

Additional Updated Policy

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State of South Carolina Department of Social Services

Child Welfare Policy: **Chapter 1: Administration, Section 1.8: Child Welfare Funding**

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| Subject: | Title IV-E Foster Care Maintenance Payments |
| Authority: | Family First Prevention Services Act of 2018, Public Law 115-123 |
| Standards: | N/A |
| Application: | All Child Welfare Programs |
| Policy Statement: | Title IV-E eligibility determination must be completed for every child that enters out-of-home care. In addition, a Title IV-E eligibility determination must be completed each time an out-of-home care episode begins. There are two (2) categories of Title IV-E eligibility criteria that impact a child's status: 1. Initial eligibility; and 2. Ongoing eligibility. |
| Purpose: | The South Carolina Department of Social Services (SCDSS) will utilize Title IV-E Foster Care funding (Title IV-E), a federal program that is authorized under and administered in accordance with Title IV-E of the Social Security Act. |
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| <p>Children placed with parents in a licensed residential family-based treatment facility for substance abuse</p> | <p>Federal foster care regulations allow title IV-E agencies to claim foster care maintenance payments (FCMPs) for a child placed with a parent in a licensed residential family-based treatment facility for substance abuse for up to 12 months in accordance with requirements in sections 472(j) and 472(a)(2)(C) of the Act. Title IV-E agencies may also claim administrative costs during the 12-month period consistent with 45 CFR 1356.60(c) for the administration of the title IV-E program, which includes such things as case management. A licensed residential family-based treatment facility for substance abuse is not a child care institution (CCI) as defined in section 472(c) of the Act. While the facility must be licensed, there is no requirement that it meet the title IV-E licensing and background check requirements for a CCI.</p> <p>The title IV-E agency may claim FCMPs in accordance with the definition in section 475(4)(A) of the Act, which includes such things as the cost of providing food, clothing, shelter, and daily supervision. However, because a licensed residential family-based treatment facility for substance abuse is not a CCI, the title IV-E agency may not include the costs of administration and operation of the facility in the child's title IV-E FCMP. Also see section 472(k)(1)(A) of the Act.</p> <p>The child must meet all the title IV-E foster care eligibility requirements except the AFDC eligibility requirements in sections 472(a)(1)(B) and (3) of the Act. The requirement that the child is under the placement and care</p> |
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| | <p>responsibility of the title IV-E agency while placed with the parent in the facility remains in effect.</p> |
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State of South Carolina

Department of Social Services

Child Welfare Policy: Chapter 1: Administration, Section 1.9:
Criminal Record and Registry Checks in Child-Care Institutions(CCI)

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| Subject: | Criminal Record and Registry Checks for Adults Working in Child-Care Institutions |
| Authority: | Family First Prevention Services Act of 2018, Public Law 115-123 |
| Standards: | N/A |
| Application: | Child Care Institution (Group Home) Licensing Staff |
| Policy Statement: | All individuals employed within a child-care institution (group home) setting must undergo a fingerprint-based criminal records check of national crime information databases to include child abuse and neglect registry checks. |
| Purpose: | To provide guidance to child care institution (group home) licensing staff regarding the changes in title IV-E requirements regarding criminal records and registry checks for all adults working in a child-care institution. |
| Procedures: | |
| Verify that criminal record and registry checks for all adults working in a child-care institution (group home) are completed. | <ol style="list-style-type: none"> Licensing staff will verify and document that any adult employed within a child-care institution (group home) setting has undergone a fingerprint-based criminal record check of national criminal information databases to include child abuse and neglect registry checks. This includes all group home employees, volunteers, and any applicant applying for employment with these facilities. The adults must undergo a South Carolina Law Enforcement Division (SLED) and national Federal Bureau of Investigation (FBI) fingerprint-based criminal record background checks, which will include a check of the National Sex Offender Registry (NSOR). The statute does not allow any exemptions or exceptions for conducting the checks on any adults who work in such settings. As such, all adults, including adults who do not work directly with children, are subject to the background check requirements when working in a CCI. |
| Forms: | SCDSS Form: 1081: Non-Criminal Justice Applicant Privacy Rights Application SCDSS Form 1083: Privacy Rights Notification |
| Resources: | Applicant Notification-Record Challenge.tif GH Provider Meeting Q&A.tif |

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| | Identogo Fingerprinting Instructions.tif Notice,(Group Home Background Checks).tif SC Fingerprinting Locations.tif |
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Original Effective Date: 10-01-2018
 Current Effective Date: 10-01-2018



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures: Child Protective Services Alerts

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| Subject: | Chapter 3 and Chapter 4 Child Protective Services Alerts |
| Authority: | S.C. Code 63-7-910; S.C. Code 63-7-1990 |
| Standards: | N/A |
| Application: | Child Welfare Services Staff |
| Policy Statement: | The Department of Social Services maintains an automated process for collection and dissemination of Child Protective Services Alerts whenever a child in an open case is deemed missing and there is a concern for present or impending danger. |
| Purpose: | To provide information and directives regarding Child Protective Services Alerts and the requirement of program staff to notify the Office of Safety Management so that information can be communicated statewide to keep children safe. |
| Definitions: | |

Child Protective Services (CPS) Alerts: a notification issued when staff are trying to locate persons listed in reports or in findings of child abuse or neglect when staff have exhausted all efforts to locate the family at the local level or there is reason to believe that the family has left the area

Present danger: an immediate, significant, and observable severe harm or threat of severe harm occurring in the present

Impending danger: a state of danger in which family conditions, behaviors, attitudes, motive, emotions, and/or situations are out of control and, while the danger may not be currently active, it can be anticipated to have severe effects on a child at any time

In-state CPS Alert: CPS Alerts initiated on open cases within the state of South Carolina

Out-of-state CPS Alert: CPS Alerts issued by and received from another state

Procedures:

A. In-State Notification of a CPS Alert

1. The Case Manager must complete [Form 2630](#) and submit the form to the Office of Safety Management at cpsalerts@dss.sc.gov within 24 hours, providing the following information:
 - a. Names of victims, perpetrator(s), or family members to be included in the alert and all known demographic information, including physical descriptions.
 - b. Circumstances requiring an alert: allegations, risks and special considerations (court orders), immediate medical needs, and law enforcement involvement that place the child at risk of present or impending danger.

Original Effective Date: 11/08/2018

Current Effective date:

Supersedes: replaces section 729 of Current Child Protective and Preventive Services Policy

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| | <ol style="list-style-type: none"> c. Descriptions of the vehicle, license tag number, or other mode of travel, if known. |
| | <ol style="list-style-type: none"> 2. The Office of Safety Management must enter information into the CAPSS system as a Child Protective Services Alert within one business day. An automated e-mail will be generated and disseminated to County Directors. <ol style="list-style-type: none"> a. A notification e-mail will be sent to County Directors. b. For CPS Alerts involving criminal activity (ex: kidnapping,) SCDSS Office of the Inspector General must be notified. c. Once the CPS Alert has been entered into CAPSS, the names of the individuals listed in the alert will appear in "blue". |

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| <p>B. Out-of-State Notification of a CPS Alert</p> | <ol style="list-style-type: none"> 1. For written requests, the employee must complete Form 2630 and submit the form to the Office of Safety Management at cpsalerts@dss.sc.gov within 24 hours, providing the following information: <ol style="list-style-type: none"> a. Names of victims, perpetrator(s), or family members to be included in the alert and all known demographic information, including physical descriptions. b. Circumstances requiring an alert: allegations, risks and special considerations (court orders), immediate medical needs, and law enforcement involvement that place the child at risk of present or impending danger. c. Descriptions of the vehicle, license tag number or other mode of travel, if known. 2. For verbal requests, the Case Manager must advise the requesting agency to send a written request to the Office of Safety Management at cpsalerts@dss.sc.gov. The Case Manager must request the following information be included: <ol style="list-style-type: none"> a. Names of victims, perpetrator(s), or family members to be included in the alert and all known demographic information, including physical descriptions. b. Circumstances requiring an alert: allegations, risks and special considerations (court orders), immediate medical needs, and law enforcement involvement that place the child at risk of present or impending danger. |
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Original Effective Date: 11/08/2018

Current Effective Date:

Supersedes: replaces section 729 of Current Child Protective and Preventive Services Policy

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| | <p>c. Description of the vehicle, license tag number, or other mode of travel, if known.</p> |
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| <p>C. Office of Safety Management Responsibilities</p> | <p>3. For all requests, the Office of Safety Management must enter the information into the CAPSS system as a Child Protective Services Alert within one business day. An automated e-mail will be generated and disseminated to County Directors.</p> <ul style="list-style-type: none"> a. A notification e-mail will be sent to County Directors. b. For CPS Alerts involving criminal activity the SCDSS Office of the inspector General must be notified. c. Once the CPS Alert has been entered into CAPSS, the names of the individuals listed in the alert will appear in "blue". |
| <p>Forms:</p> | <p>Form 2630</p> |

Original Effective Date: 11/08/2018

Current Effective Date:

Supersedes: replaces section 729 of Current Child Protective and Preventive Services Policy

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| Subject: | Chapter 5 Foster Care: Section 510.7.100 Routine Medical Consent for Children in Foster Care |
| Authority: | S.C. Code § 63-5-340, § 63-5-350, § 63-7-2310, § 63-7-20(15). 42 USC § 622(b) (15), § 671(a)(22). |
| Standards: | <ul style="list-style-type: none"> • Health Care Oversight and Coordination plan • American Academy of Child and Adolescent Psychiatry Best Principle Guidelines |
| Application: | Foster Care/Intensive Foster Care and Clinical services (IFCCS)/Adoptions Case Managers, Foster Family and Licensing Support (FFALS) Coordinators, Foster Parents, Supervisors, Program Directors, County Directors, Regional Clinical Specialists, Regional Directors, and any provider who is designated as a secondary medical consenter |
| Policy Statement: | |
| <p>A child's parent/guardian shall retain the authority to consent to medical treatment and the right to access the child's medical records unless rights have been terminated or a court order otherwise gives the agency such authority. If a parent/guardian places his or her child in foster care by signing a Voluntary Placement Agreement, the parent/guardian shall retain the authority to consent to medical treatment.</p> | |
| <p>When a court order grants DSS custody and/or authority to make routine medical decisions on behalf of a child, the case manager shall be designated the primary medical consenter for purposes of the agency making routine medical decisions. However, the case manager or other consenter must consult with and involve the birth parents, the child, and other kin in making all health care decisions, unless doing so is not in the best interests of the child. If the Child Welfare Services (CWS) case manager is unavailable, two secondary medical consenters may be designated for routine medical care. All medical consenters must receive the Health Care Oversight and Psychotropic Medications Training.</p> | |
| Purpose: | |
| <p>To reduce barriers to timely care for children in care and avoid delays in receiving necessary treatment, CWS may designate medical consenters who can also provide consent to routine medical care. Any medical consenters must be trained to ensure that children are receiving appropriate medical care to promote child well-being.</p> | |
| Definitions: | |
| <p>Primary medical consenter - CWS case manager and/or supervisor who are usually given the authority to consent to routine medical care from court for children in care and are to be the first in such authority to consent to routine medical care when available. All primary consenters must receive the Health Care Oversight and Psychotropic Medications Training. The primary medical consenter is a designation only for purposes of the agency or its designee making routine medical decisions for a minor child. When the agency or its designee makes a routine medical decision, the consenter must consult with and involve the birth parents, the child, and other kin, unless doing so is not in the best interests of the child.</p> | |
| <p>Secondary medical consenter - the designated consenter by CWS case manager and/or supervisor who may consent to routine medical care in the absence of primary consenter. This individual can be an external partner and must receive the Health Care Oversight and Psychotropic Medications Training.</p> | |

Routine medical care – the regular care from Medical Provider at routine visits outside of urgent or emergent needs and major medical care as defined in Policy 510.7 and this may include:

- Preventive care: EPSDT/Well-child exams
- Laboratory testing including STD/HIV testing/ X-Ray examination
- Dental checkups and routine treatment such as fillings and braces
- Immunizations
- Vision/Hearing/Developmental/Trauma Screening
- Allied health care services such as Physical, Speech, Occupational Therapy, and dietetic services
- Mental health treatment such as therapy, psychological assessments, and psychotropic medication administration. Psychotropic medication consent requires Psychotropic Consent DSS Form 2056 to be completed. Refer to Psychotropic Informed Consent Policy.

Major medical treatment – anything that falls outside of routine medical care that may include: surgical procedures, invasive diagnostic procedures, anesthesia, any treatment the child’s physician considers dangerous, any treatment that may be threatening to the child’s life or long term health, the voluntary admission of a child to a facility for inpatient mental health or substance abuse treatment, extraordinary medical procedures such as withholding or withdrawal of life sustaining procedures, organ donation, abortion, electroconvulsive therapy, aversion therapy, or any experimental treatment or clinical trial. See Policy 510.7 for additional information.

