Maryland
DEPARTMENT OF HUMAN SERVICES
Wes Moore, Governor · Aruna Miller, Lt. Governor · Rafael López, Secretary

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Required Actions:	Compliance with policy directive to ensure children and youth in out-of-home care receive timely and adequate health care services, including dental and behavioral health services.
Key Words:	Health, Health Care, Exam, Oversight, Health Passport, Initial, Comprehensive, Dental, Well-Child
Related Federal Law	42 U.S.C. § 5106a(b)(2): Grants to States for Child Abuse or Neglect Prevention and Treatment Programs; 42 U.S.C. § 622(b)(15) State Plans for Child Welfare Services; 42 U.S.C. § 671(a)(21): Health Insurance for Special Needs; 42 U.S.C. § 675(1)(c): Health and Education Records, and 42 CFR § 441.50
Related State Laws	Maryland Ann. Code, Family Law Article §§ 5-501, 5-504, 5-533(b)(1)(2), 5-712

	Maryland Ann. Code, Health-General § 15-102.4, 20-102, 20-103, 20-104
COMAR	07.02.07.07F Investigation of Suspected Child Abuse and Neglect — Physical Examination of a Child 07.02.11.08 Out-of-Home Placement Program, Medical Care 07.02.25.08 LDSS Resource Homes Requirements, Responsibilities of a Resource Parent 07.02.25.09 LDSS Resource Homes Requirements, LDSS Responsibly to Resource Parents 10.67.04.04 Maryland Medicaid Managed Care Program: MCO 10.67.06 Maryland Medicaid Managed Care Program: Benefits 13A.13.01.04A Referral and Screening
Title IV-E State Plan Implications?	Children and Family Services -Title IV-B Federal Financial Participation (FFP) for out of home placement /foster care and subsidized adoption – Title IV-E

PURPOSE AND SUMMARY

Ensuring timely and adequate delivery of health care services to address the needs of children and youth in out-of-home care is essential. Doing so requires communication, coordination, and collaboration between birth parents, guardians, resource parents, kinship caregivers, Local Departments of Social Services (LDSS), Child Protective Services (CPS), Family Preservation, out-of-home program staff, resource staff, placement providers, the State's Medicaid/Medical Assistance program Managed Care Organizations (MCO), and health care providers. It also requires established procedures for collecting, updating, and distributing medical information and records to relevant parties involved in a child's health care.

This policy guides LDSS in assuring and documenting that children and youth in out-of-home care receive adequate and quality health care services, including services for physical, mental, and dental health.[1] All children and youth in the care of the Department of Human Services (DHS) shall receive

[1] This policy addresses matters relating to DHS' internal management of the local departments.

timely and appropriate health care services, have the right to request medical appointments, and receive consistent quality medical attention. The LDSS must utilize the health information and reports provided by parents and health care providers to assist with service planning and oversight.

Resource parents, kinship caregivers, and out-of-home placement providers will coordinate as necessary to meet the physical, behavioral, and dental health care needs of children and youth in out-of-home care including but not limited to, providing or arranging for transportation to and from health care appointments. Out-of-home care providers are responsible for ensuring that each health care visit or service is documented in an agency Health Passport (631-E) and informing and providing health care service information to the LDSS as soon as reasonably possible.

RELATED LAWS AND REGULATIONS

As a result of federal funding provisions, Maryland made certain assurances regarding the health services provided to various populations and for the documentation of these services. The relevant federal laws include: 42 U.S.C. § 622(b)(15) (State Plans for Child Welfare Services); 42 U.S.C. § 675(1)(c) (health and education records); 42 U.S.C. § 671(a)(21) (health insurance for special needs); and 42 U.S.C. § 5106a(b)(2) (Grants to States for Child Abuse or Neglect Prevention and Treatment Programs).

State law and regulation implement federal provisions and provide specific guidance for medical services and planning provided to various populations of children and families that come into contact with local departments of social services. These include Md. Code Ann., Family Law Article §§ 5-501, 5-504, 5-533(b)(1)(2); and COMAR 07.02.11.08 (Out-of-Home Placement Program, Medical Care), 07.02.25.08 (LDSS Resource Homes Requirements, Responsibilities of a Resource Parent), 07.02.25.09 (LDSS Resource Homes Requirements, LDSS Responsibly to Resource Parents), 10.67.04.04 (Maryland Medicaid Managed Care Program - Managed Care Organization, and 13A.13.01.04A (Referral and Screening).

