



State of South Carolina

Department of Social Services

Child Welfare Policies and Procedures - Chapter 5: Foster Care

Subject:	510.7.100 Medical Consent for Children in Foster Care: Routine Medical Care and Treatment
Authority:	S.C. Code Ann. Sections 63-5-340, 63-5-350, 63-7-2310, and 63-7-20(15). 42 USC Sections 622(b) (15) and 671(a)(22).
Standards:	South Carolina Practice Model: Guiding Principles and Standards (GPS) Health Care Oversight and Coordination Plan Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) Child and Family Services Improvement and Innovations Act of 2011 (P.L. 112-34)
Application:	CWS staff, foster parents, and any provider who is designated as a secondary medical consentor
Purpose:	To explain the policy and procedures when providing medical consent to routine medical care, enabling DSS to provide timely and appropriate services to meet the individualized physical and behavioral health care needs of children who are in foster care.
Policy Statement:	Unless otherwise stated in a court order, DSS has the right and duty to provide routine medical care and treatment for a child who is in the legal custody of the department. This authority includes, but is not limited to, decisions regarding the use of Psychotropic Medications. While the Department has authority to provide routine medical care, case managers must engage the child's parents in routine health care decisions when possible. Case managers should defer to the express wishes of the child's parents concerning routine health care decisions, whenever the parents' wishes are known to the case manager and the parent is acting in the child's best interest. If there is disagreement or ambiguity concerning whether DSS can consent to routine medical care or treatment, the case manager must consult with the county legal representative to ascertain the department's authority to consent. Notwithstanding the Department's authority to provide routine medical care and treatment for a child who is in the legal custody of the Department, the parent or guardian retains the right to access the child's medical records. Note: If a parent or guardian places a child in foster care by signing a placement support agreement, the parent or guardian retains the authority to consent to any and all medical care. Unless, otherwise stated in a court order, DSS does not have the

authority to consent to any medical care for a child who is in foster care pursuant to a voluntary placement agreement.

Definitions:

Caregiver: A person that a child or young adult in the care, custody, or guardianship of DSS is placed with for temporary or long-term care. This person is responsible for the child or young adult's daily care in the placement setting (i.e., kinship caregiver, fictive-kin caregiver, foster parent, group care provider, etc.).

Medical Consenter: A person authorized to consent to medical care of a child in foster care

Primary Medical Consenter: CWS case manager, supervisor, or Regional Clinical Specialist, the first authority to consent to routine medical care and treatment.

Secondary Medical Consenter: In the absence of the CWS case manager, supervisor, or Regional Clinical Specialist, the foster parent or foster care provider to whom CWS has delegated authority to consent to routine medical care and treatment.

Routine Medical Care and Treatment: The regular care from a medical provider at routine visits outside of urgent or emergent needs. Routine medical care and treatment may include:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and well-child exams,
- Laboratory testing and x-ray examination as determined by the physician,
- Dental exam and procedures including cleaning, filling, and braces,
- Age-appropriate screening, testing, and immunizations,
- Vision and hearing tests,
- Developmental assessment and trauma screening,
- Allied health care services such as physical, speech, occupational therapy, and dietetic services, and
- Mental health assessment and treatment such as therapy, psychological assessments, and psychotropic medication treatment.

Note: Psychotropic medication consent requires completion of the [DSS Form 2056: Psychotropic Medication Informed Consent](#).

Major Medical Care and Treatment: Extraordinary, non-routine care, including 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 treatment, chronic opioid analgesia, end of life decisions or medical procedures such as withholding or withdrawal of life sustaining procedures ("Do Not Resuscitate" code status) and associated hospice or palliative care, organ donation, abortion, electroconvulsive therapy, aversion therapy, or any experimental treatment or clinical trial.

Legal Custody: The right to physical custody, care, and control of a child; the right to determine where the child lives; the right and duty to provide protection, food, clothing, shelter, ordinary or routine medical treatment, education, supervision, and discipline for a child and in an emergency to authorize surgery or other extraordinary care. Unless otherwise provided by court order, the parents retain the right to make decisions of substantial legal significance affecting the child, including consent to major medical care and surgery when there is no emergency.