Informed medical consent -- the consenter agrees to treatment after he/she gets the information about proposed medical care and alternative treatment options with their risks benefits as well as what happens without treatment.

Other kin – relatives involved in the child’s life who have the legal right to information about the child’s medical treatment via guardianship, a signed release of information, or other means.

Procedures:

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| <p>A. Primary Medical Consenter for Routine Medical Care</p> | <ol style="list-style-type: none"> 1. When the agency has authority to make medical decisions on behalf of the child, the case manager and/or supervisor are the usual and primary consenters for routine medical care. When the agency or its designee makes a routine medical decision, the consenter must consult with and involve the birth parents, the child, and other kin, unless doing so is not in the best interests of the child. 2. All primary medical consenters must receive the Health Care Oversight and Psychotropic Medications training within 90 days of hire, and then annually thereafter. Trainees must pass the quiz with a score of 70%. 3. The case manager is to closely coordinate with caregivers as to any upcoming health care appointments to ensure an individual with the right to consent is available to attend. |
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4. The case manager is required to make every effort to attend upcoming health care appointments for the child especially if psychotropic medications may be prescribed. The case manager is to get copy of medical encounter form or treatment records from medical provider during the appointment and upload it to the linked files tab in the Person screen in CAPSS.
5. If the case manager is unable to attend the health care appointment, the case manager is required to get all details from the caregiver who attended the appointment as to any health care provided during the appointment as soon as possible, but no later than next business day. This shall further include:
 - a. Obtain a copy of medical encounter form or medical provider's treatment record from the caregiver and upload to linked files in the Person screen in CAPSS.
 - b. Review carefully any psychotropic medications prescribed during the appointment to review safe and appropriate use of these medications. Any prescribed medications further need to be entered in the Medications tab in the Person screen in CAPSS within five business days.
 - c. Get a copy of DSS Form 2056, SCDSS Psychotropic Medication Informed Consent, completed by the consenter and upload to linked files in the Person screen in CAPSS.
 - d. All forms must be linked in CAPSS no later than five business days after the receipt of the forms.
6. If the case manager has any concerns over prescribed psychotropic medications, the case manager is to contact Regional Clinical Specialist for further review to monitor safe and appropriate use of these medications.
7. Case manager is further required to consult Regional Clinical Specialist before administration of medications in any of the following circumstances:
 - a. child is age 6 or under;
 - b. child is prescribed 4 or more psychotropic medications; and/or
 - c. child is being prescribed an antipsychotic medication
8. Staffing with Regional Clinical Specialist is documented under Dictation tab in CAPSS under title "Staffing (Psychotropic Medication)".
9. Case manager is to document any changes in child's diagnosis and medication in Health and Education Passport in CAPSS and document under the Dictation tab in CAPSS.
10. Any request for medical consent must be responded to by a primary consenter within 24 hours.
11. Parents, other kin, and the child must be engaged in, and informed about, any medical appointments prior to the appointment being held or changes in medical care upon completion of any appointment unless doing so is not in the best interest of the child.

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| <p>B. Medical Consent Forms for Placement with Providers</p> | <p>1. Case manager is not permitted to sign consent forms for group homes, residential treatment facilities, child placing agencies, or any provider that dictate that a child be given medication according to physician order as this allows the facility to make decisions about all medications including psychotropic medication. If the provider requires a consent form including this language the case manager must draw a line through that language regarding medication indicating that consent is not given.</p> |
| <p>C. Secondary Medical Consenter for Routine Medical Care</p> | <p>1. <u>Secondary Medical Consenter Designation</u></p> <ol style="list-style-type: none"> a. When the agency has authority to consent to routine medical care but is unable to attend and consent to such care, the case managers and/or supervisor may designate up to two secondary medical consenters that are usually the child's live in caregivers such as foster parents, relatives, professional employees of emergency shelters, and group care providers. When the agency or its designee makes a routine medical decision, the consenter must consult with and involve the birth parents, the child, and other kin, unless doing so is not in the best interests of the child. b. In group homes, the only staff who can be chosen as designated medical consenters are clinical staff, i.e. nurses and clinical care coordinators. c. Employees of Psychiatric Residential Treatment Facilities are not to be chosen as designated medical consenters. d. The case manager and/or supervisor must make sure the secondary medical consenters complete the Required Health Care Oversight and Psychotropic Medications Training prepared by South Carolina Department of Social Services and are reliable before being designated as medical consenters. e. These trainings are required initially to be designated as secondary medical consenter, and then annually thereafter. f. Documentation of completed training must be submitted to case manager and/or supervisor by the secondary medical consenter initially, and on an annual basis, or the medical consent is no longer valid. g. Case manager and/or supervisor designates medical consenter by issuing DSS Form 2055, SCDSS Designation of Medical Consenter to the secondary medical consenter, usually valid for 12 months. h. Case manager must document the designation of a secondary medical consenter in CAPSS as follows: <ol style="list-style-type: none"> i. enter in the child's Person Screen under the "Training" tab within five days that the training was completed and a designated medical consenter has been approved |

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| | <ul style="list-style-type: none"> ii. link the DSS Form 2055, SCDSS Designation of Medical Consenter to child's Person ID in CAPSS iii. provide notification to regional Foster Family and Licensing Support Coordinator so this information can be entered in the Provider Training tab <ol style="list-style-type: none"> 2. CWS may, at any time, change the designated secondary medical consenter by issuing another DSS Form 2055, SCDSS Designation of Medical Consenter to new secondary medical consenters and caregivers. 3. If a concern arises with the Designated Medical Consenter, the case manager and/or supervisor must notify and consult with the Foster Family and Licensing Support Unit to develop a plan to address the concern. |
| <p>D. Ongoing Coordination and Oversight of Designated Secondary Medical Consenter</p> | <ol style="list-style-type: none"> 1. CWS case manager is responsible for ongoing health care oversight and coordination of care and must make sure that: <ul style="list-style-type: none"> a. The designated secondary medical consenter provides copies of DSS Form 2055, SCDSS Designation of Medical Consenter to each child's doctor and other health care providers as applicable. b. The designated secondary medical consenter only consents to routine medical care and cannot consent to major medical treatment. 2. The designated secondary medical consenter must inform case manager and/or supervisor within 24 hours if the secondary medical consenter elects not to consent to the treatment being prescribed by the medical provider. 3. The designated secondary medical consenter notifies case manager and/or supervisor within two hours after any emergency care is needed including, but not limited to, significant medical conditions such as injuries or illnesses that are life threatening or have potentially serious long-term health consequences, including hospitalization for surgery. 4. The designated secondary medical consenter is authorized to access the health care history and records of the minor child or other Protected Health Information to the extent necessary to obtain services for the child and enable the consenter to give informed consent for the child's care and treatment. 5. The designated secondary medical consenter must provide information about the child's medical care to case manager including preventive care, medical care, and routine medical care such as common childhood illnesses and minor injuries, and any medications on a monthly basis, at a minimum. 6. The designated secondary medical consenter and caregiver are further required to closely coordinate with case managers as to any upcoming |

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| | <p>health care appointments to ensure an individual with the right to consent is available to attend and to engage parents and other kin unless doing so is not in the best interest of the child.</p> <p>7. “Primary medical consentor” and “secondary medical consentor” are designations only for purposes of the agency or its designee making routine medical decisions for a minor child. When the agency or its designee makes a routine medical decision, the consentor must consult with and involve the birth parents, the child, and other kin, unless doing so is not in the best interests of the child.</p> |
| Forms: | <p>DSS Form 2055, SCDSS Designation of Medical Consentor DSS Form 2056, SCDSS Psychotropic Medication Informed Consent Health Care Oversight for children in Care and Psychotropic Medications Training Certificate</p> |
| Resources: | <p>Health Care Oversight for Children in Care and Psychotropic Medications training and webinar</p> |
| Related Management Reports: | <p>Click here to enter related management reports.</p> |

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| Subject: | Chapter 5 Section 510.7.200 Psychotropic Medication Informed Consent |
| Authority: | S.C. Code § 63-5-340, § 63-5-350, § 63-7-2310, § 63-7-20(15). 42 USC § 622(b)(15), § 671(a)(22). |
| Standards: | <ul style="list-style-type: none"> • Improving Outcomes for Children in Foster Care. • Health Care Oversight and Coordination Plan. • Fostering Connections to Success and Increasing Adoptions Act of 2008 for oversight of prescribed medications and Child and Family Services Improvement and Innovations Act of 2011 requiring States to have protocol for monitoring of psychotropic medications. |
| Application: | Foster Care/intensive Foster Care and Clinical Services (IFCCS)/Adoptions Case Managers, Foster Family and Licensing Support (FFLS) Coordinators, Foster Parents, Supervisors, Program Directors, County Directors, Regional Clinical Specialists, Regional Directors, and any provider who is designated as a secondary medical consentor. |
| Policy Statement: | |
| <p>In accordance with Routine Medical Consent for Children in Foster Care Policy, if the agency has the authority to provide medical consent, any medical consentor for a child in care must complete the Health Care Oversight and Psychotropic Medications training to be trained in the basics of understanding the use, expectations, and problems posed by different choices in psychotropic medications and other psychosocial interventions prior to providing consent. Administration of psychotropic medications to a child in care requires a Psychotropic Informed Consent form to be signed by the medical consentor.</p> <p>The agency must involve birth parents, other kin, caregivers, and the child in routine medical care, unless doing so is not in the best interests of the child.</p> | |
| Purpose: | |
| <p>Informed consent promotes safe, appropriate, and effective use of psychotropic medication for children in foster care through shared medical decision making which has better outcomes for child well being. A medical consentor is the initial contact with the prescribing physician whenever a medication is prescribed. Therefore, a system of "informed consent" is critical for the oversight of psychotropic medication.</p> | |
| Definitions: | |
| <p>Psychotropic medication - a medication that is prescribed for the treatment of mental, emotional or behavioral health problems and is aimed at changing mood, behavior and cognition by working on neurotransmitters in the brain. This may include antidepressants, anti-anxiety medications, antipsychotics or neuroleptics, sedatives, hypnotics or other sleep promoting medications, agents for treatment of mania or mood disorders and psychomotor stimulants.</p> | |

Informed consent - a process by which a patient (or that patient's representative) authorizes a health care professional to provide treatment only after the healthcare professional gives information about proposed medical care, including medications and alternative treatment options with their risks benefits, as well as what happens without treatment. Informed consent is based on the moral and legal premise of patient autonomy where the patient or their guardian has the right to make decisions about their health and medical conditions.

Medical consenter - a person authorized to consent to medical care of the child.

Procedures:

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| <p>1. Training Requirement</p> | <p>1. Training</p> <ul style="list-style-type: none"> a. The primary and secondary medical consenters must complete SCDSS Required Health Care Oversight and Psychotropic Medications Training prepared by South Carolina Department of Social Services. b. For Primary Medical Consenters who are Child Welfare Services case managers and/or supervisors, these trainings are required initially within 90 days of hire, and then annually thereafter. c. For Secondary Medical Consenters who are designated consenters by CWS case managers and or supervisors, these trainings are required initially before being issued the right to consent and annually thereafter. d. Training completion must be documented as outlined in the Routine Medical Consent for Children in Foster Care Policy. e. The medical consenter should understand the CWS Policy around consent and principles of the informed consent for the administration of psychotropic medication as reviewed in the training. f. The training further reviews appropriate use of psychosocial interventions such as different therapies, behavior strategies and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications. |
| <p>2. Psychotropic Informed Consent Form</p> | <p>1. Administration of psychotropic medications to a child in care requires the Psychotropic Medication Informed Consent form to be signed by the primary or secondary medical consenter. Before signing the consent form, the</p> |

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| | <p>medical consentor must receive, review, and understand the following information provided by the medical provider as to prescribed medication;</p> <ol style="list-style-type: none"> 2. The specific condition, symptoms, or diagnosis being treated with the medication; 3. The benefits of medication, including the symptoms treated by the medication and the likely effectiveness of the medication; 4. Any alternate medication or non-medication options available to treat the condition, their likelihood of benefit, and the reason for selecting the treatment; 5. The risks of taking the medication and probable clinically significant side effects; 6. The risks of not taking the medication; 7. The name, dosage, frequency, route of administration, and duration of the prescribed medication; and 8. Any special instructions about taking the medication and any monitoring such as bloodwork required while the child is taking the medication. 9. The medical consentor should provide consent voluntarily and without undue influence. |
| <p>3. Designated Secondary Medical Consentor</p> | <ol style="list-style-type: none"> 8. When consent is given by designated secondary medical consentor the consentor must: <ol style="list-style-type: none"> a. Provide written notification to CWS case manager and/or supervisor by the next business day after consenting to psychotropic medications. b. Retain signed Psychotropic Informed Consent form and provide it to the child’s case manager. The case manager is to sign and file this form in the child’s case record and upload it to the Person screen in CAPSS within 5 business days. c. Inform CWS case manager and/or supervisor within 24 hours if the consentor elects not to consent to the recommended treatment. 9. If the case manager has any concerns over prescribed psychotropic medications, the case manager is to contact Regional Clinical Specialist for further review to monitor safe and appropriate use of these medications. |
| <p>4. Regional Clinical Specialist</p> | <ol style="list-style-type: none"> 1. The designated secondary medical consentor is to immediately notify the case manager and the case manager is required to consult the Regional Clinical Specialist before administration of medications when: <ol style="list-style-type: none"> a. Child is age 6 or under; b. Child is prescribed 4 or more psychotropic medication; and/or the |