DEFINITIONS

Comprehensive Well-Child Exam: an out-of-home care entry examination of a child or youth that reviews all available health information and identifies all health conditions (including developmental, educational, dental, and

behavioral/mental health evaluations) and supports the development of an individualized treatment plan for identified problems.

Early and Periodic Screening Diagnosis Treatment (EPSDT): the provision of preventive health care to individuals younger than 21 years pursuant to 42 CFR § 441.50 *et.seq*., and other health care services, diagnostic services, and treatment services that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions by EPSDT screening services.

Electronic System of Record: the Comprehensive Child Welfare Information System (CCWIS) for Maryland is the Child, Juvenile, and Adult Management System (CJAMS).

Emerging Adult: Youth between the ages of 14-21 who are transitioning from adolescence to adulthood.

EPSDT-Certified Provider: a physician, nurse practitioner, or physician assistant who is certified by the Maryland Department of Health (MDH) EPSDT program to provide comprehensive well-child services according to MDH periodicity schedule and program standards to enrollees under 21 years old.

EPSDT Periodic Schedule: an MDH approved list of standard and recommended preventive health care services that are to be performed at specific ages. See Maryland Healthy Kids Preventive Health Schedule.

Health Care Decision Maker (HCDM) - For purposes of this policy, a person with the legal authority to consent to routine medical or mental health care, which does not include psychotropic medications. For mental health care, in certain situations, an individual 12-years-old or older may be the HCDM if they are determined by a health care provider to be mature and capable of giving informed consent to consultation, diagnosis, and treatment of a mental or emotional disorder.[2] However, a child 12 or older does not have the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has consented to.

Health Passport (Form 631): A record containing historical and current health information (diagnoses, medical, surgical and dental provider visits, behavioral health, hospital stays, prescriptions and immunizations) about a child or youth in foster care that is accessible by resource parents, kinship caregivers, placement providers, health care providers, and LDSS staff. A health passport

[2] Health General Art. § 20–104(b)

does not contain a child's full medical records.

Initial Health Screen: An out-of-home care entry examination that identifies any immediate health care needs and documents the child or youth's current physical, dental, and behavioral/developmental health status.

Limited Medical Guardianship: Limited medical guardianship grants the LDSS, a foster parent, or other designated individual the legal authority to make specific medical decisions for the child, while the parents retain other rights and responsibilities. The scope of this authority will be dictated by the court order granting the limited medical guardianship and that defined scope must be strictly followed.[3]

Managed Care Organization (MCO): A certified health maintenance organization that is authorized to (a) receive medical assistance prepaid capitation payments; or (b) a corporation that: (i) is a managed care system that is authorized to receive medical assistance prepaid capitation payments, (ii) enrolls only program recipients or individuals or families served under the Maryland Children's Health Program, and (iii) is subject to the requirements of § 15-102.4 of the Health General Article.

Medical Home: A medical home is a network of individuals and entities providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. It includes specialty care, educational services, family support and more.

Out-of-home care: Out-of-home placement and monitoring services provided to a child in aftercare following a child's out-of-home placement.

Out-of-Home Placement Providers: Resource parents, kinship caregivers, treatment foster parents, congregate care, Residential Treatment Centers, and other Child Placement Agencies.

Primary Care Provider (PCP): A state licensed provider of health care services (physician, physician assistant, or nurse practitioner) who is the primary coordinator of care for a child or youth and is responsible for providing accessible, continuous, comprehensive, and coordinated health care services covering the full range of benefits required by the Maryland Medicaid Managed Care Program, as specified in COMAR 10.67.06.

[3] Questions about the scope of a limited medical guardianship order should be raised with LDSS counsel.

PROCEDURES AND TIMEFRAMES

Please refer to the Health Services Practice Guidance for Child Welfare Caseworkers and Supervisors for procedures related to collecting health care information, providing health services including medical assistance coverage, health care coordination, recording health services in the agency's system of record, and other information on policy implementation.

1. **Authority and Consent for Health Care Services**

1.1. Within 10 business days of a child's entry into out-of-home care, the LDSS will seek to obtain consent from the child's parent or legal guardian for the provision of routine medical services, which does not cover psychotropic medications.

1.1.1. No consent for the provision of routine medical services is required if parental rights have been terminated.

1.1.2. If parental rights have not been terminated, the LDSS shall petition the court for limited medical guardianship if it is unable to obtain consent from the child's parent or legal guardian and the child needs immediate routine medical care.