Physical Custody: Means lawful, actual possession and control of a child, but does not include legal custody unless stated in a court order.

Voluntary Placement Agreement: A written agreement between a child's parents or guardians and the DSS for the foster care placement of a child, after the child's parents or guardians request DSS' assistance. The written agreement addresses, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians and the DSS while the child is in the DSS' physical custody.

Informed Consent: The process by which a parent, primary consentor, or secondary consentor agrees to treatment after a medical provider fully informs the consentor about the proposed medical care and alternative treatment options, risks and benefits associated with the treatment, as well as what may happen 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 health and medical conditions.

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.

Guardian: An adult, other than a parent, from whose placement and care the child was removed and with whom SCDSS is working towards reunification.

Protected Health Information: Health care data created, received, stored, or transmitted by entities that relate to the provision of health care, health care operations, or payment for health care services. This information can be used to identify an individual and may include information such as diagnoses or treatments.

Procedures:	
A. Routine Medical Care and Treatment: Primary Medical Consenter (case managers, supervisors, and Regional Clinical Specialists)	1. When the DSS has the authority to make medical decisions on behalf of the child, the case manager, supervisor or Regional Clinical Specialist are the usual and primary consenters for routine medical care. 2. DSS Regional Clinical Specialists give consent for Psychotropic Medications for children in Psychiatric Residential Treatment Facilities and Psychiatric Inpatient Units. 3. The case managers, supervisors or Regional Clinical Specialists respond to any request for medical consent within 24 hours. 4. The Medical Consenter engages parents or guardians and the child, unless doing so is not in the best interests of the child. 5. All DSS medical consenters receive the Health Care Oversight and Psychotropic Medications training within 90 days of hire, and then annually thereafter. 6. 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 the health care appointment. 7. The case manager, supervisor, or Regional Clinical Specialist provides consent voluntarily and without undue influence. 8. The case manager, supervisor, or Regional Clinical Specialist must not give blanket or open-ended consent to group homes, residential treatment facilities, or child placing agencies allowing a child to receive medication according to a physician's order. Consent to the administration of medication must be individualized, case specific, and based upon the current needs of the child. 9. The case manager or Regional Clinical Specialist seeks guidance from supervisory staff or local managing DSS attorney when questions or issues arise regarding consent to medical treatment. 10. If a concern or issue arises with a secondary medical consenter, the case manager or supervisor notifies and consults with the Regional Foster Family Licensing and Support Unit, the Regional Adoption Office, or the State Office Group Home and Child Placing Agency Program Coordinator to develop a plan to address the concern. 11. The case manager is responsible for ongoing health care oversight and coordination of care for a child in foster care. 12. DSS may give a designated secondary medical consenter access to the health care history or protected

	health information of a child to the extent necessary to obtain services for the child and enable the consentor to give informed medical consent for care and treatment. 13. Refer to: Work Aid 5.8: Medical Consent for Children in Foster Care – Routine Medical Care
B. Routine Medical Care and Treatment: Secondary Medical Consenter (foster parents, relatives, pre-adoptive parents, professional employees of emergency shelters, and group care providers)	1. When the DSS has the authority to consent to routine medical care and treatment but is unable to attend and consent to such care, the Regional Foster Home Licensing and Support Unit, the State Office Group Home and Child Placing Agency Unit and the Regional Adoption Office may designate up to two secondary medical consenters. The secondary medical consenter is typically the child's caregivers such as foster parents, relatives, pre-adoptive parents, professional employees of emergency shelters, and group care providers. 2. In emergency shelters and group homes, the emergency shelter or group care facility will identify staff who will be designated to consent to routine medical care and treatment. 3. Transportation workers must not consent to any health care. 4. Employees of Psychiatric Residential Treatment Facilities and Psychiatric Inpatient Units may not be designated as secondary medical consenters. 5. Secondary medical consenters must complete the Health Care Oversight and Psychotropic Medications training prepared by DSS before being designated as medical consenters. Participation in this training is an annual requirement. 6. Foster Home Licensing and Support Unit staff, adoptive family case managers, and program coordinators with the State Office Group Homes and Child Placing Agencies Unit designate a secondary medical consenter by issuing DSS Form 2055, Designation of Medical Consenter to the secondary medical consenter. Once completed, this designation is valid for one year from the date of training. 7. Foster Home Licensing and Support Unit staff, adoptive family case managers, and program coordinators with the State Office Group Homes and Child Placing Agencies Unit document the designation of a secondary medical consenter in CAPSS. 8. DSS staff who are authorized to designate secondary medical consenters may, at any time, change the designated secondary medical consenter by issuing