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| | <p>c. Child is being prescribed an antipsychotic medication.</p> <p>2. If, after consultation, there are continued concerns, the Regional Clinical Specialist must consult with the agency Child Psychiatrist.</p> |
| Forms: | <p>DSS Form 2055, SCDSS Designation of Medical Consenter</p> <p>DSS Form 2056, SCDSS Psychotropic Medication Informed Consent</p> <p>Health Care Oversight for children in Care and Psychotropic Medications Training Certificate</p> |
| Resources: | <p>Health Care Oversight for Children in Care and Psychotropic Medications training and webinar</p> <p>Routine Medical Consent for Children in Foster Care</p> |
| Related Management Reports: | <p>Click here to enter related management reports.</p> |

Original Effective Date: May 23, 2019
Current Effective Date: June 1, 2019



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures: Chapter 5

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| Subject: | Foster Care Visitation |
| Authority: | S.C. Code Ann 63-7-1660, S.C. Code Ann 63-7-1680, S.C. Code Ann 63-7-2310; Group Home Licensing Regulation 114-590, DSS Proviso 38.30 |
| Standards: | N/A |
| Application: | All Foster Care, Intensive Foster Care and Clinical Services (IFCCS), Case Managers, Adoption Specialists, Supervisors, Program Coordinators, and County Directors |
| <p>Policy Statement: Child Welfare Services (CWS) must provide regular, quality visitation between children in foster care and their parents, siblings, and other significant persons in their life.</p> | |
| <p>Purpose: Case managers and supervisors have the responsibility to work with families to provide regular, quality visitation when in the best interest of the child. These interactions are necessary for children to preserve relationships with their parents, siblings, extended family and other significant persons in their lives. Quality visitation reduces children's length of stay in foster care, promotes healthy attachments, and mitigates the negative effects of separation.</p> | |
| <p>Definitions:</p> <p>Case Manager: Child Welfare certified staff with the classification of Human Service Specialist II or above.</p> <p>Child and Family Team: Teams developed by the family with assistance from the agency to include family selected supports and community supports who come together to develop, and/or update a plan <i>with</i> the child, youth and family.</p> <p>Clinical judgment: A clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and that is not an employee of the S.C. Department of Social Services. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. Approved LPHAs are designated by Medicaid.</p> <p>Other significant persons: Persons who are identified as being important to the child: friends, neighbors, people from church, school, or the community.</p> | |

Protective Capacity: Behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a person's ability to care for and keep a child safe.

Siblings: Children who have one or more parent in common biologically, through adoption, or through the marriage of their parents, and/or with whom the child lived before his or her foster care placement.

Visitation: An intentional face-to-face interaction between a child and their parents/caregivers, siblings, other family members, or other significant person in the child's life, designed to increase bonding and attachment between those participating in the interaction.

Monitored Visitation: Visitation in which a designated monitor is present in the location, facility, or home where the visit is occurring, and is intermittently observing the interaction of visit participants. Unless expressly prohibited by court order or it is determined to be detrimental to the child, the visitor may be allowed time alone with the child.

Quality Visitation: Visitation planned and individualized for each child and their visitor, with a focus on engagement between the involved parties, safety assessment, appropriate personal interactions and boundaries, case manager follow up on previously identified concerns, and, when appropriate, coaching to encourage visitors to engage with children and to be accountable for visitation outcomes as defined in case plans.

Regular Visitation: Visitation provided at the required frequency necessary for the child's age and developmental stage, court mandated timeframes, and case status. (For example, a child whose permanency plan is reunification in the next 90 days must have more frequent visits for a successful transition to occur.) *The minimum frequency for parent - child visitation is twice monthly. The minimum frequency for sibling visitation when siblings are in foster care and are not placed together is monthly. Note that the court may establish specific visitation requirements in certain cases*

Supervised Visitation: Visitation in which a designated monitor is present and observing at all times, within line of sight and range of hearing of the family.

Therapeutic Visitation: Visitation facilitated and documented by a Licensed Practitioner of the Healing Arts (LPHA).

Unsupervised Visitation: Visitation between the child and visitor(s) that is not supervised or monitored.

Procedures:

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| <p>E. Family Visitation</p> | <ol style="list-style-type: none">1. The case manager must arrange for parental visits to occur with the child in foster care within one (1) week of the child entering foster care, unless such visitation is prohibited by court order. These visits must also include siblings placed in foster care, as well those not in foster care.2. During the first week of placement, and on a regular basis thereafter, the case manager must arrange visits with the child's parents, siblings, or other significant adults, unless contrary to the welfare of the child, or as ordered by the court. (See definition of "Regular Visitation" for minimum frequency standards.)3. Within thirty (30) days of a child entering foster care, the case manager must create a visitation plan with input from the child, the parents/guardians, other significant persons, foster parent, the guardian ad litem or congregate care provider, and, if applicable, the child's therapist or mental health provider. (Note: this visitation plan shall serve as the "transition plan" contemplated by DSS Proviso 38.30(B). This plan must include details about locations, dates and times, types of activities, length, supervision, necessary supports, any barriers to visitation and plans to address those barriers, and any community connections that can be utilized to assist in cultivating a positive relationship between child and parent.4. Prior to the merits hearing or within ten (10) days of the hearing occurring, the visitation plan must be finalized and documented in CAPSS.5. The agency must not recommend parental visitation of less than two (2) times per month unless required by a court order. In addition to visits, other communications such as text messages, phone calls, emails, social media messages, and/or video calls must be allowed and encouraged unless contrary to the child's safety and/or well-being. These communications should be planned at the family and child team meetings and incorporated into visitation plans.6. At every opportunity, the case manager will ask the child, the child's parents, and any other person (including other professionals involved with the child) about the names and addresses of any relatives or other significant persons with whom the child might have an emotionally significant connection. The case manager will coordinate reasonable and meaningful visitation between the child and any relative or other significant persons identified in accordance with the child's best interest. The agency must promote a positive and nurturing relationship between children in foster care and any other significant persons unless maintaining the relationship is contrary to the child's safety and/or well-being. |
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| | <p>7. Neither DSS staff nor placement providers can limit or prohibit family contact as a disciplinary measure.</p> |
| <p>B. Sibling Visitation</p> | <p>1. When siblings in foster care are separated, visitation must be arranged monthly, at a minimum, and more frequently when possible. The case manager must facilitate or arrange for other ongoing, frequent interaction between siblings, such as phone calls, photo exchanges, text messaging, letters, video chats, and participation in extracurricular activities, unless one of the following exceptions is met and documented in CAPSS:</p> <ul style="list-style-type: none"> a. An existing court order specifies no or limited sibling visitation; b. the child or sibling is on runaway during a calendar month and the visit cannot occur due to inability to locate child; c. the child or sibling is incarcerated or in a facility that does not allow visitation; d. the child or sibling refuses to participate in the visit; e. despite diligent concerted efforts to provide visitation, the sibling visit is infeasible due to geographic distance (case manager must document diligent concerted efforts to make sibling visits in CAPSS and to provide alternative forms of contact between siblings when visitation is not possible); f. visitation would be psychologically harmful to the child based on “clinical judgement” as defined above and supervisory approval has been obtained and documented in CAPSS to as an exception to visitation; g. a case manager has determined, while in the field, that a visit poses immediate safety concerns and may opt to defer the visitation. The case manager must staff the matter with the supervisor by the end of the work day. The case manager must document in CAPSS the reason that the visitation did not proceed and notify, in writing, the supervisor and the County Director within three (3) business days. If the sibling visitation was court ordered, a follow up staffing will be held with the legal department within three business days to determine whether a court hearing is necessary to seek amendment of court ordered visitation. The visitation plan must be amended with the family, if necessary, to address future visitation. <p>2. In addition to visits, other communications, i.e. text messages, phone calls, emails, social media messages, and/or video calls must be allowed and encouraged with consideration to age, development and available technology. These will be incorporated into the visitation plan.</p> <p>3. Neither DSS staff nor placement providers can limit or prohibit sibling contact as a disciplinary measure.</p> |
| <p>C. Levels of Supervision</p> | <p>1. Unsupervised Visitation: Visitation between the child and visitor(s) that is not supervised or monitored. Parents can be alone with the child. This may include</p> |

overnight visits when transitioning to reunification. Visitation must adhere to the visitation plan and the court order. If DSS approves an individual or entity to coordinate a visit for a foster child, that individual or entity must provide the details of that visit to DSS in advance of the visit.

Who can coordinate: DSS case manager, case manager assistants, foster parents, other significant persons, providers, therapists, counselors.

a. When to use: When a court order allows; when there are no safety concerns; when a child is transitioning into the home environment; when risk factors are reduced as demonstrated by parental interaction with children and an overall increase in protective capacity is observed.

b. Location: Non DSS site

c. Coordinator's Role:

i. Establish clear guidelines with the family for expectations of the visit.

ii. Communicate start and end time, location of pick up and drop off, needs of child, and emergency contacts with all parties.

iii. Debrief with all parties after the visit. Children will be debriefed individually to identify strengths of the visit and any concerns that the child may have about visitation. Ensure debriefs are delivered in an age and developmentally appropriate manner.

iv. Provide feedback to parents based on information shared from debrief, to reinforce positive interaction and parenting skills. Address any concerns that arise.

v. Document the debrief with parent and include any reported interaction between the parent and the child and any coaching or mentoring provided to the parents, especially those behaviors that show progress toward or away from Case Plan goals. This must be documented in CAPSS prior to the last working day of the month.

d. DSS Case Manager Role:

i. If coordinated by another party, debrief the visit with the coordinator and obtain documentation of the visit from the coordinator. Discuss visits with the parent and child to determine strengths and needs.

ii. Document the visit and enter in CAPSS.

2. **Monitored Visitation:** The monitor is in same location, facility, or home during the visit, but may allow the parent some time alone with their children. This amount of time is determined on a case by case basis. The determination will be based on the parents' demonstration of protective capacity and their ability to positively engage with the children. Location and type of activity will also be factored into the amount of time the parents are alone with the child.

Note: Monitored visitation must not conflict with current court order. Petition the court for modifications of the visitation plan, when needed.

a. When to use:

- i. There are no safety concerns.
- ii. Risk factors are reduced as demonstrated by parental interaction with children and an overall increase in protective capacity.
- b. Who can monitor:
DSS case manager, case manager assistant, foster parents, other significant persons, providers, therapists, and/or counselors.
- c. Location:
Parent chooses the location but the site must be approved by DSS. Visits outside of the DSS office must be encouraged.
- d. Monitors Role:
 - i. Intermittently observe the interactions between child and parent and provide coaching, modeling and mentoring to parents to reinforce positive interactions, encourage bonding, and build parenting skills.
 - ii. The child(ren) must not be removed from the visit location
 - iii. Monitor the safety and emotional wellbeing of child(ren) during the visit.
 - iv. Intervene if risk arises or develops.
 - v. Debrief with all parties after visit. Children will be debriefed individually to identify strengths of the visit and any concerns that the child may have about visitation. Ensure debriefs are delivered in an age and developmentally appropriate manner.
 - vi. Document the debrief with parent and include any reported interaction between the parent and the child and any coaching or mentoring provided to the parents, especially those behaviors that show progress toward or away from Case Plan goals. This must be documented in CAPSS prior to the last working day of the month.
- e. DSS Case Manager Role:
 - i. If coordinated by another party, debrief the visit with the coordinator and obtain documentation of the visit from the coordinator. Discuss visits with the parent and child to determine strengths and needs.
 - ii. Document the visit and enter in CAPSS.

3. **Supervised Visitation:** The monitor is present and observing at all times within line of sight and range of hearing of the child and family.

- a. Use in cases of:
 - i. Concern for the physical or emotional safety or well-being of a child or when risk factors are high.
 - ii. Insufficient knowledge of family dynamics and parental capacity.
 - iii. Sexual abuse or severe physical abuse.
 - iv. Suspicion of coaching or coercion of the child by the parent.
 - v. Court ordered supervised visitation.
- b. Who can supervise: Certified DSS case manager or a trained visit facilitator at a visitation center
- c. Location: DSS office, visitation center, or other site determined by the case manager.
- d. Role of the person supervising the visit:

- i. Child must be within line of sight and range of hearing.
- ii. Continually monitor the risk, safety, and well-being of the child.
- iii. Provide coaching, modeling, and mentoring to parents to encourage positive interactions, bonding, and to help build parenting skills.
- iv. Monitor all conversations during the visit.
- v. Intervene if risk arises/develops.
- vi. Debrief with all parties after visit. Children will be debriefed individually to identify strengths of the visit and any concerns that the child may have about visitation. Ensure debriefs are delivered in an age and developmentally appropriate manner.
- vii. Document the debrief with parent and include any reported interaction between the parent and the child and any coaching or mentoring provided to the parents, especially those behaviors that show progress toward or away from Case Plan goals. This will be documented in CAPSS prior to the last working day of the month.
- e. DSS Case Manager Role:
 - i. If coordinated by another party, debrief the visit with the coordinator and obtain documentation of the visit from the coordinator. Discuss visits with the parent and child to determine strengths and needs.
 - ii. Document the visit and enter in CAPSS.