1.1.3. Consent determinations for psychotropic medication are to follow the Department's Informed Consent for Psychotropic Medications policy (SSA-CW #25-09).

1.1.4. Consent for the release of and access to a child's medical records and health information should be completed pursuant to Section 2.3.2 below.

1.2. If the LDSS believes that the child or youth has been abused or neglected, the LDSS caseworker or a law enforcement officer may take the child to a medical facility for examination and treatment to relieve any urgent illness, injury, severe emotional distress, or life-threatening health condition or to determine the existence, nature, or extent of any possible abuse or neglect without need of parental or legal guardian consent or court order in accordance with Family Law Article § 5-712 and COMAR 07.02.07.07F.

2. Health Care Oversight and Monitoring

2.1. Health Coverage

2.1.1. At a Shelter Care hearing when the court places the child or youth in an out-of-home placement, LDSS staff must ensure that, when reasonably possible, the child or youth's PCP and MCO information is obtained and provided to out-of-home program staff.

2.1.2. The LDSS is responsible for ensuring that a child or transition-aged youth entering foster care is enrolled in the State's Medical Assistance Program and has a PCP within 5 business days after the initial placement following the shelter care hearing, with any pre-existing private health insurance being the primary source of medical coverage.

2.1.2.1. Eligibility of Medical Assistance coverage should be verified with the MDH Medicaid/Medical Assistance Beneficiary Hotline. LDSS staff can call (800) 492-5231 and select option 2 to verify a child's eligibility.

2.1.2.2. PCP information should be verified, either through the MCO Special Needs Coordinator or MDH Medicaid/Medical Assistance Beneficiary Hotline.

2.1.3. Children and transition-aged youth in foster care are identified as a "special needs population" (COMAR 10.67.04.04). Each MCO will appoint a "Special Needs Coordinator" (SNC) to provide support to this population by coordinating and managing health services.

2.1.3.1. To ensure the coordination and management of physical and behavioral/developmental health care needs for children and transition-aged youth the LDSS shall coordinate care with the SNC, service providers, and caregivers.

2.1.3.2. The LDSS shall consult with the MCO to:

2.1.3.2.1. Inform the SNC about the child and transition-aged youth's placements, including contact information for the placement provider as well as the identity of the current LDSS child welfare workers.

2.1.3.3. The LDSS shall consult with the SNC to ensure:

2.1.3.3.1. That health care needs, and services (treatment resources, referrals) are received to address health conditions including children and transition-aged youth with complex medical conditions;

2.1.3.3.2. Support with information to facilitate medical placement as required or needed to the extent possible;

2.1.3.3.3. That health care information (medical and treatment history) is available to assist with the development of the child or youth's case plan and provided to placement provider in a timely manner;

2.1.3.3.4. Collaboration between resource parents, biological parents, and service providers to decrease barriers to care and promote well-being; and

2.1.3.3.5. When relevant, hospital discharge planning and aftercare process for continuity of care.

2.1.4. The LDSS case manager shall engage with the parents or legal guardian to the extent of their capability and availability to participate together in planning for the medical care of any child or transition-aged youth in foster care or in voluntary placement with the LDSS.

2.2. Health Care Information in Child or Youth's Case File

2.2.1. The LDSS shall ensure that the child or youth's case file contains medical history, the most recent copies of health care documents, and a current version of the Health Passport. All attempts to capture relevant medical documents and complete the Health Passport shall be reflected in the youth's case file.

2.2.2. Medical history and documents could include, but are not limited to, the following, if available:

2.2.2.1. Medical and surgical history

2.2.2.2. Immunizations

2.2.2.3. Allergies

2.2.2.4. Dental history

2.2.2.5. Current and past medications, including current dosage, target symptoms for psychotropic medications, and directions for administration

2.2.2.6. Past mental health and psychiatric history, including medication history and documented benefits and adverse effects

2.2.2.7. Past hospitalization, surgical, or residential treatment history

2.2.2.8. Family health history including psychiatric history

2.2.2.9. Treatment and/or service plans

2.2.2.10. Results of any clinically indicated lab work

2.2.2.11. The names and contact information for all of the child's known current and past behavioral health, dental, and medical providers

2.2.2.12. Signed consent forms, including but not limited to those for psychotropic medications.

2.3. LDSS shall exercise reasonable and diligent efforts to obtain and maintain in the child's Case File, all known health care information and documents, as listed in section 2.2.2 above, if available, as soon as the child enters out-of-home care and thereafter.

