

Medical Consents for Children in Foster Care

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<p>Supporting Case Law: <u>Carey v. Population Services International</u>, 431 U.S. 678 (1977)</p>	<p>Supporting Standards: ACS Foster Care Quality Assurance Standards, 2012</p>	<p>Supersedes: This policy replaces Procedure 102/Bulletin 99-1 (Amended), Guidelines for Providing Medical Consents for Children in Foster Care, dated October 18, 1999.</p>
<p>Related Forms: FSS 007 - Medical Authorization For Routine Treatment or Emergency Care (Attachment A) FSS 001 - Psychotropic Medications Unit (PMU) Override Consent Request (Attachment B) FSS 010 - Consent Forms Psychotropic Medication (Attachment C)</p>		
<p>Summary: When children in the custody of the Administration for Children’s Services need medical treatment, ACS and provider agency staff must act expeditiously to obtain consent for such treatment from the appropriate individual(s). This policy sets forth conditions under which parents, provider agencies, ACS, or youth may provide consent for medical, dental, and hospital services; and identifies special situations or exceptions in which a provider agency may not provide consent.</p>		
<p>Key Words: medical consent, medical, consent, foster care, foster, care, authorization, capacity, affirmative objection, informed consent</p>		

POLICY HIGHLIGHTS

- In most circumstances, medical consent must first be sought from a child's parent or guardian, as long as parental rights have not been terminated or surrendered.
- Parents whose rights have been terminated or surrendered **must not be contacted** for consent and **have no legal authority** to give consent. In such cases, ACS acts as the parent and can authorize all health care services for children in foster care.
- The following youth in foster care may **consent for their own medical, dental, and health services**:
 - Youth who **are 18 years of age or older**;
 - Youth who **are parents**, regardless of their age; or
 - Youth who **are married**.
- Youth may consent for their own **sexual and reproductive health care services regardless of their age**.
- If a parent or guardian refuses to give consent, cannot be located, or cannot be contacted after reasonable efforts, ACS has the authority to provide medical consent in some instances and may delegate this authority to the foster care agency. This delegation of authority does not extend to circumstances where the consent authority is solely the ACS Commissioner's to make.
- Treatment may be provided **without consent** when, in a **physician's judgment**: 1) an **emergency** exists and the child is in immediate need of medical attention; and 2) an attempt to secure consent would result in a delay of treatment which would increase the **risk to the child's life or health**.
- Provider agencies must establish policies and procedures to guide their medical consent process and submit them to the ACS Medical Consent Unit every two years.
- **Exceptions** to regular consent procedures apply to the following children and youth:
 - Children or youth who are paroled or are on trial discharge;
 - Children or youth whose parents' capacity to consent is questioned;
 - Parenting youth; and
 - Children or youth whose capacity to consent is questioned.

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I. INTRODUCTION

A. In support of timely delivery of medical, dental, mental health, and hospital services for children in the care and custody or custody and guardianship of the Commissioner of the Administration for Children’s Services (ACS), ACS is revising its policy for the provision of consent for medical treatment. The services for which consent may be necessary include, but are not limited to, routine or emergency surgery, hospitalization, medication, referrals to the Home and Community-Based Services Waiver Program “Bridges to Health” (B2H), admissions to New York State Office for People with Developmental Disabilities (OPWDD) programs, or admissions to New York State Office of Mental Health (OMH) programs.

B. ACS’ Standard for Culturally Respectful Practice

ACS is committed to working with children, youth, and families in a manner that is respectful of all cultural backgrounds. Accordingly, ACS and provider agency staff must be sensitive to the beliefs and values of clients when discussing or providing information about medical consent. Staff should never allow their own cultural values to interfere with their responsibility to provide unbiased information and quality services.

II. GENERAL POLICY GUIDELINES

ACS’ policy is that, except in certain circumstances described in this document, medical consent must always be sought first from a child’s parents/legal guardians, if parental rights have not been terminated or surrendered.¹

A. Youth in Foster Care Who May Consent for Themselves²

The following youth in foster care may provide consent³ for their own medical, dental, health, and hospital services⁴:

1. Regardless of age, youth may consent for their own sexual and reproductive health care services (see section IV(H) below about consent for sexual and reproductive health care services);
2. Youth who are 18 years of age or older;
3. Youth who are parents, regardless of their age; or
4. Youth who are married.

¹ Parental consent includes consent to using the particular specified medical provider (e.g., hospital or doctor) for the proposed treatment.

² See also section IV(H) below about consent for sexual and reproductive health care services.

³ See Section IV(D) below regarding youth whose capacity to consent is questioned.

⁴ See Public Health Law § 2504(1).

In these circumstances, there may not be an override of the youths' declining of medical treatment.⁵

B. ACS' Authority to Consent

If the parents/guardians refuse to consent, cannot be located, or cannot be contacted after reasonable efforts to locate them, contact them, and obtain consent, ACS has the authority to provide medical consent in some cases. Such authority applies in the following situations:

1. When a child has been placed in the custody of ACS under Family Court Act Article 10⁶;
2. When a child has been taken into or kept in protective custody with ACS or has been removed by ACS from the place where he or she has been residing for child protective reasons⁷;
3. When a child has been placed at disposition in the custody of ACS under Family Court Act Article 3 and requires routine medical treatment⁸; and
4. When a child has been placed voluntarily in foster care⁹ and requires routine medical treatment except if otherwise specified in the voluntary placement agreement.

C. Delegation of Authority to the Foster Care Provider Agencies

In cases where ACS has the legal authority to consent, as described and outlined in this policy, ACS delegates this authority to consent to the Executive Directors (or their designees) of the authorized foster care agencies responsible for the care and planning of the foster child. This delegation of authority does not extend to circumstances where the consent authority is solely the ACS Commissioner's to make. See sections II(G) and V(J) for more details.

D. Treatment Without Consent

Medical, dental, health, and hospital services may be rendered to children placed with ACS without the consent of a parent/guardian when, in the physician's judgment: 1) an emergency exists and the child is in immediate need of medical attention; and 2) an attempt to secure consent would result in a delay of treatment which would increase

⁵ Except in circumstances covered under section II(D) of this policy. See Public Health Law §2504 (4).

⁶ See Social Services Law § 383-b.

⁷ *Ibid.*

⁸ See Family Court Act § 355.4(2).

⁹ In all cases, a voluntary placement agreement must be reviewed to confirm that its contents do not conflict with this policy. If a conflict exists, the voluntary placement agreement supersedes this policy.

the risk¹⁰ to the child's life or health.¹¹ In such cases the physician may render treatment without seeking consent.

E. Parents Whose Rights Have Been Terminated or Surrendered

Parents whose rights have been terminated or surrendered must not be contacted for consent and have no legal authority to give consent. When parents' rights have been terminated or surrendered, ACS acts as the parent and can authorize all health care services for children in foster care.