4. Therapeutic Visitation: A visit facilitated by a licensed clinician.

- a. When to use:
 - i. DSS staff determine that family dynamics require therapeutic assistance to facilitate attachment, child well-being, transition, or other relationship needs.
 - ii. Or court ordered
- b. Who can arrange:
 - DSS case manager, case manager assistants, foster parents, other significant persons, providers, therapists, counselors
- c. Location:
 - To be determined by therapist
- d. Case Manager's Role:
 - i. Provide clear expectations to the family.
 - ii. Communicate family's dynamics to the therapist.
 - iii. Debrief with all parties after visit. Children will be debriefed individually to identify strengths of the visit and any concerns that the child may have about visitation. Ensure debriefs are delivered in an age and developmentally appropriate manner.

Document the debrief with parent; include any reported interaction between the parent and the child and any coaching or mentoring provided to the parents, especially those behaviors that show progress toward Case Plan goals. This must be documented in CAPSS prior to the last working day of the month.

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| <p>E. Significant Events</p> | <p>1. Events significant to the child:</p> <ul style="list-style-type: none"> a. When the Agency becomes aware of a significant event including: weddings, births, death, or illness involving the child's birth family or other significant persons, the case manager is ultimately responsible for notification to the child and for documenting CAPSS with details of the notification. The case manager must consult and coordinate with the foster parents, guardian <i>ad litem</i>, and mental health professionals to confirm that the child is notified in a trauma-sensitive manner and provide an opportunity for the child to process the event. b. The case manager must staff with the the foster parents, guardian <i>ad litem</i>, and mental health professionals to determine whether attendance at an event or travel by the child is appropriate and, if applicable, to plan for child's attendance or trip. <p>Such planning must take into consideration:</p> <ul style="list-style-type: none"> i. The age of the child; ii. The relationship between the child and the relative or other significant persons; iii. The expressed wishes of the child; iv. Any recommendations by the child's mental health provider; v. Whether or not a DSS representative needs to accompany the child; vi. Arrangements for out of state travel; and vii. Whether the attendance or trip is appropriate for the child's safety and well-being, given the child's trauma history. <p>Unless clear reasons suggest that the child's involvement is contrary to his or her safety or well-being, the case manager must coordinate with the foster placement, the relatives or other significant persons, and relevant DSS staff to provide the child with an opportunity to participate in or attend the event.</p> <p>2. Birth Family Connections and Termination of Parental Rights (TPR)</p> <ul style="list-style-type: none"> a. An important step in preparing a child for adoption is the good-bye visit with his/her birth parents. The good-bye visit represents a significant change in the child's life and relationship with the birth parents. Refer to Good-bye Visitation Practice Guide Good Bye Visits SCDSS.docx for guidance regarding purpose, planning, and facilitating the visit. b. Children may benefit from contact with their birth family after the finalization of the TPR. The case manager should facilitate visitation between a child and his or her biological family after the finalization of the TPR, if such visitation is in the child's best interest. Input of the child and child's therapist should be considered when making a best interest determination. <p>Once TPR occurs, the case manager must continue sibling visitation when such visitation is in the child's best interests. Sibling visitation standards will continue to apply until the child is adopted.</p> |
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| <p>F. Case Supervision and Monitoring</p> | <ol style="list-style-type: none"> 1. Supervisors are responsible for providing support and guidance to case managers to promote consistent, quality visitation takes place each month in a manner that promotes, supports, and maintains positive relationships between the child, siblings, and parents, and moves the child toward permanency. <ol style="list-style-type: none"> a. By the twentieth day of the month, the case manager must request a staffing with a supervisor if there is a risk of missing a family or sibling visit. b. If a case manager has a scheduled or unexpected absence, the supervisor is responsible for facilitating the planned visitation during their absence. c. A missed visit will be documented in CAPSS using the Exception Report dictation code. The Foster Care Oversight Report (DSS Form 30207) must be sent to the County Director / Program Director and Regional Director by the eighth day of the month to report the exception. 2. If a case is transferred out of county or to another unit within the county, the supervisor of the sending unit will be responsible for the completion of all parent and sibling visitation during the month of transfer by the sending county. |
| <p>G. Visitation Plans:</p> | <ol style="list-style-type: none"> 1. Within thirty (30) days of foster care entry, the Visitation Plan must be developed with the child, parents, and family supports, with input from the foster caregivers and guardians <i>ad litem</i> and entered in the Visitation tab in CAPSS. <ol style="list-style-type: none"> a. The Visitation Plan must be reviewed with the family team at a minimum of every six (6) months or when significant events occur. b. Prior to planned reunification, the Visitation Plan must be reviewed and updated to reflect the changes in visitation during the transition from the foster care placement to the parent / family home. |
| <p>Forms:</p> | <p>DSS Form 30207: Foster Care Oversight Form</p> |
| <p>Resources:</p> | <p>Goodbye Visitation Practice Guide</p> |
| <p>Related Management Reports:</p> | <p>CAPSS Batch Reports: Foster Care Management Report-SF 170-R01, Foster Care Attention Report- SF 180- R01, Foster Care Measures- SF250-R01 HS Dashboard Report: Performance Measure 14a- Face to face with Foster Children.</p> |



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures: Chapter 13: Out of Home Abuse and Neglect

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| Subject: | Investigation of Foster Homes (OHAN), Residential Institutions and Child Care Facilities |
| Authority: | S.C. Code of Laws § 63-7-1210; S.C. Code of Laws § 63-7-20; S.C. Code of Laws § 63-7-920; S.C. Code of Laws § 63-7-490; S.C. Code of Laws § 63-7-670; S.C. Code of Laws § 63-7-1960; S.C. Code of Laws § 63-7-1990 |
| Standards: | SC Reference Code Regulations 114-4520 |
| Application: | Out of Home Abuse and Neglect Unit; Foster Care/Intensive Foster Care and Clinical Services (IFCCS) Case Managers, Adoption Specialists, Licensing Staff, and Child Care Licensing Staff |
| Policy Statement: | |
| The South Carolina Department of Social Services receives and investigates reports of abuse and neglect of children who reside in or receive care or supervision in foster homes, residential group homes and institutions and child care facilities. | |
| Purpose: | |
| To provide safety to children who reside in or receive care or supervision in foster homes, residential group homes and institutions, and child care facilities by receiving and investigating reports of abuse or neglect; to enhance protection of children in these settings; and to take steps to alleviate any concerns for other children in the foster home, residential group home or institution or child care facility. | |
| Definitions: | |
| <p>Out-of-home setting - a setting where children reside or receive care or supervision by caregivers, including settings such as childcare facilities, daycare facilities, residential child caring institutions, group homes, and foster homes.</p> <p>Caregiver - a foster parent, kinship foster parent, or employee of a group home who is designated to make decisions regarding age or developmentally appropriate activities or experiences on behalf of a child in the custody of the department placed in any residential program, any child placed privately in a residential or group home placement, or any person whose duties include direct care, supervision, and guidance of children in a childcare facility.</p> | |
| Procedures: | |
| F. State Office Central Intake Case Manager | 12. The central intake case manager receives reports relating to child abuse and neglect and evaluates those reports by applying the three screening criteria to determine whether the allegations meet the statutory definitions that authorize DSS action: |

- a. the victim or subject of the alleged maltreatment is younger than eighteen (18) years of age
- b. there must be an allegation or a description of actual harm that has occurred to a child or is occurring concurrently with the report, or the acts or omissions present a significant risk of harm in the immediate or foreseeable future to the child as defined by SC Code 63-7-20.
- c. The alleged perpetrator is a person responsible for the child's welfare. This includes a foster parent, an operator, employee, or caregiver of a public or private residential home, institution, agency, or child care facility, or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. A person whose only role is as a caregiver and whose contact is only incidental with a child, such as a babysitter or a person who has only incidental contact but may not be a caretaker, has not assumed the role or responsibility of a parent or guardian. According to the SC Children's Code 63-7-20 "An investigation, pursuant to Section 63-7-920, must be initiated when the information contained in a report otherwise is sufficient under this section does not establish whether the person has assumed the role or responsibility of a parent or guardian of the child." Therefore, DSS is to investigate a report when the agency has sufficient information based upon the report alone to determine that a child has possibly been abused and/or neglected but cannot readily determine whether the alleged perpetrator has assumed the role or responsibility of a parent or guardian.
- d. Reports which include an allegation that a child has perpetrated a sexual assault or physical assault on another child in a foster home, a child care facility or residential institution are investigated by OHAN when the allegations suggest involvement by facility staff or failure to provide adequate supervision (neglect) by facility staff.

13. The central intake case manager conducts an interview of the reporter to determine the nature of the alleged harm, the urgency of response needed, and location of the child. The intake case manager advises the reporter that the reporter's identity is confidential and will not be shared with the staff person or facility. The intake case manager uses the intake interview guide to ensure a thorough interview.

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| | <p>14. The central intake case manager notifies the appropriate state or local law enforcement agency within 24 hours of any report alleging:</p> <ul style="list-style-type: none"> a. sexual abuse/sexual assault; b. child exploitation (substance abuse or contributing to the delinquency of a minor); c. human trafficking; d. severe injuries (requiring professional medical attention) resulting from caretaker's acts or omissions; e. any other case as required by the local DSS/ Law Enforcement Protocol; f. child has perpetrated a physical assault on another child for whom the agency feels criteria meet the standard of criminal activity due to such factors as the age difference, the developmental differences of the victim to the perpetrator, severity of the injuries, or the circumstances appear to be bullying or gang-like, etc. <p>15. The central intake case manager immediately initiates the referral process on the automated system to check all agency records pertinent to the report of abuse and neglect. This should include, but not be limited to, previously screened out referrals, prior agency involvement, and checks with licensing/regulatory to determine if Corrective Action Plans are in place which might have an impact upon the suspected neglect or abuse.</p> <p>16. The central intake case manager makes a decision to screen out or accept the report. The central intake case manager will meet with the supervisor/designee for supervisory staffing. After review and final decision is made to screen out or accept, the intake clerk enters the intake referral and decision in CAPSS per procedures, within 24 hours of receipt of the intake.</p> |
| <p>G. State Office Central Intake Supervisor</p> | <ul style="list-style-type: none"> 1. The Intake OHAN Supervisor/designee reviews the intake decision made by the intake case manager and assesses the degree of risk to the child(ren). Through consultation with the intake case manager, determines if there is impending, imminent, or present danger to determine the response time for the assignment of the investigation. The supervisor makes the decision to screen out or assign the report based upon the criteria and information obtained from the reporter. 2. For licensed providers who are found to have violated their signed discipline agreement (DSS Form 30219) including the corporal punishment prohibition, licensure revocation may be implemented, but, in all cases, will begin after three incidents in the most recent last six months. |

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| | <p>3. An OHAN Supervisor must ensure that the Licensing Unit receives specific notification of the fact that the licensed provider has had three violations in the last six months.</p> |
| <p>H. Pended Referrals</p> | <p>10. If the reporter does not have sufficient information for a screening decision (e.g., needs time to gather more information or cannot provide the child’s identity):</p> <ul style="list-style-type: none"> a. Places the referral in pending for up to 24 hours while gathering more information and; b. Checks to see if DSS has had previous involvement with the child, family, alleged perpetrator or facility (by checking OHAN files, calling county CPS or other agencies, consulting the CPS database, Central Registry, other agency automated systems, or records as appropriate and available, to include Family Assistance records) and; c. Within 24 hours of receiving the call and researching the information the report is accepted for investigation or the report is screened out using the screening criteria and a referral is made to any other appropriate entity for follow-up (i.e. law enforcement, licensing, DHEC, etc.). |
| <p>I. Screened Out Referrals</p> | <p>1. The OHAN Supervisor/designee reviews screened out reports for appropriateness of decision and completes the referral decision section of DSS Form 3022 If the OHAN Supervisor/designee concurs with decision to screen out the report, the completed DSS Form 3022 is provided to the intake clerk who enters the report decision in CAPSS, and enters information as Unfounded Category IV.</p> <p>2. If the report does not meet the child protection screening criteria, but there is a concern such as a licensing violation, specific service need, or criminal activity, the Supervisor/designee immediately contacts the following appropriate entity, by telephone if the situation is an emergency, or in writing within 24 hours for non-emergency situations as the report dictates:</p> <ul style="list-style-type: none"> a. county DSS staff; b. regional staff (Child Care Licensing, Adoptions, IFCCS); c. appropriate State Office Licensing staff; d. other involved agencies such as Department of Health and Environmental Control (DHEC), Department of Disability and Special Needs (DDSN), Department of Juvenile Justice (DJJ); and e. law enforcement. <p>3. If the report does not meet the criteria because the alleged victim is age 18 or over, or because the alleged abuser is not "a</p> |

person responsible for the child's welfare", and if there is possible violation of the law, the OHAN intake worker refers the information in writing within 24 hours of receipt to the appropriate law enforcement agency. The OHAN Supervisor/designee immediately consults with Adult Protective Services (APS) to determine if the situation should be referred for an APS investigation.