2.3.1. Initial Efforts

2.3.1.1. When a child enters out-of-home care, LDSS shall make efforts to collect pertinent health information from the child's parents, the child (when developmentally appropriate), and/or any legal guardians or other family members involved in the child's healthcare to complete Parts I and II of the Health Passport.

2.3.1.2. Efforts to complete Parts I and II of the Health Passport shall also include requesting the contact information for a child's current/past medical and/or behavioral health providers, if this information is known to any of the individuals listed in 2.3.1.1); requesting (verbally at an appointment or in writing before/afterward) information directly from any known current/past medical or behavioral health care providers (including any hospital records); contacting the special needs coordinator with the child's identified MCO; and gathering records from past out-of-home care placements.

2.3.1.3. Using the known and available information collected pursuant to 2.3.1.1 and 2.3.1.2, the LDSS shall complete Parts I and II of the Health Passport form within 5 business days after a child enters out of home care.

2.3.2. Extended Efforts

2.3.2.1. When the LDSS is the HCDM or has limited medical guardianship, the LDSS shall complete and submit written requests for release of information from the following providers, if applicable, within 5 business days of a child entering out of home care: pediatrician/primary care, dental, psychiatric and therapeutic providers. When a parent or youth is the HCDM, written release requests shall be completed as soon as reasonably possible.

2.3.2.2. The applicable HCDM or person with limited medical guardianship—whether LDSS or the parent or youth—can complete the department's standard release form (Health Passport form 631F) or the relevant provider's specific release form. The HCDM or person with limited medical guardianship should be mindful that some providers or health care institutions may require use of their particular release form.

2.3.2.3. Within 10 business days of receiving signed releases from the parent or the youth, or of receiving contact information for a child's current/past medical or behavioral health providers from someone involved in the child's health care, the LDSS shall submit a written request for pertinent records from the relevant provider(s) or healthcare institution(s). If no records are received within 45 business days of the original written request, then the LDSS will submit a second written request to the relevant provider(s) or institution(s).

2.3.2.4. The LDSS will ensure that written requests to a child's or youth's current/past medical, surgical or behavioral health providers are stored in the electronic system of record within 5 business days after a request is made.

2.3.2.5. Within 5 business days after the LDSS receives a medical record pursuant to a request made under subsection 2.3.2.3 above, the LDSS will upload the record to the electronic system of record and, as relevant, review the record and update Parts I and II of the Health Passport with any new and pertinent changes to a child or youth's medical information.

2.4. The LDSS will ensure that any medical visit, including those with any medical, behavioral, or other relevant health care providers, is recorded in the health tab of the electronic system of record within 5 business days from the date of service.

2.4.1. If the LDSS accompanies a child to an appointment, then as soon as reasonably possible after the appointment but no later than 30 calendar days thereafter, the LDSS must obtain supplemental supportive documentation from the visit (e.g., Health Passport part 3, 631-E form/Health Visit Report; patient discharge instructions; health and after visit summary reports for health services received (after visit information); or some other equivalent discharge documentation); upload the document(s) into the electronic system of record; and give the document(s) to the child's out-of -home placement provider.

2.4.2. If the out-of-home placement provider accompanies the child to an appointment, then as soon as reasonably possible after the appointment but no later than 30 calendar days thereafter, the LDSS will obtain from the out-of-home placement provider the relevant information from the appointment and upload the document(s) into the electronic system of record. If the out-of-home placement provider has not received relevant information from the appointment within 30 calendar days of the appointment, LDSS shall request the information from the medical, behavioral health, or other health care provider, and document these efforts in the electronic system of record.

2.4.3. If the worker or placement provider who accompany the child to the appointment notice that the summary document clearly lacks information about any pertinent changes to the child's diagnosis, medication regimen, or treatment plan, then the worker or placement provider should follow up with the health care provider to update the documentation from the visit to reflect such information.

3. Health Passport

3.1. Parts I and II of the Health Passport serve as a summary of current health of the youth while in the care of the Department. Information in Part I & II should be collected immediately at the time of removal of a child or youth and updated as engagements with family are ongoing, and updated, as needed, with new information obtained from medical and behavioral health providers.

