/strength of medication.
6. To document on the MAR (Medical Administration Record) medication administered to each youth, both for prescription and non-prescription drugs. The documentation should be made immediately on the MAR provided by Boys & Girls Homes of NC, Inc. The MAR shall include the following: child's name; name, strength, and quantity of the drug; instructions for administering the drug; date and time the drug is administered, discontinued, or retuned to Boys & Girls Homes of NC, Inc. or the person legally authorized to remove the child from foster/adoptive care; name or initials of person administering or returning the drug; child requests for changes or clarifications concerning medications; and child's refusal of any drug; and follow-up for child requests for changes or clarifications concerning medications with an appointment or consultation with a licensed medical provider.
7. To carefully monitor expiration dates for ordinary over-the-counter drugs and dispose of out-dated medications. Make sure to retain the manufacturer's label with the expiration dates visible on non-prescription drug containers not dispensed by a pharmacist.
8. Return to the legal custodian or consultant any medication(s) when youth are discharged from the foster/adoptive home or if any prescription medications are discontinued. The legal custodian will then dispose of the medication.
9. Under no circumstances do Foster/Adoptive parents maintain or administer aspirin or medications containing aspirin to youths except under direction of a

physician. Only non-aspirin medications are used with youths.

10. When admitting new youths to the home, the Foster/Adoptive Parents should discuss medication management with the youth and the family/legal custodian.
11. Upon admission to the program, the youth's legal custodian signs a *Medical/Dental Agreement* and an *Informed Consent* form authorizing the Foster/Adoptive Parent to administer prescription and non-prescription medication.
12. If youths bring medication to the home, Foster/Adoptive Parents refer and follow the Medication Administration Record (MAR). The Foster/Adoptive Parents take responsibility for supervising and administering the medication. If by prescription, the Foster/Adoptive Parents verify the prescription with the attending physician and document the verification on the MAR. A copy of the prescription order is maintained by the foster parents. Foster/Adoptive Parents obtain any additional information or instructions concerning the prescription and the youth's condition. Foster/Adoptive Parents actively monitor to detect the possession of medication both at admission and subsequent to admission as the youth visits with family, relative, friends, foster family resources, etc.
13. Foster/Adoptive Parents ensure each prescription medication is reviewed by a physician for continuing appropriateness at least every six months. When these reviews are done by the youth's physician, the Foster/Adoptive Parents document that date on the Service Log. Foster/Adoptive Parents give copies of the MAR sheet to their consultant monthly.
14. Foster/Adoptive Parents also monitor for any over-the counter drugs brought into their home. Foster/Adoptive Parents require youths and their families to take these medications known and to place them in safekeeping (locked) with the Foster/Adoptive Parents. They do not allow aspirin or aspirin-containing drugs into the home, except under specific prescription by the physician. Allow non-prescription medications to be administered to a child taking prescription medications only when authorized by the child's licensed medical provider; allow non-prescription medications to be administered to a child not taking prescription medication, without the authorization of the parents, guardian, legal custodian, or licensed medical provider.
15. Allow injections to be administered by unlicensed persons who have been trained by a registered nurse, pharmacist, or other legally qualified person only.
16. Foster/Adoptive Parents who personally use aspirin store this item separate and apart from youth medications and in such a manner as to be inaccessible to the youths.
17. Foster/Adoptive Parents refrain from the application of exotic or unusual "home remedies" for youths.
18. Foster/Adoptive Parents actively teach each youth responsibility, caution, safety and good judgment in the use of prescription and non-prescription drugs.
19. Foster/Adoptive Parents educate youth and their family on the medication regimen, what side effects to report, and maintain the educational material as well as documentation of the education in the youth's file.
20. Foster/Adoptive Parents obtain (or require parents to obtain and provide) a sufficient number of prescription bottles with labels prepared by the pharmacist such that one can be given to the school (if necessary), one can be sent on home

visits with sufficient dosages for the duration of the visit, and the primary supply can remain in the foster/adoptive home. The intent is to ensure that a consistently sufficient amount of properly labeled medication is available in each setting in which the youth is present. The primary supply should not accompany the youth from setting to setting.

21. Arrange for any child receiving psychotropic medications to have his/her drug regimen reviewed by the child's licensed medical provider at least every six months. Report the findings of the drug regimen review to the supervising agency and document the drug review in the MAR along with any prescribed changes, if applicable
22. Report any drug administration errors or adverse drug reactions immediately to a licensed medical provider or pharmacist and document the drug administered and the drug reaction in the MAR.

Foster/Adoptive Parent: _____ Date: _____

Foster/Adoptive Parent: _____ Date: _____

Trainer/Recruiter/Licensing Worker: _____ Date: _____

FIREARMS RESPONSIBILITY IN THE HOME

Regarding firearms, as a licensed foster parent, you are responsible for knowing how to properly handle your firearm(s) and how to secure your firearm(s) in a safe manner in your home. By signing this agreement, you agree to adhere to the following:

RULES FOR SAFE STORAGE OF FIREARMS:

I agree to:

- Always make absolutely sure that firearms in my home are securely stored out of the reach of children, in a locked, safe, firearm vault, or storage case. For additional safety, unloaded firearms can be secured with a firearm locking device to make them inoperable. These can usually be obtained at no charge from your local police department.
- Always store ammunition in a locked location separate from firearms and out of reach of children.
- Firearms should never be worn on any person when around foster children. Even if there is a concealed license to carry, firearms should never be on any person when around foster children.
- Always clean and place firearms in their proper storage location immediately after returning from a hunting trip or a day at the range.
- Always re-check firearms carefully and completely to be sure that they are still unloaded when removed from storage. Accidents have occurred when a family member has borrowed or loaned a firearm and returned it to storage while it was still loaded.
- Always make absolutely sure that firearms in your home are securely stored and inaccessible to children.
- Make certain the firearms in my home are not casually accessible to anyone – especially curious young people.