F. When Neither ACS Nor the Provider Agency is Authorized to Consent

There are certain situations in which neither ACS nor provider agencies¹² are authorized to consent to medical care and are required to seek a court order to obtain medical treatment or services. These exceptions are set forth in Section IV, titled "Exceptions to Agency or ACS Consent" below.

G. Provider Staff Who May Consent on ACS' Behalf

Provider agency Executive Directors or their designees are able to provide direct medical consent for children in their care and custody on behalf of ACS in the circumstances described in this policy. The designee shall be a senior staff member, director of social services, director of family foster care, or director of residential care. For children who are in the care and custody of ACS where the Division of Child Protection (DCP) is responsible for case management (e.g., children who are in the hospital awaiting placement), the Deputy Director of the Borough Office in which the case is assigned may provide consent. For children who are in the care and custody of ACS where the Division of Family Permanency Services (FPS) is responsible for case management (e.g., youth in special school placements), the Deputy Commissioner for FPS or his or her designee may provide consent. Similarly, for youth in non-secure and limited secure juvenile justice placement, the Deputy Commissioner for the Division of Youth and Family Justice (DYFJ) or his or her designee may provide consent. Staff who are not in these categories do not have the authority to provide medical consent for children in foster care.

1. Authority to consent is contingent upon the child being in the legal custody of ACS when medical services are required.

¹⁰ Risk is determined by the attending physician.

¹¹ See Public Health Law § 2504(4).

¹² For the purposes of this policy, "provider agencies" include foster care agencies and DYFJ/OYFD non-secure juvenile justice placement provider agencies.

H. Division of Child Protection Cases Involving Sexual/Physical Abuse

For DCP cases involving physical or sexual abuse see Procedure 102A, *Medical Consents and Medical Referrals in Suspected Child Sexual/Physical Abuse Cases* (May, 2002), which addresses the investigative stage in such cases.

I. 24-Hour Access to Someone With Authority to Provide Consent

All provider agencies must verify that foster parents, approved relatives, child care workers, and social service staff have access to a contact number providing 24-hour access to someone with the authority to provide medical consent.

J. Medical Authorization for Routine Treatment or Emergency Care Form

ACS will continue to use Attachment A, Form FSS 007¹³ (formerly CM-339), *Medical Authorization for Routine Treatment or Emergency Care*, as its written consent form when a physician or medical facility requests written consent for medical or surgical treatment for children in foster care. Once agency consent is given, the provider agency Executive Director or his or her designee is authorized to sign physician-specific or hospital-specific consent forms if such forms are required by the treatment provider.

1. For children placed outside of New York State in accordance with the Interstate Compact on the Placement of Children (ICPC), the policy and procedures for obtaining medical consent shall be the same as for children placed within New York State as described in this policy.

K. Parental Pre-Authorization for Routine¹⁴ and Emergency Care¹⁵

1. Although it is the policy of ACS to attempt to involve parents/guardians in all medical consents on an individual treatment basis, when applicable, it is also essential that parents/guardians be given the opportunity to *pre-authorize* ACS and its provider agencies to provide routine medical and/or mental health screening, immunizations, medical treatment, and emergency medical or surgical care in the event that the parent/guardian cannot be located at the time such care becomes necessary.¹⁶

¹³ This is the only consent form that should be used by provider agencies.

¹⁴ Routine medical treatment is defined as medical, dental, mental health and hospital services which are customarily given as part of preventive health care and /or for ordinary childhood diseases or illnesses (FSS 007).

¹⁵ Emergency medical, dental, health and hospital services or surgical care is defined as care that should be provided immediately because delay of such care places the health of the child in serious jeopardy or in the case of a behavioral condition places the health of each child or others in serious jeopardy.

¹⁶ For further information, see the OCFS *Manual - Working Together: Health Services for Children in Foster Care*. Links to chapters and appendices can be found at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp.

2. In the case of emergencies, such as life-threatening medical conditions or traumatic injuries when, in the physician's judgment:
 - a. An emergency exists and the child is in immediate need of medical attention; and
 - b. An attempt to secure consent would result in a delay of treatment which would increase the risk to the child's life or health, medical, dental, health, and hospital services may be rendered without the consent of a parent or legal guardian.¹⁷ It is the responsibility of the provider agency to inform the parent/legal guardian of such emergency treatment as soon as possible.
3. Even if the parents/guardians of a court-placed child initially decline to sign such a pre-authorization, the case planner should make ongoing efforts to explain its benefit and encourage parents/guardians to sign the form. The pre-authorization, when signed, must be kept in the medical section of the foster care record. If the child is transferred to a foster home or facility under the supervision of another agency, the case planner must forward the pre-authorization form to the new planning agency. A pre-authorization is valid if signed by one parent whose parental rights have not been terminated or surrendered.
4. In the event that the parents/legal guardians do not sign the FSS 007 form or affirmatively object [see section III(A)(9) of this policy] to routine or emergency care, the agency's Executive Director or his or her designee has the authority to sign the FSS 007 form as the temporary consentor for routine and emergency medical care. However, see sections III(C) and III(D) below for information about voluntary placement agreements and Article 7 PINS placements. There is no need to contact Children' Services for an override in this situation.

L. Principles and Guidelines for Obtaining Non-Routine Treatment Consents

1. Beginning with the first day of a child's placement with a provider agency, that agency becomes responsible for the management of the non-routine consent process.
2. Non-routine treatment refers to any medical or mental health care component not generally provided as part of primary health care. Any such non-routine treatment requires specific informed consent by the child's parent/guardian or authorized representative, where appropriate, from ACS or the provider agency, including the elements of informed consent as listed below [see section II(L)(5) below for additional information on informed consent]. Non-routine treatment includes, but is not limited to, psychiatric evaluations, psychotherapy, psychotropic medications,

¹⁷ See Public Health Law § 2504(4).

any hospitalization, any procedure that requires general anesthesia, any surgery, or any invasive diagnostic procedure or treatment.

3. For non-routine treatment, the agency must confine each consent to a specific procedure and/or treatment, or a specific medication and range of medication dosages, to avoid providing “blanket consents.” This practice will help encourage the medical professional to provide timely notification to the agency of any changes in the child’s health/treatment status.
4. If emergency treatment is necessary, the agency must secure a written diagnosis and recommendation for treatment prior to the child leaving an emergency treatment setting, which must be dated and signed by an appropriate qualified clinician.
5. “Informed consent” means that the person giving consent has had the opportunity to discuss any questions or concerns about the treatment with a qualified individual and has conveyed understanding of the following information wherever applicable:
 - a. Nature of the procedure/treatment;
 - b. Diagnosis and symptoms being treated;
 - c. How the procedure/therapy fits within the treatment plan;
 - d. Expected benefits;
 - e. Major risks and side effects;
 - f. Expected course and duration of treatment;
 - g. Alternative treatment choices along with their risks and benefits, including the choice of no treatment;
 - h. Monitoring plan for complications and side effects;
 - i. For medications: whether or not a medication is U.S. Food and Drug Administration (FDA) approved for the patient’s condition and major risks including any FDA Black Box¹⁸ warnings;
 - j. How to contact the clinical provider of the proposed procedure/treatment;
 - k. Location where the procedure/treatment will be performed;
 - l. Necessity, type, and risks of anesthesia, if any; and
 - m. Proposed length of hospitalization, if any.
6. Qualified agency personnel or a health professional at the provider agency shall make best efforts to obtain informed consent by discussing the above elements in detail and documenting this discussion on a signed consent form and/or in the medical section of the patient’s foster care record.