3.2. The LDSS shall provide the out-of-home placement provider with the Health Passport with all available information collected from the caregiver or other parties within 5 business days of a child's removal and placement into out of home care. At that time, the LDSS shall obtain a signature from the out-of-home placement provider confirming that they received the Health Passport. This will be documented in the child's electronic system of record.

3.3. Following a child's appointment for any medical, surgical, dental, or behavioral health services, the LDSS will ensure Parts III through V of the Health Passport, or equivalent discharge documentation, are included in the electronic system of record for a child and provided to the out-of-home placement provider in accordance with the timelines specified above. The LDSS will also ensure that Parts I and II of the Health Passport are regularly updated with the essential information covered at these appointments following the monthly visits pursuant to 3.5 below.

3.4. In the case of an emergent medical, surgical, dental, or behavioral health appointment or hospitalization, or follow-up specialist appointment, LDSS will ensure Parts III through V, if applicable, and/or any equivalent discharge documentation are updated and included in the electronic system of record, and provided to the child's placement provider, within 10 business days after receipt of the information.

3.5. At each monthly visit with the out-of-home placement provider, the LDSS will review updates to the Health Passport to ensure that the Health Passport held by the out-of-home placement provider and the Health Passport stored in the electronic system of record are each current with the most updated health information, such as any diagnosis changes, medication changes, medication side effects experienced, or treatment plan changes.

3.5.1. Following this reconciliation review during the monthly visits, the LDSS will update Parts I and II of the Health Passport with any new and pertinent changes to a child's medical information to ensure that those sections reflect the most current information available to the LDSS. Updated Health Passports—including any changes to Parts I and II or additions to Parts III through V (or equivalent documentation)—will be stored in the electronic system of record.

3.5.2. The LDSS will clearly convey to out-of-home placement providers, through training and as a part of the monthly visit discussions, that the Health Passport must accompany a child to initial mental health care appointments.

3.5.3. The out-of-home placement provider or worker attending an appointment must review the health summary in the Health Passport and convey pertinent information to the treating provider. The out-of-home placement provider or worker attending an appointment will note for the care provider that the most current copy of the health passport, reflecting any updates captured during the monthly visits, can be given to the care provider if the care provider needs and requests it (a version will have already been given to the provider before the child's initial mental health appointment pursuant to 3.8 below).

3.5.4. For children prescribed medication while in out of home care, the LDSS worker must review the medication log maintained by the provider and address administration discrepancies, if observed. Discrepancies between the prescribed and administered medication and any instances where information is missing from a medication log shall be communicated to the provider, LDSS, Office of Licensing and Monitoring, the Social Services Administration, and the child's medical provider.

3.6. When a Child or Youth Transitions to a Different Out-of-Home Placement

3.6.1. Prior to a placement move, LDSS must ensure that the Health Passport held by the existing out-of-home placement provider and the Health Passport stored in the electronic system of record are current with the most updated information.

3.6.2. When the child or youth transitions to a new out-of-home placement, LDSS must ensure that a printed copy of the child's most current Health Passport from CJAMS accompanies the child to the new placement as the transition occurs. LDSS shall obtain a signature from the new out-of-home placement provider confirming receipt of the Health Passport. Receipt of the Health Passport will be documented in the child's electronic system of record.

3.6.3. If LDSS receives new health information from the prior out-of-home placement provider as the transition to a new placement is occurring, LDSS will upload the new information into the electronic system of record, and within 5 business days of receiving the new health information, provide the new information to the child's new out-of-home placement provider.

3.7. When an Emerging Adult Leaves Out-of-Home Placement

3.7.1. Prior to the time an Emerging Adult leaving out–of-home placement, the LDSS must ensure that the Health Passport held by the existing out-of-home placement provider and the Health Passport stored in the electronic system of record are current with most updated information; and

3.7.2. LDSS must give the updated Health Passport to the Emerging Adult, or if appropriate, to their legal guardian or caretaker.

3.7.3. Receipt of the updated Health Passport will be documented in the child's electronic system of record.

3.8. New Mental Health Provider

3.8.1. To ensure the Health Passport is delivered to a youth's new mental health care provider(s), the LDSS will securely email an updated version of a child's health passport to a new mental health care provider within 5 business days after learning about the youth's initial appointment with a new provider.

3.8.2. If the LDSS learns about an initial appointment with a new mental health care provider after the initial visit has already occurred, the LDSS will securely email the updated passport to that new provider as soon as is reasonably possible after acquiring the new provider's contact information.