- If the 18-year-old victim is in a residential institution, the situation is assessed for safety of other minor residents who also reside in the institution, to determine whether the situation is isolated to the alleged 18-year-old or is a safety factor for children.

4. The Supervisor/designee notifies the unit director if CAPSS shows more than two reports have been screened out within ninety (90) days on the same foster home, facility, or institution. The unit director/designee schedules a staffing to be held within thirty (30) days of the most recent screened out report. The unit director/designee assembles a committee and schedules a staffing. The committee members will include the following: the SCDSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, a supervisor other than the one who made the screen out decision, a third person with child protective services experience and a regulatory/licensing supervisor.

- The committee reviews the screened out reports to assess the appropriateness of the screened out decision and to confirm concerns for the safety of the children were addressed during the intake process. Should there be any other concerns that rise to the level of child abuse and/or neglect criteria, an OHAN report will be made by the committee. If there appears to be additional regulatory concerns, the appropriate licensing staff will be notified and required to address the concerns.

5. If a screened out report involves a child harming another child, OHAN informs licensing/regulatory staff as appropriate. If the report occurred in a foster home or residential institution, the OHAN Supervisor assesses the severity of the harm and risk to other children in the foster home or institution and informs the DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, and county operations of the circumstances. OHAN Director/Designee will follow up with the licensing staff to assess the provider's response and efforts to address the allegation to determine what other steps should be addressed for the safety

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| | <p>of children placed within the home or facility. OHAN Director/Designee will provide the Corrective Action Plan to the DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, and county operations of the circumstances. Corrective Action Plans will document what the provider's actions are to address the allegation and ensure the safety of the other children.</p> |
| <p>J. Investigation Procedures</p> | <p>4. The OHAN Investigator must initiate a fair, impartial, and thorough investigation within two to 24 hours of receipt of the report, by making face-to-face contact with the alleged victim child to assess safety and well-being of the child. If the information provided by the reporter indicates imminent or present danger to the child, face-to-face contact must be initiated within two hours. Should the OHAN Investigator not be able to physically get to the location within the designated time period, the OHAN Investigator or Supervisor secures the assistance of the CPS staff in the county of the foster home, institution, or child care facility to ensure the child is seen within the two-hour time frame. The person making initial contact must document that contact in CAPSS within 48 hours.</p> <p>5. Exceptions to the standard requiring face-to-face contact by the investigating worker are:</p> <ul style="list-style-type: none"> a. Another certified county CPS or foster care worker is first to see the child. If this exception applies, the OHAN Investigator must make contact as soon as possible with the person who made initial contact, to be briefed before assuming lead responsibility for the investigation; b. The child has been returned to his/her biological home and the family refuses contact; c. The child is deceased; d. The child is in a facility that restricts access due to medical requirements; e. Child is missing (e.g. kidnapping, trafficking, runaway); f. Natural disasters. <p>6. The OHAN Supervisor/designee must notify the subjects (foster parents, child placing agencies, Institution Director/manager, social worker, house parent, Child Care Director and/or staff) of the report that an allegation of child maltreatment is being investigated by providing a completed Referral Response sheet within 3 days. Information in this notice includes the following, without releasing any identifying information about the reporter:</p> <ul style="list-style-type: none"> a. The allegations b. The name and phone number of the OHAN Investigator assigned. |

7. The OHAN Investigator shall make the alleged perpetrator aware of the nature of the allegations and the rights of those involved in the investigation. The OHAN Investigator must provide a copy of DSS Brochure 3053, Child Protective Services: A Guide for Out of Home Caregivers and a copy of DSS Booklet 30253, Child Abuse, Child Neglect: What Out of Home Caregivers Should Know if They Are Investigated to describe the legal and due process considerations for the alleged perpetrator and confirm that the alleged perpetrator will be notified in writing of the findings at the conclusion of the investigation.
8. Agencies, counties, and regional staff who now have custody of the child will be notified within 24 hours.
9. Those to be notified by the OHAN Investigator within 5 days of the report are the following:
 - a. The subject of a report (defined as a person who is alleged or determined to have abused and/or neglected the child);
 - b. Child(ren) who were determined to be the victims and their parents;
 - c. The Guardian ad Litem (GAL) of the victim child;
 - d. All parents of children at risk in the home;
 - e. An Interstate Compact on the Placement of Children (ICPC) case where SCDSS has knowledge or supervision of the placement, the ICPC Unit is to notify the child's state of origin;
 - f. Child Placing Agency/Facility Administrator.
10. The OHAN Investigator conducts an investigation to include a safety assessment which includes, but is not limited to:
 - a. An on-site visit to the physical premises where the incident is alleged to have occurred.
 - b. Private interviews with the child(ren) (before talking with staff in most cases), as appropriate for their developmental levels and history of abuse and/or trauma.
 - i. Arrange for an interpreter or other special assistance if child has an impairment which would require such assistance, for example sign language skills or if the child's primary language is not English.
 - ii. If following the interview with the child, circumstances merit that the parents of the victim should be interviewed, the OHAN

investigator arranges for interview to be completed as part of the investigation.

- c. Arrangements for emergency medical treatment, consultation, or examinations (e.g., physical exam, radiological work, psychological evaluation) as appropriate to the child's needs and the integrity of the CPS investigation. Obtain parental consent for medical exams of children who are not in the state's custody.
- d. OHAN investigators shall consult with and follow the recommendations of a South Carolina Child Advocacy Medical Response System Certified Child Abuse Pediatrician during the course of any investigation involving physical abuse, sexual abuse, or medical neglect of a child. OHAN investigators shall use their discretion to determine the necessity of such consultation when investigating other maltreatment typologies.
- e. Interviews the alleged perpetrator(s), witnesses, others with pertinent information (e.g., parents of alleged victims).
- f. Explains the allegations, the investigative process, and the possible consequences to the caretaker face-to-face, while protecting the reporter's identity and enlisting the caretaker's cooperation.
- g. Reviews documents and/or records related to the incident.
- h. Records all interviews, evidence, and observations in a manner consistent with training and Child Protective Services (CPS) performance standards (including preservation of physical evidence and photos. Photographs should be documented as to the child's name, when taken, by whom, and the number of photos.) The Investigator does not alter or change, in any way, physical evidence collected or photographs taken.
- i. Assesses the risks of further maltreatment to all children in the setting, using the approved risk assessment references and documents observations in the dictation.
- j. OHAN may request the foster home licensing file, child care licensing record, the institutional licensing file, or the foster home licensing file to determine if there are any patterns of regulatory issues that might have contributed to the neglect or abuse and consults with the appropriate licensing worker/specialist as needed.
- k. Completes other actions as required to ensure a comprehensive child protective investigation.

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| | <p>11. The OHAN Investigator must request the pertinent authorities (e.g. law enforcement, licensing staff, county staff, or medical personnel) take the necessary steps to protect children from imminent danger or impending risk. The OHAN Investigator must remain on the physical premises until the proper authorities arrive and assist with supervision of children.</p> <ul style="list-style-type: none">a. If the children are in DSS custody, the OHAN Investigator must notify, the foster care case manager, supervisor, or program coordinator to assist with removal of the child to a safe placement. If legal action is needed for removal and placement, the OHAN worker must work with the legal department of the county to testify and provide evidence, as necessary.b. If the children are not in DSS custody, the OHAN Investigator must determine who has legal custody of the child and notify that party or agency. The OHAN Investigator must request county office assistance to coordinate with law enforcement for emergency physical/protective custody.c. In a child care setting, the OHAN Investigator must contact the regulatory/licensing unit. In a situation of imminent danger, the OHAN Investigator must coordinate with the director of the facility to assure all parents are notified. The children must be supervised until the parents arrive on the premises. If needed, the OHAN Investigator and regulatory/licensing unit will follow up with legal action.d. When allegations pertain to a foster home, residential facility or a child care facility, the OHAN Investigator requests licensing action from the regulatory/licensing unit.e. The OHAN Investigator must notify the ICPC unit when the investigation involves a child placed in South Carolina by another state so the the sending state can be notified. If the child needs to be returned to the sending state or an alternative placement must be located, the ICPC case manager and OHAN Investigator will cooperate with local law enforcement and county staff for decisions on removal of a child placed through ICPC.f. For investigations that occur within the Department of Disability and Special Needs (DDSN) facilities, the OHAN Investigator requests the assistance of the facility administrator or department personnel in taking protective action, or petitions the court for injunctive action.g. If a child/youth is placed by DJJ in the out-of-home setting and the child/youth is under the supervision of DJJ, the |
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OHAN Investigator contacts DJJ for assistance with placement and protective action for the child/youth.

12. Within 24 hours of discovery, the OHAN Investigator must notify law enforcement by telephone and follow up in writing describing the allegations and any assessments completed when allegations of the following are received:

- a. Sexual abuse/sexual assault or suspected sex/human trafficking;
- b. Child exploitation (substance abuse or contributing to the delinquency of a minor);
- c. Severe injuries (requiring professional medical attention) resulting from caretaker's acts or omissions;
- d. Any other case as required by the local DSS/Law Enforcement Protocol;
- e. Child has committed a physical assault on another child that appears to meet the standard of criminal activity due to factors such as age difference, developmental differences, severity of the injuries or the circumstances appear to be bullying or gang-like activities, etc.

These reports are also investigated by OHAN for involvement of or failure to provide adequate supervision (neglect) by facility staff.

13. The OHAN Investigator must document the date and time of initial contact and other pertinent information in CAPSS within 48 hours of receiving the report.

14. If the victim child is in the custody of DSS, the OHAN Investigator must notify the following persons by phone or e-mail within twenty four hours:

- a. The county or regional office with custodial responsibility for each alleged child victim in an out-of-home setting;
- b. If Termination of Parental Rights (TPR) has not occurred, the birth parents must be notified that a report is being investigated. The OHAN Investigator follows up with a letter to the birth parents of alleged victims which encompasses the following information from SC § 63-7-920(D):
 - i. the names of the investigators;
 - ii. the allegations being investigated;
 - iii. whether the person's name has been recorded by the department as a suspected perpetrator of abuse or neglect;
 - iv. the right to inspect department records concerning the investigation;

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| | <ul style="list-style-type: none">v. statutory and family court remedies available to complete the investigation and to protect the child if the parent or guardian or subject of the report indicates a refusal to cooperate;vi. how information provided by the parent or guardian may be used;vii. the possible outcomes of the investigation; andviii. the telephone number and name of a department employee available to answer questions. within three working days after receiving the report. A copy of the letter should be provided to the case manager for the child. <p>c. The case manager for the child must notify the GAL of the report and ongoing OHAN investigation and provide the name and number of the OHAN Investigator.</p> <p>15. The OHAN Investigator must document in CAPSS the date and time the verbal and written notifications were made.</p> <p>16. The OHAN Investigator must inform pertinent case contacts (e.g. the foster parents, residential facility or child care facility staff, and any other persons deemed necessary) in the investigation of their obligation to cooperate with the agency in its attempt to discover the facts.</p> <p>17. The OHAN Investigator must assess safety and risk for all children residing in a foster home, residential facility, or being cared for at the child care facility.</p> <ul style="list-style-type: none">a. The OHAN Investigator must inform the OHAN director of imminent risk to other children in the out-of-home setting. DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, and county operations of the circumstances who have children placed within the out-of-home setting that a risk exists and request a staffing to address the safety and placement of children pending the full investigation.b. The staffing must result in decisions about any actions case managers are to take regarding safety for, and placement of, the children pending the full investigation. The DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, will notify all staff/agencies with children in the identified out-of-home setting of the agency's decision regarding actions for safety. |
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18. When information suggests that children other than those being named as the victim in the investigation have been harmed or threatened with harm, the OHAN Investigator must make a CPS report of the allegations to the appropriate Intake Hub within 24 hours. (i.e. the birth child of the alleged perpetrator or a child for whom they may have custody/guardianship)

19. Before leaving the out-of-home setting, the OHAN Investigator must assess if there are children in the foster home, facility, or institutional setting who are at risk or in danger. When risk or danger is present, the OHAN Investigator negotiates and documents a Safety Corrective Action Plan (S-CAP) in conjunction with the person who is judged to have protective capacity in the residential institution or child care facility and who is most capable of ensuring the children's well-being to promote the safety of the child and other children during the investigation. The S-CAP must be:

- a. signed by the Foster Parent(s), Director or Executive Manager of the institution/facility and the person who is designated to act in a protective capacity role.
- b. provided to the Foster Care Staff and the regulatory/licensing staff who determine the best interest of the continued placement of the child in the foster home or facility/institution pending the results of the investigation.