I, _____ (print name), agree to follow the above precautions and safety measures that have been discussed in this agreement.

Foster Parent Signature & Date : _____

Foster Parent Signature & Date : _____

To learn more about firearms ownership and storage, visit: www.projectchildsafe.org.

BOYS & GIRLS HOMES REQUEST FOR REMOVAL OF A CHILD

In this request you should explain in detail what the behaviors/concerns are and what strategies/services you have put in place to help assist the child. Once your request is reviewed, a home visit will be scheduled with you, your consultant, and a licensing worker. If after the visit you still feel the child must be moved, Boys & Girls Homes of NC will have up to thirty days to move the child.

- **Why are you requesting that the child/children be moved from your home? Please give specific examples of behaviors.**

- **Have you addressed your concerns regarding the child's/children's behavior with your Boys & Girls Homes consultant? If so, please list the dates and a summary of the conversation.**

- **What types of behavior management and/or discipline have you used? Why was it not effective?**

- **What additional services and/or agencies have you tried to put in place to assist the child/children with their behavior? Please list when you began the services.**

- **What could be done so that disruption does not have to occur?**

- **Please list any comments you have that were not addressed above.**

Print Foster/Adoptive Parent Name

Print Foster/Adoptive Parent Name

Foster/Adoptive Parent Signature & Date

Foster/Adoptive Parent Signature & Date

Client and Foster Parent Grievance

Every client/foster parent in the Community-Based Services Program has the right to present his/her grievances in accordance with the following established guidelines and procedures:

Guidelines:

1. All staff members are familiar with and understand all policies and procedures and guidelines associated with the client/foster parent procedures.

2. All grievances are to be handled in a professional manner.

3. A Consultant/Trainer or the Vice President of Community-Based Services works with the foster client and parent(s) in order to find a suitable solution or outcome to a particular grievance.

Procedures:

1. The client/foster parent filing the grievance will complete a "Client Grievance Form" and submit it to the Vice President of Community-Based Services or appropriate consultant.

2. The family and/or client will meet with the consultant/case worker to resolve the grievance within two working days of the filing date.

3. If the family and/or client reach an understanding or agreement, the results are noted on the Grievance Form by the consultant/case worker and placed in the client's file.

4. If the grievance is not resolved within three working days of the meeting, this is noted on the Grievance Form and the Vice President of Community-Based Services will then receive the Grievance Form within the next two working days.

5. The Vice President of Community-Based Services then has ten days to meet with the client and/or the foster family involved and submit a final decision in writing to the parties involved. The Grievance Form and written decision are then filed in the client's/foster parent's record.

CONFIDENTIAL
Client and/or Parent/Custodian Concern/Grievance Form

Date of Complaint: _____

So that we may contact you for further information, or to let you know the outcome of your concern or grievance, please provide us:

Print Client's Name: _____

Signature of person filing the concern: _____

If you are a family member, advocate, etc. please provide us:

Print Your Name: _____ Phone Number_____

Mailing Address: _____

Describe the issue, including who, what, where and how.

_____

_____

This portion is to be completed during resolution process.

Date form received by Consultant: _____ **Date form given to Foster Care Director:** _____

Steps that were taken by BGHNC to resolve the issue:

1. _____
   ____**I, the client, agree/disagree with the resolution of my concern or grievance.**
2. _____
   ____**I, the client, agree/disagree with the resolution of my concern or grievance.**
3. _____
   ____**I, the client, agree/disagree with the resolution of my concern or grievance.**
4. _____
   ____**I, the client, agree/disagree with the resolution of my concern or grievance.**

_____ _____
Signature of Person Filing Concern or Grievance Date

_____ _____
Signature of Staff Member Involved Date

_____ _____
Signature of Foster Care Director, if applicable Date

Date form given to VP of CBS: _____ **Date form given to President/CEO:** _____

_____ _____
Signature of Vice President of CBS, if applicable Date

_____ _____
Signature of President/CEO, if applicable Date

_____ _____
Signature of Board Member, if applicable Date

Date submitted to Clients Rights Committee: _____

Congratulations! Welcome to the Foster Care Team at Boys and Girls Homes of North Carolina!

Thank you for becoming part of the BGH Team!!!! We hope that you are ready for the ride, as this is an adventure that will rock your world! Yes, sometimes in a good way and sometimes not, but together we can make it. Remember this is about the kids and the impact that you and your family make on them. An impact that will last them a lifetime!

When you think you are not getting through to them, or they are not listening….they are!!!! Try not to take their behavior personally. Often times, there are behavioral issues due to what they have been through or what they have seen. YOU are being a positive influence in their lives. So, here we go….we are off on an adventure to change lives! Thanks again,

Donna Yalch, VP of Community Based Services

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Post Office Box 127
Lake Waccamaw, NC 28450
910.646.3083 (ext. 261) ~ Fax: 910.356.4067
Toll-free at 877.211.5322
www.boysandgirlshomes.org