¹⁸ Drugs that have special problems, particularly ones that may lead to death or serious injury, may have this warning information displayed within a box in the prescribing information. This is often referred to as a “boxed” or “black box” warning. See <http://www.fda.gov/downloads/ForConsumers/ConsumerUpdates/ucm107976.pdf> for drug safety terms.

7. Although the consent of a child (under the age of 18) is not required for the provision of medical treatment or medication, clinicians shall provide all children and youth with a developmentally appropriate explanation of the treatment and the opportunity to ask and receive explanations to any questions. Whenever possible, and where a child has the capacity to do so, the child's assent¹⁹ to the treatment should be sought. This is particularly important for adolescents, who should be encouraged to be active participants in health-related decision-making. When a youth does not assent to treatment, the provider must document it in the case record and continue to explain the importance of the procedure or treatment for the child's safety and well-being. As noted above, youth who are 18 years of age and older, youth who are parents, or youth who are married may consent for their own medical and psychiatric care, and the consent of no other person shall be necessary.

M. Sharing Medication Information for Children in Child Welfare Placements

Qualified provider agency personnel or a health professional at the provider agency must share medication information including name, dosage, indication, and potential side effects with the foster parent in order for the foster parent to provide information to the prescribing physician regarding changes in the child's medical condition and response to the medication.

N. Psychiatric Hospitalization Requirements

For cases in which a child in foster care, including non-secure juvenile justice placement, is psychiatrically hospitalized, provider agencies and DCP or DYFJ must continue to adhere to the procedures set forth in the revised Policy # 2010/03 entitled *Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System*²⁰.

O. Treatment of Non-Routine Acute Illnesses

Provider agencies seeking consent from parents/guardians or ACS for medications or procedures to manage acute (new onset, not chronic) illnesses must document in the child's medical record and in the CONNECTIONS (CNNX) Health Narrative tab that the child has received at least one physical examination [complete or focused on the organ system(s) involved] within one month of entering care. Appropriate laboratory tests (as they apply to the specific diagnosis or condition) shall accompany the request and

¹⁹ Assent applies to children under 18 years of age for whom someone else's consent is needed to allow the child to receive a procedure, medication, and/or medical/mental health treatment. Assent means the child's affirmative agreement and willingness to receive the procedure, medication, and/or medical/mental health treatment.

²⁰ This document is available at the online ACS Policy Library, which can be accessed through this link: http://www.nyc.gov/html/acs/html/home/policy_library.shtml.

must be conducted within accepted time frames for standards of care for that diagnosis.

P. Treatment of Chronic Illnesses

For children who suffer from chronic illnesses or who require long-term medical, dental, or hospital services, an agency may approve an entire treatment plan rather than individual treatments. A “treatment plan” is defined as a detailed plan setting forth the child’s medical condition; the manner in which the health care provider intends to provide services for the condition; the benefits and consequences of such services; and the alternative treatments, including their benefits and consequences, which may be used if the initial treatment proves unsuccessful. The agency must document that the child has received at least one physical examination [complete or focused on the organ system(s) involved] within six (6) months of the request for consent. Appropriate laboratory tests (as they apply to the specific diagnosis or condition) shall accompany the request and must be conducted within accepted time frames for the standards of care for that diagnosis.

Q. Parental Objection to Specific Treatments

1. For cases in which the parents/guardians are available but affirmatively object²¹ to the recommended medical treatment, the case planner or case planning team is required to consult with the ACS Medical Consent Unit or Psychotropic Medications Unit (PMU), depending on the nature of the treatment and/or diagnosis, in order to request authorization to provide consent against parental objection. All requests should be directed to the Medical Consent Unit, except those regarding psychotropic medication or psychiatric hospitalization, which should be directed to the PMU. The provider agency or relevant DCP, FPS, or DYFJ unit is responsible for submitting the legal and clinical information necessary for the relevant unit to review the consent request. Provider agency and ACS staff may request these forms from the Medical Consent Unit. Please send all requests of this nature, including the date by which a response is needed, via email to: MedicalConsentRequests@acs.nyc.gov or for the PMU, to PsychMeds@acs.nyc.gov.
2. The reviewing unit will then send its recommendations to the Office of the General Counsel’s (OGC) Legal Counsel Unit or the Division of Family Court Legal Services (FCLS) Legal Compliance Unit.
3. The FCLS Legal Compliance Unit attorney or OGC Legal Counsel Unit attorney will review the case for legal authority and compliance with ACS’ procedures and refer the matter back to the PMU or the Medical Consent Unit. If the treatment plan appears to be clinically appropriate and the Medical Consent Unit or PMU makes

²¹ See section III(A)(9) below.

the decision to override the parental objection, the decision will be forwarded to DCP, FPS, DYFJ, or the requesting provider agency whose Executive Director or designee will sign the consent form. As appropriate, the need for court intervention will be determined on a case-by-case basis in consultation with the FCLS Legal Compliance Unit and/or assigned attorney.

- a. If one parent affirmatively objects to the treatment but the other parent (whose rights have not been terminated or surrendered) consents, the consent is valid, and no override is needed. In the event that both parents/guardians are available but affirmatively object²² to the recommended medical treatment, refer to the guidelines in section II(Q) above, entitled “Parental Objection to Specific Treatments.”
- b. The case planner must document a parent’s affirmative objection to non-routine and non-emergency medical care in CNNX.

R. Psychiatric Treatment and Psychotropic Medication

1. Psychotropic Medication Consent and Review

- a. Consent for psychotropic medication must be sought first from parents/guardians whose rights have not been terminated or surrendered. In order to achieve informed consent and the appropriate use of psychotropic medication, the person signing²³ the consent must understand the reason for its use, the benefits it should provide, its unwanted effects or dangers, the treatment alternatives, and the other information elements listed above in section II(L)(5) of this policy. Persons authorized to sign treatment consents have the right to have any questions or concerns addressed before giving consent. Clinical providers must use Form FSS 010A or FSS 010B (Attachment C) *Consent for Psychotropic Medication*²⁴.
- b. Psychotropic medication consent requests must be filled out and signed by the clinician who prescribed the psychotropic medication. The clinician must be a child and adolescent psychiatrist, a developmental behavioral pediatrician, or another medical clinician who has been approved by the PMU or accredited by OMH or the New York State Department of Health (DOH), or an equivalent out-of-state agency to prescribe psychotropic medications to children as specified

²² See section III(A)(10).