If the victim child is believed to be at risk of imminent danger, the child's case manager must make other placement plans for the child pending the investigation. A second S-CAP may be developed later to address with the foster home, Child Placing Agencies, or facility/institution any regulatory issues identified during the investigation.

20. The S-CAP must be based upon the following:

- a. The safety threats and/or risk factors that:
 - i. pose severe or immediate threat to the child's safety;
 - ii. what specific steps will be taken to alleviate risks and dangers, and
 - iii. who specifically is responsible for enacting the steps;
- b. The best interests for safety, emotional, and developmental well-being of all children at risk in the setting;
- c. The reasonable expectations of the child's birth parent or legal guardian;

- d. The child's attachment to the caretaker and the assessment of any potential for harm after negotiated safety measures are in place;
- e. The S-CAP is shared with the foster parents, facility director/management, the person named in the plan as having protective capacity, the regulatory/licensing unit, the Foster Care worker, and child or youth as age and developmentally appropriate. All DSS staff involved in the case are to observe the foster home/facility to ensure that the S-CAP is being implemented while it is in place. The licensing/regulatory worker must communicate with the foster parents/director of the facility/institution to obtain updates on the S-CAP and to receive documentation of action step completions as noted in the plan.

21. A Supervisory staffing must be held between 20 to 30 days into the investigation to present information of the investigation. Before the staffing, the OHAN Investigator must confer with county or regional staff responsible for the victim child(ren) and the child(ren)'s GAL. The 20/30 day staffing must include regulatory/licensing representatives. The OHAN Investigator presents information gathered from the investigation to analyze the facts and determine what other information may be needed in order to make a case decision. The staffing may be face-to-face or arranged through other means. This staffing may occur sooner if determined to be in the best interest of the child. Additional staffings may be held as determined by the facts of the case, and to coordinate services to the child. Any safety outcomes must be discussed.

22. Prior to a determination decision:

- a. The OHAN Investigator/Supervisor must arrange a multidisciplinary staffing when a child is hospitalized due to injuries received or if a child has suffered severe injuries believed to result from abuse or neglect even if the child did not require hospitalization.
- b. The OHAN Investigator must invite forensic interviewers, medical and mental health providers, law enforcement, the DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, Child Health and Well-Being, and regional/county staff who have custody of the child to attend the staffing.
- c. The OHAN Investigator must consult with regulatory/licensing personnel to discuss violations of standards and to review the corrective action history of the setting.

- d. The OHAN Investigator must consult with county CPS and Foster Care or regional office case managers to discuss the child's vulnerability, abuse history, and the circumstances surrounding the child's placement.

23. The OHAN Investigator must notify the alleged perpetrator by certified mail, no later than the 35th day of the investigation, of the individual's right to request a limited scope preliminary review of the evidence that supports the decision to indicate. With good cause shown, i.e. awaiting results of a forensic report, medicals, or additional interviews to be scheduled, the notice for a preliminary review may be extended until the 40th day. The individual will have five days to provide information to the agency. If the individual states they plan to provide information that will take longer than the 45 day investigative period, or if the review will extend past the 45th day, the worker will apply for a 15 day extension. This request is considered a compelling reason for the approval of an extension. At a minimum, the notice will include the following information:

- a. That the preliminary administrative review is separate from the case decision staffing and will take place before the official case decision is made in order to preserve the individual's right to due process.
- b. That the review process will allow the alleged perpetrator or their representative an opportunity to provide additional information about the incident that the alleged perpetrator believes is important for DSS to know.
- c. That the individual can present information to the agency by telephone, e-mail, and facsimile message, or by US mail.
- d. That the preliminary review process cannot delay the statutory timelines set for completing investigations or for the appeals process.
- e. That the additional information provided can affirm or overturn the preliminary case decision or can prompt further investigation.
- f. That the individual will be promptly notified of the outcome of the administrative review and subsequent official agency case decision.

24. The OHAN Investigator must complete the Out of Home Investigative Summary taking the following steps:

- a. Describes the evidence supporting and/or refuting the allegations in a draft Determination Fact Sheet, [DSS Form 3070](#).

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| | <ul style="list-style-type: none"> b. Analyzes the facts as appropriate from law enforcement, the child's county case manager, medical and mental health practitioners, the agency's administrator, the GAL, and the OHAN supervisor. c. Documents staffing in CAPSS case record dictation and on the OHAN Case Staffing form with participants' signatures. If the staffings are held by telephone conference, the OHAN Investigator emails the OHAN Case Staffing form to the supervisor for signature by staffing attendees before filing in the OHAN file. <p>25. The determination decision must be made using the totality of the information gathered, by application of the statutory criteria, and the preponderance of evidence as the standard of proof of the facts.</p> |
| <p>K. OHAN Supervisor Duties During an Investigation</p> | <ul style="list-style-type: none"> 1. The OHAN Supervisor will conduct a preliminary staffing within three days of case acceptance to assist the OHAN Investigator with identification of core witnesses. 2. The OHAN Supervisor will participate/lead case staffing at 7 day and 20/30 day intervals and enter the staffing information into the CAPSS case record. 3. The OHAN Supervisor will staff the case for closure at the 42nd day of the investigation to determine if all core witnesses have been interviewed, dictation is completed, and a case decision is made that is supported by a preponderance of the evidence. 4. The OHAN Supervisor must review the Determination Fact Sheet DSS Form 3070 for accuracy and document the approved case determination in CAPSS within 45 days of the date the case was accepted for OHAN investigation. 5. The OHAN Supervisor may request a one-time extension of 15 days to the Unit Director if the decision cannot be made within the 45 days, but is reasonably expected to be made within the 15 day extension. The request for the extension must be made by day 42 of the investigation and must include documentation of the staffing of the case with the supervisor which includes the justification for the extension. An extension may be granted at the discretion of the Unit Director or designee if: <ul style="list-style-type: none"> a. the child or other relevant party who could not be located within 45 days despite the best efforts of the department, is expected to be located within the next 15 days; or b. specific diagnostic information which was initiated or requested within the initial 45 days, has not been received |

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| | <p>and due to circumstances beyond the control of the department, will not be available within the 45 days, but can reasonably be expected to be completed within the 15 days; or</p> <p>c. other compelling reasons as presented by staff on a case-by-case basis that there is a reasonable expectation that the investigation can be completed in an additional fifteen (15) days, such as completion of the preliminary administrative review.</p> <p>L. If there are more than two unfounded case decisions on the same residential institution or child care facility and the investigations occurred within six months, the OHAN Supervisor must notify the Unit Director.</p> <p>a. The Unit Director/designee must schedule a staffing to be held within 30 days of the last unfounded case decision. The committee members will include the DSS Directors of Child Welfare Operations, Safety Management, Permanency Management, and Child Health and Well-Being, a supervisor other than the one who was involved in the case decisions, the licensing and regulatory units, and staff from the county or region who have placed the child(ren) in the institution.</p> <p>b. The committee must examine any concerns and patterns involving the facility, institution, or staff and how the concerns should be addressed from each division's perspective during face-to-face visits to the facility. Placement and planning issues for children in the facility/institution must be addressed. All Corrective Action Plans will be reviewed and evaluated for effectiveness. If additional concerns regarding child abuse and/or neglect are revealed during this staffing, a new report will be made to OHAN.</p> |
| <p>G. Notification and Communication Procedures Following Supervisor's Approval of Case Decision</p> | <p>1. The OHAN Investigator notifies the subjects of the report of an indicated case determination within five working days via certified mail using DSS Forms 3061 and 3070. Notification must include the perpetrator's right to appeal the case decision and that the perpetrator's name is being placed on the Central Registry. The letter must exclude any information identifying the reporter.</p> <p>2. The OHAN Investigator notifies the subjects of the report of an unfounded case determination within five working days via USPS using DSS Form 3065.</p> |

3. The OHAN Investigative file must be updated as to the case decision. If the case is unfounded, it should be noted if it is classified as Category I, II, or III.
4. The OHAN Investigator must upload and link the "Determination of Facts Sheet" and the "Letter of Determination" within five business days of Supervisor's approval of case determination.
5. The OHAN Investigator must notify the following of an indicated case decision within 5 days:
 - a. The subject of a report (defined as a person who is alleged or determined to have abused or neglected the child);
 - b. The alleged victim child if it is age and developmentally appropriate to inform, and in the child's/youth's best interest.
 - c. County/regional DSS offices or other agencies that have custody of the child;
 - d. The GAL of victim child;
 - e. The parents/guardians of the victim child who were the parents/guardians notified of the receipt of the report. Notification will be made when the timeframe for appeal has elapsed
 - f. Directors/owners of the child placing agency, or the facility administrator regarding the staff member named as alleged perpetrators;
 - g. The licensing unit or regulatory entity that issued the license;
 - h. County or regional staff that have case management of the victim child or other children in the facility that may be affected by the indicated decision;
 - i. ICPC staff when the victim child is a child whose placement is subject to ICPC approval.
6. The OHAN Investigator must notify the following of an unfounded case decision within 5 days:
 - a. The subject of a report (defined as a person who is alleged or determined to have abused or neglected the child);
 - b. County/regional DSS offices or other agencies that have custody of the child
 - c. Directors/owners of the child placing agency, or the facility administrator regarding the staff member named as alleged perpetrators;
 - d. The licensing unit or regulatory entity that issued the license;

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| | <p>e. ICPC staff when the victim child is a child whose placement is subject to ICPC approval.</p> <p>The notice/letter must advise that a determination has been reached and whether the allegations were indicated or unfounded. It also provides the name and phone number of the OHAN investigator.</p> <p>7. The OHAN Supervisor must update CAPSS of the case decision and enter the name of the perpetrator in the Central Registry. The indicated report is placed into the Central Registry, within five working days of the case decision.</p> <p>8. When completing the investigative documentation, the OHAN Supervisor at case decision reviews the intake to determine if the reporter requested feedback. If so, the OHAN Supervisor notifies the reporter of the determination decision and whether services were provided in the best interest of the child, and if the reporter has legal responsibility for the child. The OHAN Investigator notifies the mandated reporters of the case decision.</p> <p>9. If law enforcement wasn't notified at intake, the OHAN Supervisor must provide notification if the facts indicating abuse or neglect also appear to indicate a violation of criminal law. This would include all indicated reports of severe injuries resulting from abuse, neglect, or exploitation.</p> <p>10. The OHAN Investigator must cooperate with the Office of General Counsel (OGC) to prepare for the department's case at an Appeals Hearing should the perpetrator request an appeal. The OHAN Program Assistant must document the findings of the appeals hearing in case record/CAPSS.</p> <p>11. The OHAN Investigator must participate in any family court hearings to testify to the findings of the investigation, as needed.</p> |
| <p>M. Corrective Action Plan Upon Case Determination</p> | <p>1. The OHAN Supervisors and Investigators must participate in a multidisciplinary team staffing to assess and develop a Corrective Action Plan (CAP) with the foster parent(s), Child Placing Agency/facility administrator, or a designee.</p> <p>2. The Licensing/Contract Monitoring Unit must provide the terms of the CAP to the facility's administrator/designee and ensures that the CAP is signed by the director/administrator or designee. If the owner/ director is not available to sign/receive a copy of the CAP onsite, it is mailed to the foster parent, Facility Director, or Manager within five working days of the completion of the CAP.</p> |

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| | <ol style="list-style-type: none"> 3. If a Safety CAP was developed during the investigation by OHAN for immediate safety of children in the foster home or facility, OHAN and Licensing must re-evaluate the CAP to determine if any of the items listed in the original Safety CAP need to be included in the CAP that is being developed by Licensing to alleviate deficiencies. 4. The Licensing/Contract Monitoring Unit must monitor the CAP on a monthly or quarterly basis (dependent upon the severity of the violation and frequency stated in the CAP). Licensing staff will document that the foster home/facility is in compliance with regulations and safety factors as they are completed. 5. The Licensing Unit must provide a copy of the CAP to County, Regional IFCCS, or Adoption staff who have the victim children in the home/facility. Case Managers will be asked to report lack of cooperation or compliance of the foster home/facility to the Licensing Unit immediately. The Licensing/Contract Monitoring Unit will collaborate with other DSS staff going into the foster home/facility for information that the provider is complying and cooperating with the CAP. |
| <p>N. Appealed Case Decisions</p> | <ol style="list-style-type: none"> 1. The OHAN Investigator must meet with the Office of General Counsel to prepare for testimony at the appeals hearing if the perpetrator appeals the indicated case. 2. The OHAN Investigator must request the assistance of the Office of General Counsel for any appeals in foster homes, residential institution, or child care facilities, or of the county attorney for family court activity involving out-of-home investigations. 3. The appointed designee of the State Director conducts an interim review of the case record of an indicated case within 14 days of receipt of the request to appeal the agency’s decision. The review determines if there is a “preponderance of the evidence” that the child was abused and/or neglected and that the appellant committed the abuse or neglect. The interim review will result in one of three outcomes: <ol style="list-style-type: none"> a. The indicated finding that the appellant abused and/or neglected the child is not supported by a preponderance of evidence: <ol style="list-style-type: none"> i. the case is converted to unfounded and the appellant’s name must be removed from the Central Registry. ii. At this time, the OHAN Unit Director notifies the Office of Administrative Hearings (OAH) and the |