	another DSS Form 2055, Designation of Medical Consenter to the new secondary medical consenters. 9. If a concern or issue arises with the designated secondary medical consenter, the case manager, supervisor, or Regional Clinical Specialist notifies and consults with the Foster Family Licensing and Support Unit, the Regional Adoption Office, or the State Office Group Home and Child Placing Agency Program Coordinator to develop a plan to address the concern. 10. The case manager is responsible for ongoing health care oversight and coordination of care. 11. DSS may give a designated secondary medical consenter access to the health care history or protected health information of a child to the extent necessary to obtain services for the child and enable the consenter to give informed consent for care and treatment. 12. Refer to the following Work Aids: Work Aid 5.8: Medical Consent for Children in Foster Care – Routine Medical Care Work Aid 5.9: Medical Consent for Children in Foster Care – Non-Emergency
C. Routine Medical Care: Psychotropic Medication	1. Whichever is applicable, the primary medical consenter or the secondary medical consenter must complete the DSS Form 2056, Psychotropic Medication Informed Consent and upload the form to CAPSS, for a child in foster care to receive Psychotropic Medication. 2. If a case manager has any concerns related to the prescribed Psychotropic Medication, the case manager contacts the Regional Clinical Specialist for further review to monitor safe and appropriate use of the psychotropic medication. 3. If, after consultation, concerns still exist, the Regional Clinical Specialist consults the DSS Psychiatrist. 4. The designated secondary medical consenter must notify the case manager and the case manager must consult the Regional Clinical Specialist before the administration of a newly prescribed Psychotropic Medication when the: a. the Child is age 6 or under; b. the child is prescribed 4 or more psychotropic medications; or c. the child is being prescribed an antipsychotic medication. 5. If a physician states that emergency administration of a Psychotropic Medication is deemed necessary to prevent harm to the child or others, the child must receive the medication per physician's order. A physician does not

	need prior consent to administer health care to a child in an emergency. The case manager must maintain regular contact with the child's health care provider, sufficient to be on notice when a health care provider identifies such an emergency. 6. Regional Clinical Specialists provide consent for the administration of Psychotropic Medications for a child in Psychiatric Residential Treatment Facilities and Psychiatric Inpatient Units. 7. Refer to DSS Form 1214: SCDSS Informed Consent and Notification Regarding Psychotropic Medication Note: Some medications are used for mental health as well as medical reasons such as for blood pressure, seizures, headaches, etc. Only medications used for mental health diagnosis or used as psychotropic medications require Psychotropic Medication informed consent.
Forms:	DSS Form 2056, SCDSS Psychotropic Medication Informed Consent DSS Form 2055, SCDSS Designation of Medical Consenter Form Work Aid 5.9 – Medical Consent for Children in Foster Care-Non-Emergency Work Aid 5.8 – Medical Consent for Children in Foster Care-Routine Medical Care DSS Form 1214: SCDSS Informed Consent and Notification Regarding Psychotropic Medication
Resources:	Health Care Oversight for Children in Care and Psychotropic Medications Training Health Care Oversight for Children in Care and Psychotropic Medications Training Certificate
Related Management Reports:	