²³ The child’s parent/guardian, the child if able to consent (see section II(A) above), or an authorized representative where appropriate from ACS or the provider agency.

²⁴ There are different versions of this form for parents or legal guardians, foster care agency designees, and youth. Each version of the form includes the elements of informed consent required by ACS.

below.²⁵ At a minimum, any child who is being considered for psychotropic medications must, prior to the initiation of drug treatment, be assessed by:

- i. A board certified or board eligible child and adolescent psychiatrist; or
 - ii. A pediatrician who is board certified or board eligible in pediatric neurology, neurodevelopmental pediatrics, or developmental behavioral pediatrics.
- c. In addition to the diagnosis and medical recommendation for the drug(s), the agency's medical records must contain documentation of appropriate monitoring of the child's behavioral/physiological reaction, laboratory results, and side effects to the drug(s) at least as frequently as recommended by the prescribing clinician. ACS will conduct random reviews of case records, including medical records of children who are receiving or who have received psychotropic medication. When consenting to psychotropic medication, it is appropriate to consent to either a specific dosage or to a therapeutic range as prescribed by the treating clinician. Agencies must document the child's prescribed maintenance dosage.
- d. Under no circumstances may psychotropic medications be prescribed or used solely to control a child's behavior, except as permitted pursuant to the New York Codes, Rules and Regulations²⁶, which addresses, among other forms of restraints, "pharmacological restraint."²⁷ As part of seeking consent for psychotropic medication, the agency must document that the child has received an initial physical examination [complete, or focused on the organ system(s) involved or that may be affected by the medication] from a pediatrician and appropriate laboratory tests within 12 weeks prior to the administration of medications.
- i. Thereafter, children on psychotropic medication must have a documented physical examination and appropriate laboratory tests every six (6) months. A pediatrician, psychiatrist, and/or certified family, pediatric, or psychiatric nurse practitioner may perform the follow-up examination and laboratory tests. Agencies must use the *Alternative Medication Safety Exam* form to document the follow-up physical and laboratory findings and may request the form by emailing: PsychMeds@acs.nyc.gov.
- e. Any questions regarding psychotropic medications and the pharmacological treatment of mental health-related conditions of children in foster care must first be directed to the agency's clinical, medical and/or mental health director

²⁵ For more information on the process for approval of clinicians, please contact the PMU at PsychMeds@acs.nyc.gov.

²⁶ See 18 NYCRR § 441.17.

²⁷ **Note:** No agency may use any form of restraint, unless the New York State Office of Children and Family Services has approved the agency's restraint policy in writing.

or an individual serving in a corresponding capacity. In cases that involve overriding a parent's/guardian's refusal to consent, the clinical or medical director who is reviewing a case may contact the PMU for any needed clarification of ACS treatment guidelines or for specialty consultation. Agencies are responsible for verifying that ACS' guidelines are followed and that any PMU recommendations are carried out appropriately. Providers must consult with the PMU in the following circumstances:

- i. Whenever there is a request to override a parent's/guardian's affirmative objection to psychiatric treatment for a child in foster care pursuant to Family Court Act Article 10, including requests for psychotropic medication, hospitalization and/or placement in a psychiatric treatment facility;²⁸ and
 - ii. When, after reviewing a psychiatric treatment plan, a provider agency's clinical or medical director questions the appropriateness of the plan, even when the parent or guardian has given consent; in these situations, the agency must request a review by the PMU within ten (10) working days of the clinician's proposal for the new medication or other treatment.
- f. To request a consent review for override authorization, the referring agency must submit the necessary legal and clinical information by email to: PsychMeds@acs.nyc.gov.
- i. Using Form FSS 001 PMU Override Consent Request (Attachment B). The PMU will then review the case materials and make a recommendation regarding the medical appropriateness of the treatment in question.

S. Continuity of Active Psychotropic Medication Treatment During Transitions

1. When a youth who is being treated with psychotropic medication is transitioned into a new setting (e.g., from the hospital into foster care, including juvenile justice placement), as with other medications, the youth must be able to continue the treatment regimen prescribed by his or her previous medical provider until the medication plan is reviewed by a new licensed medical provider. All medications prescribed by the former mental health provider, for which consent had previously been obtained, must be thoroughly reviewed by the new provider within one month of the entry of the youth into the new setting, at which time a renewed consent request must be initiated. If the agency has authority to provide the consent, then the medication should not be stopped.

²⁸ See ACS Policy #2010/03, *Guidelines for Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System*, revised November 3, 2010.

2. For youth placed pursuant to Article 3 of Family Court Act, the new medical provider must determine whether the administration of medication for a particular youth is part of that youth's ongoing mental health plan. If it is part of a youth's ongoing mental health plan, the provider agency has the authority to continue the psychiatric medication as part of the youth's routine care.²⁹ Any revisions made to the youth's prescription must be based on an appropriate medical professional's clinical review of the youth's progress and response to treatment.

T. Psychotropic Treatment Requirements and Waivers of Requirements

1. ACS requires that all psychotropic medications be:
 - a. Prescribed by a child and adolescent psychiatrist; and
 - b. Clinically reviewed by that psychiatrist every month.
 - c. Board certified specialists in pediatric neurology, neuro-developmental pediatrics, or developmental-behavioral pediatrics may also prescribe psychotropic medications.
2. All provider agencies must verify the credentials of the health care providers that serve their population based on documentation of updated licenses and certificates maintained by the health care institution under which the health care providers are employed.
3. Clinicians affiliated with OMH or DOH certified clinics³⁰ do not need their credentials verified by ACS. Similarly, clinicians in out-of-state facilities having their own credentialing processes do not require verification by ACS.
4. On a case-by-case basis the PMU may grant a waiver to permit follow-up appointments by clinicians or practitioners other than the aforementioned to prescribe psychotropic medication. Such practitioners would include:
 - a. Board certified/eligible general pediatricians;
 - b. Board certified/eligible general (adult) psychiatrists; and
 - c. Advanced practice nurses (APNs)/nurse practitioners in psychiatry (PMHNPs) certified in psychiatry/mental health by the New York State Department of Education.
5. The psychiatric APN/PMHNP may prescribe psychotropic medication pursuant to a joint protocol with a collaborating child and adolescent psychiatrist according to the following criteria:³¹

²⁹ See Family Court Act § 355.4(3) (2013).

³⁰ See Article 31 of the Mental Hygiene Law and Article 28 of the Public Health Law.

³¹ See New York Education Law § 6902(3).