3.8.3. When the new mental health care provider is contemplating prescribing a new psychotropic medication or changing an existing psychotropic prescription and the LDSS is the child's HCDM, the LDSS must follow the informed consent procedures enumerated in the informed consent policy, SSA-CW #25-09.

3.9. Youth and their HCDM(s) are encouraged to discuss any critical changes to the child's health records with the appropriate provider(s), and they can raise questions or concerns about their health records with the assigned worker, who can bring those to the provider's attention, as appropriate.

4. Examinations and Health Care Services

4.1. **Initial Health Screening.** The LDSS must ensure that a child or youth entering out-of-home placement, or re-entering for any reason, has an initial health care screen to identify any immediate medical, urgent mental health, or dental needs and any health conditions of which the LDSS or placement providers should be aware.

4.1.1. In accordance with COMAR 07.02.11.08J the initial health screen must occur before placement or within 24 hours of placement, but not later than 5 working days following placement, except that a child who may have been abused shall receive immediate medical attention.

4.1.2. In accordance with COMAR 07.02.11.08(K) within 10 working days of a child entering initial placement, the local department shall refer the child for a comprehensive health assessment. The local department shall ensure that every effort is made to secure the written assessment report by the 60th day of placement.

4.1.3. Preferably, the child or youth's previous PCP should complete the initial screen, if reasonable, but other providers, i.e. local child advocacy centers, urgent care centers, and emergency departments, can do the screening as appropriate and feasible.

4.1.4. To reduce any barriers with a child's initial health screen being completed due to provider reimbursement or provider scheduling, LDSS staff will use the MCO SNC for health care coordination services.

4.2. **Comprehensive Well-Child Exam.** The LDSS must ensure that health care providers complete the comprehensive well-child health exam to identify acute and chronic health, developmental and mental/behavioral conditions and, ultimately, to assist the health care providers in developing individualized treatment plans for identified conditions.

4.2.1. A child or youth entering, or reentering out-of-home care after case closure for any reason, shall receive a comprehensive well child exam within 60 calendar days of initial or return placement or replacement.

4.2.2. The LDSS should ask the child or transition-age youth's usual PCP to conduct this exam when possible and if the exam can be provided within 60 days.

4.2.2.1. In the event the child's PCP is unable to conduct a comprehensive exam within the required timeframe, the LDSS shall arrange for the child to receive the exam from another EPSDT certified provider.

4.2.3. The LDSS may permit the child's PCP to make the clinical judgment to perform the initial health screen and comprehensive well child exam at the time if the PCP has the appropriate time to complete all aspects of the evaluation.

4.2.4. The LDSS will ensure that the health care provider summarizes the results of the comprehensive well child exam, including any referrals and timing of upcoming medical visits.

4.3. **Mental Health Assessment.** If the health care provider diagnoses a child or transition-age youth with a mental, behavioral, or developmental health condition, the local department must ensure that the child or youth receives an appropriate referral to relevant mental, behavioral or developmental health resources.

4.3.1. The LDSS must confirm that any psychotropic medication or medication management plan adheres to guidelines in the current Psychotropic Medication and Oversight Policy.

4.4. **EPSDT and Specialty Services.** LDSS will access health care services for the provision of routine EPSDT and specialty services as needed to meet the physical and behavioral health care needs of a child and transition-age youth and in the agency's care.

4.5. **Exam Upon Returning to Care.** Children and transition-age youth who return to their placement after running away or being otherwise missing must have a physical exam performed as soon as reasonably possible following their return. Please reference the most recent Runaway Policy for further information. See also COMAR 07.02.11.18C.

4.6. **Dental Examination.** The local department is responsible for scheduling an initial oral health evaluation.

4.6.1. A child of 1 year or older will have this examination performed by a licensed dentist or a licensed dental hygienist working under the supervision of a licensed dentist within 90 calendar days of initial placement, if possible.

4.6.2. A child less than 1 year upon entering foster care must have an initial oral health evaluation by a licensed dentist within 90 calendar days of the child's first birthday.

4.6.3. Subsequent to the initial oral health examination, children and transition-age youth in out-of-home placement will be seen by a dentist for dental cleaning, assessment of medical needs, including updated diagnoses (ensuring appropriate diagnosis received), medication and any required examination or according to a schedule recommended by the dentist.