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| | <p>appellant or appellant’s representative in writing that the Interim Review found the appellant did not abuse or neglect the child and that the case decision is overturned.</p> <ul style="list-style-type: none"> iii. The OAH then dismisses the appeal. <p>b. The appellant did not abuse or neglect the child but the child was abused or neglected by someone else or person unknown:</p> <ul style="list-style-type: none"> i. The indicated case finding remains but the appellant’s name is removed as perpetrator of the abuse or neglect and from the Central Registry. ii. OHAN Unit Director notifies the appellant or appellant’s representative and OAH that the case remains indicated but the appellant will not be listed as perpetrator. iii. OAH then dismisses the appeal. <p>c. The indicated finding is supported by a preponderance of the evidence that the appellant abused or neglected the child:</p> <ul style="list-style-type: none"> i. The OHAN Unit Director notifies the appellant or appellant’s representative in writing that the finding is upheld and the appeals process will continue. ii. A copy of the letter is sent to the OAH. <p>4. The appointed designee of the State Director must document the findings of the interim review in the case file and return the file to the OHAN Unit. Then OHAN Program Assistant must record the findings resulting from the interim review in CAPSS. If the case decision is overturned, The OHAN Program Assistant ensures that the appropriate changes are made to the Central Registry and to CAPSS by removing name of individual from Central Registry. (Reference Section 725 – Administrative Appeals Process)</p> |
| <p>O. County Case Manager of Victim Child</p> | <ul style="list-style-type: none"> 1. The child’s Case Manager must provide assistance to the OHAN Investigator throughout the investigation including, but not limited to, initiating contact when needed, supporting the child, and building rapport with caregivers and child(ren). 2. When needed, the Case Manager makes necessary placement changes for the child pending the investigation. When a safety threat is present the child must be moved until all safety threats are resolved. |

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| | <p>3. The Case Manager must schedule the victim child for counseling and/or medical services within one business day as needed. All appointments and encounters must be documented in CAPSS in the Person Screen.</p> <p>4. The Case Manager must notify the victim child’s birth parents of the report of abuse or neglect in the foster home or at the institution within 24 hours and provides the name and contact information of the OHAN Investigator to the parents. If the parental rights have been terminated, the birth parents are not entitled to notice.</p> <p>5. The Case Manager for the child must notify the GAL of the report within 24 hours. The GAL is to be provided with the name and number of the OHAN Investigator.</p> <p>6. The Case Manager must assist with monitoring the improvements or conditions specified in the S-CAP, should the child remain in the home or facility and must report any non-compliance to the OHAN Investigator within one business day.</p> <p>7. The Case Manager must report any non-compliance with the CAP to the Licensing unit within one business day for further review of continuation of the license.</p> |
| <p>P. Record Maintenance</p> | <p>1. The OHAN Supervisor preserves all information which must be maintained in a paper file, completes the case summary narrative report within 10 days of the case determination, and verifies that all required documents are in the file, all relevant parties have been interviewed and notified, and that documentation supports the case decision.</p> <p>2. The OHAN Supervisor must destroy information related to unfounded reports five years from the date the report was determined to be unfounded provided no new reports are received in the five years. The OHAN supervisor uses any old information available if a new report is received prior to five years.</p> <p>3. The OHAN Unit must maintain, indefinitely, the records of all indicated cases.</p> |
| <p>Forms:</p> | <p>3022 Intake/ Central Registry 3061 Central Registry Information for Indicated Child Protective Services in Foster Homes, Residential Facilities or Childcare Facilities and Notice of Your Right to Appeal the Department’s Findings 3065 Notice of Unfounded Investigations/ Assessments</p> |

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| | 3070 Determination Fact Sheet |
| Resources: | 3053 Child Protective Services: A Guide for Out of Home Caregivers 30253 Child Abuse, Child Neglect: What Out of Home Caregivers Should Know if They Are Investigated 2416 Know your Civil Rights in Social Services Programs |
| Related Management Reports: | SC110-R01 – Intake Accepted for Investigation or Assessment Daily SC110-R02 – Intake Accepted for Investigation or Assessment Office Summary Daily SC115-R01 – Intake Accepted for Investigation or Assessment Initial Contact 24 Hours Daily SC115-R03 - Intake Accepted for Investigation or Assessment Initial Intake 24 Hours by Worker Daily SC110-R04 – Intake Accepted With No Investigation or Assessment SW215-R04 – Intakes With No Decisions by Worker Daily |



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures: Chapter 16: Special Topics

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| Subject: | 1600 Sex Trafficking Victims |
| Authority: | CAPTA, P.L. 114-22, Justice for Victims of Trafficking Act of 2015; S.C. Code § 63-7-20(6)(b); S.C. Code § 16-3-2010 |
| Standards: | N/A |
| Application: | All Child Welfare Programs |
| Policy Statement: | CWS must identify and assess all reports involving children known or suspected to be victims of sex trafficking. CWS must coordinate with law enforcement, juvenile justice, and service providers to provide comprehensive services for children who are sex trafficking victims. |
| Purpose: | To set forth procedures for identifying minors who are, or who are at risk of becoming, sex trafficking victims and to provide services to those victims. |
| Definitions: | |

Sex trafficking - the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act. For minors 18 years old and under, there is no requirement of force, fraud, or coercion.

Commercial sex act - any sex act for which anything of value is given or received by any person.

Case manager – staff providing case management services, in any program area, for victims of sex trafficking.

Procedures:

A. Intake

1. Intake Practitioners (IPs) must ask all reporters if there is concern, suspicion, or knowledge of prostitution, pornography, or sexual exploitation regarding any child the reporter is calling about.
 - A. If the answer is “yes”, this must be documented in CAPSS as follows:
 - i. by selecting the “Victim of Sex Trafficking” characteristic in the Person screen and selecting the Typology of Sexual Abuse under the Relationship tab.
 - ii. If the perpetrator is unknown or is someone other than an individual who is in loco parentis, an unknown perpetrator can be added as a recipient. Parents can be coded as nonperpetrators.
 - iii. Safety Factor #4 must be selected in the CPS Assessment.
 - iv. The Sufficiency Screen must be completed with a “Yes” for both the questions regarding ability to locate and if the alleged maltreater is the parent/caregiver of the child. (For suspected victims of child sex trafficking the perpetrator does not have to meet this criteria but in order to accept the report, this must be answered with an affirmative.)

- v. Explain in the box below this statement that the perpetrators are not the parents if the perpetrator isn't in loco parentis.
- vi. If information regarding the child/youth's county of residence is not available at Intake, the county of origin defaults to the child's location when the report is made.
- vii. IP and Supervisor must accept for Investigative Assessment and refer to Law Enforcement if the report wasn't received from LE.

B. Initial Identification/Assessment

1. Referred by Law Enforcement:

If the child/youth are picked up by law enforcement and are suspected and/or identified as being a sex trafficking victim, the case worker must:

- a. Take the child/youth to the local hospital/ER for a medical assessment as soon as possible and no later than 24 hours.
- b. Consult with Regional Clinical Consultant regarding safe placement prior to initial placement being made.
- c. Complete DSS Form 3010: Critical Incident Reporting Form item E5 and forward to County Director with Incident Category.
- d. Contact the State Human Trafficking Coordinator at 803-6380566 or via email at STC@dss.sc.gov.
- e. Complete and link DSS Form 1544: Sex Trafficking Screening Tool into CAPSS under the Case ID.
- f. Document in CAPSS via the Characteristics section of the Person screen and update the Characteristics screen if the child was not initially identified as a sex trafficking victim.

2. Referred by outside agency (shelter, group home, hospital, etc.)

If the child/youth are referred by an outside agency and are suspected and/or identified as being a sex trafficking victim, the case manager must:

- a. Contact local law enforcement within 24 hours.
- b. Take the child/youth to the local hospital/ER for a medical assessment as soon as possible, and no later than, 24 hours.
- c. Consult with Regional Clinical Consultant regarding safe placement prior to initial placement being made.
- d. Complete DSS Form 3010: Critical Incident Reporting Form item E5 and forward to County Director with Incident Category E5.
- e. Contact the State Human Trafficking Coordinator at 803-6380566 or via email at STC@dss.sc.gov.
- f. Complete and link DSS Form 1544: Sex Trafficking Screening Tool into CAPSS under the Case ID.
- g. Document in CAPSS via the Characteristics section of the Person screen and update the Characteristics screen if the child was not initially identified as a sex trafficking victim.

3. Self-report

If the child/youth self-reports, or it is suspected, that they are a victim of sex trafficking, the case manager must:

- a. Contact local law enforcement within 24 hours.
- b. Take the child/youth to the local hospital/ER for a medical assessment as soon as possible, and no later than, 24 hours.
- c. Consult with Regional Clinical Consultant regarding safe placement prior to initial placement being made.
- d. Complete DSS Form 3010: Critical Incident Reporting Form item E5 and forward to County Director with Incident Category E5.
- e. Contact the State Human Trafficking Coordinator at 803-6380566 or via email at STC@dss.sc.gov.
- f. Complete and link DSS Form 1544: Sex Trafficking Screening Tool into CAPSS under the Case ID.
- g. Document in CAPSS via the Characteristics section of the Person screen and update the Characteristics screen if the child was not initially identified as a sex trafficking victim.

4. Runaways or Missing Children

If a child/youth has run away or is missing, the case manager must immediately, but no later than 24 hours:

- a. Report to law enforcement authorities for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigations.
- b. Report to National Center for Missing & Exploited Children (NCMEC) <http://cmfc.missingkids.org/ReportHere>. If there are any delays in obtaining the necessary forms, contact NCMEC at 1(800)843-5678.
- c. Complete DSS Form 30233: Endangered Runaway Checklist for Case Managers, Child Bio Information Form and Information Release and Verification Form.
- d. Notify child's parent/guardian.
- e. Notify the State Human Trafficking Coordinator via email at STC@dss.sc.gov.
- f. Notify the child/youth's guardian ad litem.
- g. Notify child/youth's current service providers and school officials.
- h. Make diligent efforts to locate child/youth and document all efforts in CAPSS dictation.
- i. Link completed DSS Form 30233 in CAPSS.

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| <p>C. Provision of Services</p> | <ol style="list-style-type: none"> 1. When a child/youth has been identified as victim of sex trafficking the case manager must: <ol style="list-style-type: none"> a. Make a referral to a Children’s Advocacy Center (CAC) for a forensic interview within 24 hours. b. Make referrals to needed services as identified by CAC assessment . c. Assess family strengths and needs in order to provide services in the least restrictive environment while maintaining family stability. d. Determine the availability of evidenced based services in order to maintain family engagement and make referrals to available services. 2. Case manager must conduct face to face visits in the home with child and family, at a minimum of monthly, and conduct weekly telephone contacts with the family. <ol style="list-style-type: none"> a. Case manager must educate the parents about possible high risk behaviors associated with sex trafficking victims. b. Case manager must work the family to develop safety procedures such as outside cameras, an alarm system, and interior/exterior motion sensors. c. Case manager must ensure that the family addresses and monitors child/youth internet access, messaging, and telephone contacts. d. Case manager must document in CAPSS all face to face contacts, telephone contacts, and any other interactions with the child/youth and family no later than the last working day of the month. |
| <p>Forms:</p> | <p>DSS Form 30233: Endangered Runaway Checklist for Case Managers DSS Form 1544: Sex Trafficking Screening Tool</p> |