- a. The collaborating physician must be board certified or board eligible in child and adolescent psychiatry;
- b. The working relationship between the PMHNP and collaborating physician³² must be meaningful and substantial;
- c. The following specifications must be included in Section 3 of the New York State Education Department Office of Professions Division of Professional Licensing Services Nurse Practitioner Form 4NP: Verification of Collaborative Agreement and Practice Protocol:
 - i. Prescribing of psychotropic medication to children in foster care will occur according to the evolving prescribing guidelines supported by the New York State Office of Child and Family Services (OCFS) and ACS.
 - ii. New York State law requires the Collaborating Agreement between a physician and nurse practitioner to contain specific language to authorize the nurse practitioner to prescribe medications. In addition, ACS requires that the Collaborating Agreement must specify that direct discussion between the nurse practitioner and the collaborating physician must occur for specific cases as noted below in this policy. This discussion may include diagnosis, drug selection, dosage change, drug strength, overall treatment plan, and other medical concerns.
 - iii. The collaborating physician in this agreement shall review with the nurse practitioner any patient under six (6) years of age who takes any psychotropic medication, any child patient taking three (3) or more psychotropic medications simultaneously, all children/patients taking antipsychotic medications for more than a three (3) month period, and any child taking psychotropic medication who is not receiving psychotherapy.
 - iv. The collaborating physician in this agreement must discuss clinical matters with the nurse practitioner by phone or in person a minimum of twice per month for approximately 60 minutes per discussion, with more time being spent whenever determined by clinical need.
- d. A copy of the Nurse Practitioner Form 4NP must be submitted to PMU along with other necessary materials as part of the waiver request.

³² The Nurse Practitioners Modernization Act will become law on January 1, 2015. For more information, see <https://npagr.enpnetwork.com/nurse-practitioner-news/46031-nurse-practitioners-modernization-act-will-become-law>.

6. A pediatrician or family physician, board certified pediatric APN/NP, board certified family APN/NP, or board certified psychiatric APN/NP may prescribe stimulant medication to a child for uncomplicated attention deficit hyperactivity disorder (ADHD). Clinicians providing such treatments do not require a waiver request pertaining to other requirements. However, if the child is also being treated for another psychiatric disorder by another specialist, the prescriber must coordinate care with that professional.
7. Agencies may submit requests to the PMU for a waiver of the above mentioned requirements (in 1-5 above), if appropriate, given the circumstances of the case. Requests regarding waivers for non-child and adolescent psychiatrists or other pediatric specialists as described above must be requested via:
PsychMeds@acs.nyc.gov.
8. Waiver requests may be made for either of two situations:
 - a. When the provider agency is interested in hiring a non-child and adolescent psychiatrist or other pediatric specialists as described above to provide medication prescription and/or oversight to multiple children in its care (i.e., a clinician-specific waiver); or
 - b. When the provider agency is interested in having a community-based, non-child and adolescent psychiatrist or other pediatric specialists as described above to provide psychotropic medication to an individual child for a specific clinical reason (i.e., a child-specific waiver).

U. Interviews to Determine Youth Eligibility for Programs

Parental consent is not required in order for a case planner to refer a child or bring a child to a facility (such as an OMH residential treatment facility) for an eligibility interview.

V. Quality Assurance Requirements

1. Provider agencies must establish internal policies and procedures to guide their medical consent process. Procedures shall describe the level/title of staff eligible to provide medical consents [see section II(G), (I) and (J) for the type of information required to give informed consent]; the use of second opinions listed in section III(A)(8)); the availability of medical and mental health staff to provide consultation 24 hours a day, seven days a week in section II(I); and internal prospective and retrospective review of medical consents.
2. Note: Every two (2) years, provider agencies must submit their internal medical consent policies via email to the Medical Consent Unit at:
MedicalConsentRequests@acs.nyc.gov.

III. GUIDELINES BY TYPE OF ENTRY INTO FOSTER CARE³³

Requirements for ACS and its provider agencies to consent for medical, dental, mental health, and hospital services vary depending on whether a youth is placed in foster care for child protective reasons; whether a youth is placed on a juvenile delinquency (JD) case pursuant to Family Court Act Article 3; whether a youth is placed through a voluntary placement agreement; whether a youth is placed on a Persons in Need of Supervision (PINS) case pursuant to Family Court Act Article 7; and whether a youth is placed as a destitute child. Parents whose rights have been terminated or surrendered must not be contacted for consent and have no legal authority to give consent. ACS functions as a parent and can authorize all health care services for children in foster care whose parents' rights have been terminated or surrendered.

A. Children Remanded or Placed in Foster Care for Child Protective Reasons

1. For children who have been taken into protective custody and/or have been removed from the place where they have been residing for child protective reasons, or who have been remanded or placed in foster care pursuant to Family Court Act Article 10, the children's parents/guardians are the primary persons from whom consent must be sought.
2. Attempts to secure parental consent in these situations must be made for all medical care **except** when, in the physician's judgment, an emergency exists and the child is in immediate need of medical attention and an attempt to secure consent would result in a delay of treatment which would increase the risk to the child's life or health. In such cases the physician may render treatment without seeking consent.
3. A provider agency Executive Director or his or her designees may provide consent for this group of children when:
 - a. The parents'/guardians' current whereabouts are unknown and reasonable efforts have failed to locate them;
 - b. The parents'/guardians' whereabouts are known but they cannot be contacted despite reasonable efforts;
 - c. The parents/guardians have been contacted and decline to consent but do not affirmatively object [see section III(A)(9) below for information on "affirmative objection"] to medical treatment; or

³³ See section II(E) of this policy for authorization of consent in situations where parental rights have been terminated or surrendered.

- d. The parents/guardians have been contacted and verbally consented but refuse or are unwilling to sign the consent form.
4. For each of the above scenarios, the agency shall document its reasonable efforts to secure parental consent, including all dates and methods used to secure the consent, in the child's medical record and in CNNX. Reasonable efforts must include the following actions at minimum:
 - a. One telephone call if a phone number is known;
 - b. One personal visit to the parents'/guardians' current or last known address; and
 - c. One letter to the parents'/guardians' current or last known address.
5. The efforts to secure consent must be directed toward each parent/guardian, regardless of whether the parents/guardians live together or separately from one another. Reasonable efforts must be properly documented (dated and signed) in the child's records (i.e., CNNX and medical record).
6. Note that "parent" does not include an individual whose parental rights have been terminated or surrendered. Consent from a father should be obtained only if he is considered a "consent" father under the law.³⁴ This is true even if such an individual is listed as a "father" or "respondent" on a child protective petition.
7. For purposes of authorizing treatment, one parent's/guardian's consent is sufficient.
8. If a parent/guardian wishes to obtain a second opinion regarding a proposed medical treatment, the provider agency must arrange one as appropriate and feasible. ACS does not provide clinical second opinions.
9. "Affirmative objection to treatment" means any statement, orally or in writing, indicating that the parent is opposed to the treatment. The case planner must document such statements in CNNX and place a copy of the CNNX entry in the medical record section of the foster care record to satisfy this requirement.
10. Parents'/guardians' affirmative objection to treatment is addressed above in Section II(Q) *Parental Objection to Specific Treatments* and Section II(R) *Psychiatric Treatment and Psychotropic Medication*.
11. Children for Whom Parental Rights have been Terminated or Surrendered

When ACS and the foster care agency have custody and guardianship of a child through a termination of parental rights or surrender (i.e., the child is freed for

³⁴ As described in Domestic Relations Law § 111(1) and applicable case law.

adoption), ACS and/or the provider agency may consent for medical treatment. Consents signed by individuals whose parental rights have been terminated or surrendered, or former guardians, are neither necessary nor valid.