4.7. **Vision Screening.** The local department is also responsible for scheduling all children and transition-age youth in out-of-home placement for an annual vision screening and exam and uploading the documentation to the electronic record.

4.7.1. The PCP may conduct the vision screening during the EPSDT and well child examination.

4.7.2. If the vision screening at a child's elementary school detects a vision concern and refers the child for an appointment with an optometrist or ophthalmologist, the LDSS must ensure that the child is seen for the referral, follows through on recommendations and or referrals based on the screen, and provides documentation of screening and exam is in the electronic record.

4.8. **Hearing Screening.** A universal hearing screening will be conducted at least 1 time during the child's early adolescence,

middle adolescence, and late adolescence visits as recommended by the American Academy of Pediatrics (AAP) Bright Futures.

4.9. **Missed Immunizations.** The local department will follow the current recommendations of the Centers for Disease Control and Prevention (CDC)/Advisory Committee on Immunization Practices (ACIP), as approved by the AAP.

4.9.1. Unless medically advised otherwise, all missed or needed immunizations will be provided according to these recommendations.

5. Health Care Planning

5.1. Based on the initial health screen and the comprehensive well child exam, the LDSS:

5.1.1. Will integrate health care planning into a child's case plan no later than 60 calendar days from entering foster care; and

5.1.2. Coordinate any required or recommended follow-up recommended as part of preventive health care and treatment or care of any identified acute or chronic conditions.

5.2. The LDSS is responsible for ensuring routine examinations and EPSDT are performed for all children and transition-age youth in out-of-home placement as required by the Maryland Healthy Kids Preventive Health Schedule.

6. Referrals to Maryland Infants and Toddlers Program

6.1. The local department must refer the following children under 3 years of age to the Maryland Infants and Toddlers program for assessment and any indicated early intervention services if:

6.1.1. The child was a victim in a CPS case with a finding of "indicated" child abuse or neglect;

6.1.2. The child has a suspected disability; or

6.1.3. If the child is affected by prenatal substance exposure.

7. Children Under the Age of 18 Who May Consent for Health Care Services

7.1. In Maryland, children under the age of 18 have the same capacity as adults to consent to diagnosis and treatment of certain health services.

7.1.1. A child's legal authority to consent to certain health services does not necessarily afford the child the right to refuse health services if the parent or guardian consents.

7.1.2. Your LDSS Legal Office can provide guidance and be available to consult on such matters involving a minor's legal authority to consent to certain health services.

7.1.3. Information on health services that a minor can give consent to are listed on the Health Care Services Minor Consent.

7.2. When a child legally consents to a health care services, the child's caseworker must support the child by:

7.2.1. Providing and reviewing information about the consented health care services with the child;

7.2.2. Ensuring that the minor has transportation to all appointments, including follow-ups;

7.2.3. Arranging for an adult to accompany the child on appointments;

7.2.4. Ensuring that all prescriptions are filled and refilled, and that the minor understands the importance of taking the medication as prescribed;

7.2.5. If the minor's medication regimen or unavoidable appointments require them to be absent from school, arrange required documentation to notify the child's school so that the absence will be excused.

8. Implementing a Health Care Plan for Transition-Age Youth 18 or Older

8.1. Legally, anyone 18 or older has responsibility for making health care decisions, providing they have the capacity to consent.

8.2. A transition-aged youth 18 or over may refuse certain health care services.

8.2.1. When a transition-aged youth 18 or older refuses health care services, the LDSS must discuss the decision with the youth and provide the information necessary for the youth to make a responsible decision regarding the youth's health care needs, the available services, and treatment options, all paramount to the individual's well-being.

8.3. Despite a caseworker's best efforts, a youth 18 or older may continue to refuse to attend required health exams, screenings or appointments as defined in Section 4 of this policy.

8.3.1. The LDSS must record the refusal and complete the Health Care Services Authorization Form: DHS/SSA/3032/August2022

8.3.2. The form will be completed bi-annually (every 6 months) to record that youth's decision to comply and receive health services or decline health services.

8.3.2.1. At any time when a youth age 18 or older changes a health care decision, the caseworker must update the form.

8.3.3. The LDSS must upload and appropriately label the form in the system of record within 48 hours of form completion. Refer to the form for further details and instructions.

FORMS AND ATTACHMENTS

Health Passport

Health Services Practice Guidance for Child Welfare Caseworkers and Supervisors