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures: Chapter 16

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| Subject: | Plan of Safe Care for Substance Affected Infants |
| Authority: | <p>The “Keeping Children and Families Safe Act” of 2003 Public Law 108-36 that amended and reauthorized the Child Abuse Prevention and Treatment Act</p> <p>Child Abuse Prevention Treatment Reauthorization Act of 2010 Public Law 111-320; amended by Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016</p> |
| Standards: | N/A |
| Application: | All Child Welfare Workers |
| Policy Statement: | |
| <p>When a health professional makes a report to CPS alleging that an infant is “substance affected”, County CPS staff will support a process to implement a “Plan of Safe Care” or plan to promote the infant’s safety following the release from the care of said health professional.</p> | |
| Purpose: | |
| <p>To describe how County Child Protective Services’ (CPS) will respond when a health professional in South Carolina makes a report that an infant is “substance affected”.</p> | |
| Definitions: | |
| <p>The Plan of Safe Care should be based on a comprehensive, multidisciplinary assessment that is coordinated across disciplines to determine the infant’s, mother’s and any other caregivers’ physical, social-emotional health and safety needs, as well as the mother’s strengths and parenting capacity. The Plan of Safe Care should address the risk of future maltreatment, resources available to the family to care for the child, and protective factors. The Plan of Safe Care should specify with whom the child will be discharged and ensure protective capacity of the parents and/or other family members are sufficient to care for the infant.</p> <p>Substance affected infants meet one of the following definitions: An infant, birth to one year, who is born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal exposure from the use of illegal drugs or the misuse of legal drugs or chemical substances, diagnosed with Neonatal Abstinence Syndrome (NAS) or Fetal Alcohol Spectrum Disorder (FASD.) If a healthcare provider has identified the infant as exhibiting harmful effects in his/her physical appearance or functioning that is attributed to the mother’s substance or alcohol use, that infant is also “substance affected.”</p> | |
| Procedures: | |

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| <p>Q.Intake</p> | <ol style="list-style-type: none">1. Intake will receive and enter all reports from health care professionals on “substance affected” infants. Upon receiving the referral, the intake worker will complete the Intake screening tool and document available information on conditions or behaviors and other factors that may indicate risk of harm and the absence of protective factors. 2. All families that are the subject of a “substance affected infant” report from a health care professional that is accepted for CPS investigation will receive the support of an assigned CPS caseworker who will partner with other service providers (ex. medical, substance use disorder treatment, public health, etc.) to offer the Plan of Safe Care for the infant, family and/or caregiver that is the subject of a “substance affected infant” report. 3. In addition to the areas of family functioning outlined in policy, collect the following information:<ol style="list-style-type: none">a. Type of substance use.b. Was the drug prescribed or non-prescribed to the caregiver?c. What drugs were administered to the caregiver during labor and delivery?d. If prescribed, is the level within normal limits of prescribed use?e. What is the level of the substance in the caregiver’s and/or child’s screen?f. Medical reports/test results, if applicable.g. What is the frequency of use?h. What were the location(s), the caregiver was using the substances?i. Are there drugs (legal or illegal) in the home? If so, where are they located?j. How the caregiver’s use, abuse, addiction impacts his/her ability to protect a child and to ensure the well-being needs of a child are being met.k. How is the caregiver functioning despite substance use/abuse?l. What is the caregiver’s plan to address the substance use, abuse or addiction including plans to ensure the child’s well-being?m. Is there a relapse plan in place?n. Has the caregiver ever experienced black outs? |
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| | <ul style="list-style-type: none"> o. Does the caregiver make impulsive decisions that place the children in unsafe situations due to substance abuse addiction? p. Is the caregiver currently intoxicated and unable to perform basic parental duties? q. Is the caregiver functioning appropriately despite using substances? s. Do the children have access to the drugs? t. Were the children present when/where the caregiver was using the substances? u. How well are the children supervised? Are they left alone for extended period? v. Medical diagnoses of the mother. w. Behavioral description of withdrawal symptoms the infant may be experiencing related to prenatal drug exposure or indications of FASD. x. A description of any facial abnormalities, growth deficiencies, skeletal deformities, organ deformities, or central nervous system handicaps that may accompany a diagnosis of FASD. y. Are there other children in the home, and if so, are they aware of the substance abuse/use or impacted by the substance use, abuse or addiction? |
| <p>R. Investigation and Assessment</p> | <p>1. Assigned County CPS assessment staff will investigate and assess all reports on “substance affected” infants for suspected abuse and neglect. The investigation should include:</p> <ul style="list-style-type: none"> a. any medical treatment needed by mother or infant; b. whether the mother was under the influence of substances at the time of hospital admission for the birth; c. the mother’s attitude and behavior with the infant; d. family’s protective capacities; e. refer the mother and other family members to treatment if necessary; f. determine placement resources; The Plan of Safe Care must specify to whom the child will be discharged, ensure protective capacity of the parents and or other caregivers are sufficient to care for the infant. g. whether the mother is receiving substance abuse treatment; h. whether the mother is compliant with substance abuse treatment; i. whether the parents are homeless; |

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| | <ul style="list-style-type: none"> j. whether the parents are prepared for the infant's care and protection; k. whether other children of this mother are in the long-term care of other persons; l. whether there is evidence of a support system for the infant and mother m. Case coordination with the Plan of Safe Care provider. <p>2. Reports which meet the criteria for abuse or neglect are assigned to CPS treatment or Foster Care for child /family assessment, service planning, service provision, progress monitoring, and case plan evaluation. Should circumstances warrant, transfer the case to Family Preservation to continue monitoring and coordinate Plan of Safe Care services and focus on the long-term well-being of the infant, mother and family.</p> <p>3. If the child is not abused, neglected, or harmed, and the Mother is compliant with treatment, then the case will be unfounded for child abuse and/or neglect.</p> |
| S. Family Preservation/Foster Care | <p>Family Preservation or Foster Care Case Managers will meet with the family face to face on a monthly basis to continue to assess for risk and safety and to ensure the Plan of Safe Care is addressing the needs of the infant, Mother and other family members as needed. The case manager will:</p> <ul style="list-style-type: none"> 1. Assist the family in constructing a way to think about the problem (safety concern) that promotes real change. 2. Work collaboratively with the Plan of Safe Care provider to identify the behaviors that need to occur or the necessary skills a family must have in order to predict safety more accurately (consensus) and to establish partnership with the family focused on change. 3. Use the case assessments to build the case plan. 4. Engage the family, supports and providers in the case planning process. 5. Incorporate the Plan of Safe Care into the Case Plan. |
| Forms: | DSS Form 3027 Plan of Safe Care |
| Resources: | Health Care Referral/Report Guidelines #9 Medical Care maps |

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| | Criteria for Qualified Providers of Substance Use Disorder Services |
| Related Management Reports: | N/A |



State of South Carolina Department of Social Services

Child Welfare Policies and Procedures:

1620 Persons with Disabilities Right to Parent Act

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| Subject: | Protection for the parenting rights of people with disabilities |
| Authority: | South Carolina Code of Laws 63-21-10; 63-21-20; 63-21-30 |
| Application: | All Child Welfare Staff |
| Policy Statement: | South Carolina Department of Social Services (SCDSS) must give parents with disabilities an equal opportunity to take part in all programs, services, or activities available to non-disabled parents. SCDSS must provide help when needed to assist people with disabilities understand what is being said or done. SCDSS must make accommodations to eliminate barriers that create inaccessibility. |
| Purpose: | SCDSS is required by the law to establish policies and safeguards applicable in child custody, child protection, and probate guardianship proceedings that protect persons with disabilities from being denied the right to parent or to have custody of or visitation with a child because of a disability. Child placing agencies and adoption service providers are prohibited from denying persons with a disability the right to access services. The law prohibits termination of parental rights solely on the basis of a disability. |

Definitions:

1. **Disability:** a physical or mental impairment that substantially limits one or more of the major life activities of an individual, a record of an impairment, or being regarded as having an impairment, consistent with the Americans with Disabilities Act, as amended, and as interpreted broadly under that act. An individual who is currently engaging in the illegal use of drugs or the abuse of alcohol, drugs or other substances is not an individual with a 'disability' for the purposes of this policy.
2. **Prospective parent:** includes prospective biological, foster and adoptive parents
3. **Caregiver:** any individual in loco parentis of the child including kin or fictive kin
4. **Adaptive parenting equipment:** equipment or any other item that is used to increase, maintain, or improve the parenting capabilities of a person with a disability.
5. **Adaptive parenting techniques:** strategies for accomplishing childcare and other parenting tasks that enable a person with a disability to execute a task

safely for themselves and their children alone, or in conjunction with, adaptive parenting equipment.

6. **Supportive services:** services that help a person with a disability compensate for those aspects of the disability that affect the ability to care for a child and that enables the person to fulfill parental responsibilities including, but not limited to, specialized or adapted training, evaluations, and assistance with effective use of adaptive equipment, and accommodations that enable a person with a disability to benefit from other services, such as braille, text, or sign language interpretation.

Procedures:

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| <p>A. Individualized Treatment</p> | <ol style="list-style-type: none"> 1. If a parent is identified as having a disability, case manager must utilize Part II, Section F of the Investigative Assessment in CAPSS and the Child and Family Assessment Services Plan (CFASP) to determine parent functioning related to safety and protection of the child. 2. Case manager must make reasonable efforts, which are individualized and based upon a parent's or legal guardian's specific disability, to avoid the removal of a child from the home. 3. All reasonable efforts must be made prior to the removal of a child from the home. Reasonable efforts include: <ol style="list-style-type: none"> a. Referrals for access to adaptive parenting equipment b. Referrals for instruction on adaptive parenting techniques c. Reasonable accommodations regarding accessing services that are otherwise made available to a parent or legal guardian who does not have a disability |
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| <p>B. Prospective Parent</p> | <ol style="list-style-type: none"> 1. Case manager must consider prospective parents and/or caregivers as placement options without regard to disability. 2. If a disability is present, case manager must assess the prospective parent and/or caregiver to identify accommodations required to support the placement of the child. 3. Once the child is placed with a parent or caregiver with a disability, reasonable efforts must be made to provide needed accommodations. Reasonable efforts include: <ol style="list-style-type: none"> a.) Referrals for access to adaptive parenting equipment b.) Referrals for instruction on adaptive parenting techniques c.) Reasonable accommodations about accessing services that are otherwise made available to a parent or caregiver who does not have a disability. |
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| <p>C. Reasonable Efforts & Modifications</p> | <p>1 Auxiliary aids must be furnished for meetings involving parent, prospective parent, caregiver or prospective caregiver with a disability affecting communication.</p> <p>a. Examples include, but are not limited to: qualified interpreters, note takers, accessible electronic and information technology, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, and telecommunications devices for deaf persons (TDD's). See the Civil Rights Toolkit located on the Unite site.</p> <p>2. Case managers must provide referrals for adaptive parenting equipment.</p> <p>a. Examples include, but are not limited to: adapted holding, carrying, and transfer devices; mobility aids for vision needs; adapted vehicle for driving; adapted stroller, etc. 3. Caseworkers must provide referrals for instruction on adaptive parenting techniques. See "Resources" section.</p> |
| <p>Forms:</p> | <p>Accommodations Assessment DSS Form 2664 Assessing the Protective Capacity and Kinship Caregiver Site Visit DSS Form 30212</p> |
| <p>Resources:</p> | <ul style="list-style-type: none"> ● Civil Rights Toolkit |

- Center for Independent Living (CIL): consumer-controlled, community-based, cross-disability nonprofit agency operated by individuals with disabilities and providing an array of independent living services. CILs in South Carolina:

- Able South Carolina <http://www.able-sc.org/>
 - South Carolina's State Affiliate of the Southeast ADA Center
 - Lead agency in enacting the Persons with Disabilities Right to Parent Act
- AccessAbility <http://www.abilitysc.org/>
- Walton Options <https://www.waltonoptions.org/> ●

Protection & Advocacy for People with Disabilities, Inc.: An independent, statewide, non-profit corporation that protects and advances the legal rights of people with disabilities. <https://www.pandasc.org/>

- South Carolina Assistive Technology Program (SCATP): Technology-related assistance program that provides the devices that increase, maintain or improve functional capabilities. <http://scatp.med.sc.edu/>
- Disabled Parenting Project: an online space for sharing experiences, advice, and conversations among disabled parents as well as those considering parenthood. <http://www.disabledparenting.com/>
- Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children: <https://www.ncd.gov/publications/2012/Sep272012>
- Protecting the Rights of Parents and Prospective Parents with Disabilities: Technical Assistance for State and Local Child Welfare Agencies and Courts under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act: https://www.ada.gov/doj_hhs_ta/child_welfare_ta.html
- Assistive Technology for Parents with Disabilities: A Handbook for Parents, Families, and Caregivers http://idahoat.org/Portals/60/Documents/Services/Resources/AT_ParentsHandbook.pdf

- Auxiliary aids: qualified interpreters on-site or through video remote interpreting (VRI) services;

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| | <ul style="list-style-type: none">• Note takers;• real-time computer-aided transcription services;• written materials; exchange of written notes;• telephone handset amplifiers;• assistive listening devices;• assistive listening systems;• telephones compatible with hearing aids;• closed caption decoders;• open and closed captioning, including real-time captioning;• voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices;• videotext displays;• accessible electronic and information technology;• or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing:<ul style="list-style-type: none">• qualified readers;• taped texts;• audio recordings;• Brailled materials and displays;• screen reader software;• magnification software;• optical readers;• secondary auditory programs (SAP);• large print materials;• accessible electronic and information technology;• or other effective methods of making visually delivered materials available to individuals who are blind or have low vision. |
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