B. Youth Placed with ACS in Juvenile Justice Placements Pursuant to Article 3³⁵

1. Under the Close to Home legislation, ACS has been granted the authority to consent to routine medical, dental, and mental health services and treatment to youth placed with ACS on or after September 1, 2012³⁶ under Family Court Act Article 3 on juvenile delinquency cases after a dispositional hearing. Non-routine services and treatment require a parent's consent. If consent cannot be obtained, then a court order must be sought³⁷. The case planner must call in a report to the Statewide Central Register (SCR), or as appropriate, request any currently assigned DCP Child Protective Specialist (CPS) to consider holding a Child Safety Conference if a parent's failure to consent is endangering the health or safety of the child.
2. In these situations, provider staff shall make attempts to secure parental consent [see section III(A)(5) above] for all medical care **except** when, in the physician's judgment, an emergency exists and the child is in immediate need of medical attention and an attempt to secure consent would result in a delay of treatment which would increase the risk to the child's life or health. In such cases the physician may render treatment without seeking consent.

C. Youth Placed Through Voluntary Placement Agreements

1. Authority to provide medical consent for children who are voluntarily placed into family foster care or residential care shall be in accordance with this policy unless it conflicts with the terms set forth in the voluntary placement agreement (VPA). Non-routine services and treatment require a parent's consent unless otherwise specified in the VPA. If consent cannot be obtained, then a court order may be sought as appropriate.
2. The standard VPA used by ACS includes provisions in which the parent/guardian authorizes the Commissioner or his or her designee to consent to regular medical examinations, routine immunizations, and tests and treatments, including dental treatments that are needed for a child's well-being³⁸. The VPA also provides that if

³⁵ The term "placement" in this context does not include Article 3 detention.

³⁶ For youth placed with ACS prior to September 1, 2012, staff must seek parental consent for any treatment, including routine treatment.

³⁷ FCLS has a designated attorney in each borough for Close to Home cases so that when a court order is needed for medical consent, the case planner can contact the FCLS attorney.

³⁸ DCP-006 Voluntary Placement Agreement by Parent/Guardian has the parental preauthorization for routine and emergency care. The FSS 007 form is not signed in voluntary placement cases because the VPA already includes the pre-authorization.

a physician decides that the child has a medical emergency, and waiting to find the parent/guardian to obtain consent would place the child's life or health in danger, emergency medical, mental health, dental, or hospital services and/or emergency surgical care may be provided to the child without the parent's/guardian's consent.

3. When ACS or the foster care agency requests a parent's/guardian's consent for a non-routine medical procedure or treatment for a child voluntarily placed in foster care and the parent/guardian does not grant his or her consent, and the Commissioner or his or her designee believes that the parent's/guardian's failure to provide such consent endangers the life or health of the child, the case planner must contact the assigned FCLS attorney immediately in order to discuss the appropriateness and feasibility of obtaining a court order for the medical care. The case planner must call in a report to the SCR, or as appropriate, request any currently assigned DCP CPS to consider holding a Child Safety Conference if the parent's failure to consent is endangering the health or safety of the child.
4. When a person entrusted with a child's care (as opposed to a parent or guardian) is the individual who signs a voluntary placement agreement (known as an "entrustment agreement" in this situation), that person retains no rights to consent to medical care under this policy and must not be consulted. The Commissioner or his or her designee must seek the consent of the parent or guardian even if this requirement is not explicit in the agreement.

D. Youth Placed with ACS on PINS Petitions Pursuant to Article 7

1. Authority to provide medical consent rests with the parents of children who are placed under Family Court Act Article 7 on Persons In Need of Supervision (PINS) cases. Neither ACS nor the provider agencies have the authority to provide consent for medical treatment for children who are remanded or placed on PINS cases in absence of a court order.
2. Only parents/legal guardians may consent for medical treatment for PINS youth remanded or placed with ACS pursuant to Article 7. The foster care agency must request authorization in writing from the child's parent/guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical and surgical care if the parent/guardian is unavailable when such care becomes necessary.³⁹ The provider agency must make this request within 10 days after the child is taken into care. In the event that consent cannot be obtained, a court order may be sought as appropriate.

³⁹ Refer to 08-OCFS-INF-02 which indicates that, pursuant to 18 NYCRR § 441.22(d), local social services districts must request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary.

3. If foster care agency staff or appropriate ACS staff are concerned about a parent's/guardian's refusal to provide medical consent, they must consult with FCLS to determine whether to seek a court order for treatment. The case planner must call in a report to the SCR or request any currently assigned DCP CPS to consider holding a Child Safety Conference if the parent's/guardian's failure to consent is endangering the health or safety of the child.

IV. EXCEPTIONS TO AGENCY OR ACS CONSENT

As noted above, there are several populations of children in foster care for whom there are exceptions to the regular consent procedures.

A. Subject Children Under Family Court Act Article 10 Cases Who are Not Physically in the Custody of ACS

1. This group includes, but is not limited to, children who are "paroled" (i.e., in the temporary custody of a parent or other person) or on trial discharge status. Only parents/legal guardians may consent for medical treatment for children in this category. If foster care agency staff or appropriate ACS staff are concerned about the parent's/guardian's refusal or inability to provide consent for medical care to children on parole or trial discharge status, the staff must immediately consult with the FCLS attorney as to whether seeking a court order for treatment would be appropriate and feasible. If a parent's lack of consent is endangering the health or safety of a child, the foster care agency must immediately take steps to resolve the situation, or as appropriate, take the child into the physical custody of ACS and contact the FCLS attorney. In the case of a parole, ACS must seek to modify the order in court before removing the child unless there is imminent danger to the child and insufficient time to seek a court order.
2. For cases still in the investigative stage that involve physical or sexual abuse, see Procedure 102A, *Medical Consents and Medical Referrals in Suspected Child Sexual/Physical Abuse Cases*, available at the online ACS Policy Library through the following link: http://www.nyc.gov/html/acs/html/home/policy_library.shtml.

B. Children for Whom Parental Capacity to Consent is Questioned

1. For cases in which there is doubt or question about the capacity of the parent/legal guardian (whose rights have not been terminated or surrendered) to provide informed consent, the case planning agency must send an email inquiry⁴⁰ to: MedicalConsentRequests@acs.nyc.gov.

⁴⁰ See the ACS policy titled, *Security of Confidential, Case Specific and/or Personally Identifiable Information*, December 6, 2010. This document is available via search in the ACS Intranet Policy Library located at <http://nycacs/lib-pl> using key word "confidential."

2. The Medical Consent Unit will consult with the assigned attorney from FCLS regarding the appropriateness and feasibility of seeking a court order. In the event that the parent/guardian gains the ability to provide informed consent for treatment, the case planning agency must obtain such consent from him or her as described in this policy.

C. Parenting Youth Cases

Parenting youth, including youth who are under age 18 and are parents who are in foster care, must consent to their own medical treatment.⁴¹ Pregnant youth who are minors may consent to medical, dental, mental health, and hospital services related to prenatal care.⁴² Youth who are minors and have given birth are also the sole persons authorized to consent for their child's medical treatment when the child is not in ACS' custody (i.e., a minor parent in foster care who resides in the same foster care placement as his or her child who is *not* in foster care).⁴³

D. Youth Whose Capacity to Consent is Questioned

1. For cases in which there is doubt or question about the capacity of a youth otherwise legally authorized to consent to his or her own medical treatment to provide informed consent for his or her own treatment, the case planning agency must obtain an independent assessment of the mental capacity of the youth by a mental health professional appropriately trained and qualified to make such an assessment.
2. If the assessment shows that the youth is incompetent to provide consent or that there is doubt about his or her capacity to consent, the case planning agency must contact the Medical Consent Unit at: MedicalConsentRequests@acs.nyc.gov. The Medical Consent Unit will consult with the assigned attorney from FCLS. If appropriate, and if there is a legal basis to do so, the attorney will seek a court order for treatment.

⁴¹ See Public Health Law § 2504(1) and Mental Hygiene Law § 33.21(a)(1).

⁴² See Public Health Law § 2504(3).

⁴³ Any delegation of authority for consent of health care by the minor parent must be in compliance with General Obligations Law § 5-1551, regarding the power of a parent to designate a person in parental relation. Otherwise, the agency has no authority to consent for health care for the minor parent's child (unless that child is also placed pursuant to Article 10 of the Family Court Act). The law does not preclude an authorized agency from giving effective consent if the minor parent agrees to this. If an authorized agency believes that a minor parent is not making prudent decisions concerning his or her health care or the health care of his or her child, and there are safety concerns, the agency should make a report to the SCR. The agency should alert the FCLS attorney to discuss informing the Court and parties, as well as the appropriateness and feasibility of seeking a court order for treatment. Health-related decisions that are made by the minor parent should be clearly documented in CNNX as contemporaneously as possible.

3. In the event that the youth gains the ability to provide informed consent for treatment, the case planning agency must obtain such consent from him or her as described above.

E. Children Who are Placed with an Agency Under the Auspices of a Governmental Agency Other Than ACS

Authority to provide consent for medical care to children in the custody of and placed in a facility operated by OCFS, OMH, OPWDD, or with their contractors rests with the appropriate oversight agency and not with ACS. Children who are legally placed with ACS but are physically placed in an OCFS, OMH, or OPWDD facility, however, remain subject to the policies herein.⁴⁴

F. Children Who are Placed as Destitute Children

Typically these children's parents are deceased, unknown, or unavailable. Case planners shall consult with FCLS as necessary regarding medical consent involving these children.

G. Children Who are in Foster Care but Whose Legal Status Needs Confirmation

Case planners who need to confirm the legal status of a child who needs medical treatment shall consult with FCLS before taking action with respect to medical consent.

H. Consent for Sexual and Reproductive Health Services⁴⁵

1. In New York State, a youth, regardless of age, is authorized to consent to receive reproductive health and family planning services,⁴⁶ sexually transmitted infection testing and treatment,⁴⁷ and abortion services.⁴⁸ Consent for these services is not required from the child's parent/guardian, ACS, or an authorized agency.
2. When a minor (defined as a youth under the age of 18) consents to his or her reproductive health care, that health care and information is confidential and must not be disclosed, even to the minor's parents, unless an appropriate written consent has been obtained from the youth.
3. The case planner must ask a pregnant youth about whether she wants to notify her parent/legal guardian about the pregnancy. No disclosure to the youth's

⁴⁴ See Mental Hygiene Law Article 80 and 14 NYCRR § 633.11 for information concerning medical consent for individuals who are residents of facilities operated or certified by OPWDD or OMH.

⁴⁵ See Procedure #2007/01, *Policy Guidelines for Family Planning and Pregnancy Related Information and Service*, November 8, 2007 (in revision, to be renamed *Sexual and Reproductive Health Care for Youth in Foster Care*).

⁴⁶ See United States Supreme Court decision in Carey v. Population Services International, 431 U.S. 678 (1977).

⁴⁷ See Public Health Law § 2305(2).

⁴⁸ See Public Health Law § 2504(1) and (3).

parent/legal guardian may occur unless the youth gives written consent. The case planner must document discussions, including topic areas discussed, in the CNNX Health Narrative field.

I. Testing for HIV⁴⁹

The parent/guardian must provide written consent before his/her child can be tested for HIV unless the child has the capacity to give consent to such testing and has consented for him/herself. No one other than the child can consent to an HIV test if the child has the capacity to consent. If there is an urgent need for the child to be tested for HIV, and the parent/guardian refuses to give consent, or ACS cannot find the parent, or the parent is unable to give consent due to mental or physical illness, staff at the case planning agency must contact FCLS to determine whether obtaining a court order for the child to be tested is appropriate and feasible.

J. Consent for Autopsy or Organ Donation (Anatomical Gift)

Only a deceased child's "next of kin," a district attorney, a sheriff, the chief of a police department of a city or county, the superintendent of state police, or coroner or medical examiner may authorize an autopsy.⁵⁰ Neither the Commissioner of ACS nor an authorized agency may consent for an autopsy under any circumstances.

For organ donation, there is a specific statutory priority list describing who may provide consent.⁵¹ Under no circumstances may staff at a foster care agency or ACS, other than the Commissioner, provide consent for organ donation. If a request is made, the provider must consult with the ACS Office of Child and Family Health (OCFH).

K. Religious Objections to Treatment or Immunizations

Parental objections to treatment that are based on religious beliefs, including routine immunizations, shall be discussed on a case-by-case basis. If there is a concern, the case planner must consider calling in a report to the SCR as necessary or seek to have DCP convene a Child Safety Conference (if the case is active in DCP), and must also consult with FCLS.

L. Do Not Resuscitate (DNR) or Withhold or Withdraw Life-Sustaining Treatment Orders

Other than the Commissioner of ACS, under no circumstances may any staff at ACS or a foster care agency provide consent to a "Do Not Resuscitate" (DNR) order or an order to withhold or withdraw life-sustaining treatment.

⁴⁹ See 18 NYCRR § 441.22.

⁵⁰ See Public Health Law § 4210.

⁵¹ See Public Health Law § 4301.

MEDICAL AUTHORIZATION FOR ROUTINE TREATMENT OR EMERGENCY CARE

1. I/We _____ (and) _____,
parent(s)/guardian(s) of _____ born on _____,
a child in the legal custody of the New York City Commissioner of Social Services, authorize the Commissioner or his representative to consent to any routine treatment that my/our child may need while placed in foster care and for emergency medical or surgical care in the event that I/we cannot be contacted at the time that such care becomes necessary, or when a physician determines that the time needed to secure my consent would endanger my child's immediate welfare.
 - Routine medical treatment is defined as medical, dental, mental health and hospital services which are customarily given as part of preventive health care and/or care for ordinary childhood diseases or illnesses.
 - Emergency medical, dental, health and hospital services or surgical care is defined as care that should be provided immediately because delay of such care places the health of the child in serious jeopardy or in the case of a behavioral condition places the health of such child or others in serious jeopardy. (New York State Public Health Law § 4900(3).)
2. I/we understand that the Commissioner or his representative will keep me/us informed of my/our child's progress, development and health.
3. I/we understand that this authorization will remain in effect for the duration of my/our child's stay in foster care, without regard to the authorized agency or facility in which my/our child is placed, unless I/we expressly revoke the terms of this authorization.
4. I/we understand that if I/we refuse to sign this consent, the Commissioner of Social Services or his representative may provide consent (in lieu of my/our consent) where authorized under Section 383-b of the Social Services Law.
5. I/we understand that when I/we object to a medical procedure and the Commissioner or his representative believes that my/our objection would endanger the life, health or safety of my/our child, a court proceeding may be initiated to review the decision to provide such care.

Signature of Parent/Guardian	Date
Signature of Parent/Guardian	Date
Signature of Witness	Date

ACS Division/Authorized Agency: _____
Address: _____ **City** _____ **State** _____ **Zip** _____

AUTORIZACIÓN PARA TRATAMIENTO DE RUTINA O URGENCIA

1. Yo/Nosotros _____ (y) _____

padre(s)/guardián(es) de _____ nacido _____
Ciudad de Nueva York, autorizo(mos) al tanto autorice cualquier tratamiento de rutina o de urgencia (emergencia) que mi niño/a pueda necesitar mientras está alojado en el sistema de hogares de crianza en caso de que tal cuidado sea necesario, o cuando un médico determine que el período necesario para tener mi consentimiento arriesgaría el bienestar inmediato de mi niño(a).

- El tratamiento médico **rutinario** es definido como el servicio médico mental y dental, servicios de salud y hospitales el cual no es rutinariamente dado como parte de salud preventiva y/o cuidado por enfermedades ordinarias de la niñez.
- El tratamiento **urgente** (emergencia), es definido como el servicio médico (pediátrico y psiquiátrico), dental, servicios de salud y hospitales el cual no es rutinariamente dado como parte de salud preventiva y/o cuidado por enfermedades ordinarias de la niñez.

2. Yo entiendo que el Comisionado o su representante me mantendrá informado del progreso del desarrollo y salud de mi niño(a).

3. Yo entiendo que esta autorización permanecerá en efecto por la duración del alojamiento de mi niño en el sistema de hogares de crianza, sin importar la agencia autorizada o facilidad en la cual se encuentre mi niño, al menos que yo expresamente revoque los términos de esta autorización.

4. Yo entiendo que si me niego a firmar esta autorización, el Comisionado de Servicios Sociales o su representante proveerá consentimiento (en mi lugar) como lo autoriza la Sección 383-b de las Leyes de los Servicios Sociales.

5. Yo entiendo que si yo no consiento a un procedimiento médico y el Comisionado o su representante creen que mi negativa al dar dicho consentimiento pondría en peligro la vida, salud o seguridad de mi niño, un procedimiento del servicio protectorial podría ser iniciado ante la corte para el procedimiento médico.

Firma del Padre/Guardián

Fecha

Firma del Padre/Guardián

Fecha

Firma del Testigo

Fecha

División de ACS/Agencia Autorizado: _____

Dirección: _____ Ciudad _____ Estado _____ Código Postal _____

Consent for Psychotropic Medication

FOSTER CARE AGENCY		PROGRAM NAME	
AGENCY CONTACT NAME	TITLE	CONTACT PHONE NUMBER	CONTACT EMAIL ADDRESS
NAME OF CHILD			DATE OF BIRTH
PRESENTING PROBLEM(S)			
PRIMARY PSYCHIATRIC DIAGNOSES (DSM-5)			
SOCIAL AND ENVIRONMENTAL FACTORS (V or Z Codes)			
PROPOSED MEDICATION AND DOSE RANGE		SPECIFIC TARGET SYMPTOMS	
EXPECTED BENEFITS		RISKS/POSSIBLE UNTOWARD EFFECTS	
IS THERE A BLACK BOX WARNING ON THIS MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPECIFY: _____		IS THIS MEDICATION FDA-APPROVED FOR THE PATIENT'S CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO AND FOR THE PATIENT'S AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ESTIMATED DURATION/LENGTH OF TREATMENT			
Using this form, consent may be requested for one alternative medication to be prescribed if above medication is not effective. Signature on this form <u>does not</u> indicate consent to prescribe both medications simultaneously beyond the period of cross-titration.			
PROPOSED <i>ALTERNATE</i> MEDICATION AND DOSE RANGE		TARGET SYMPTOMS	
EXPECTED BENEFITS		RISKS/POSSIBLE UNTOWARD EFFECTS	
IS THERE A BLACK BOX WARNING ON THIS MEDICATION? <input type="checkbox"/> NO <input type="checkbox"/> YES (SPECIFY): _____		IS THIS MEDICATION FDA-APPROVED FOR THE PATIENT'S CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO AND FOR THE PATIENT'S AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CURRENT NON-PSYCHOPHARMACOLOGICAL TREATMENT MODALITIES			
NON-PSYCHOPHARMACOLOGICAL TREATMENT MODALITIES BEING CONSIDERED			
REQUEST SUBMITTED BY (printed name of psychiatrist)	SIGNATURE OF PSYCHIATRIST (or authorized prescriber)		DATE
The information contained in this form has been explained to me to my satisfaction. Permission is hereby granted to provide the above-named psychotropic medication(s) to the above-named child as indicated. I understand this this consent can be withdrawn by so advising the medication prescriber and foster care agency in writing.			
PARENT OR LEGAL GUARDIAN (NAME)	RELATIONSHIP TO CHILD	PARENT OR LEGAL GUARDIAN (SIGNATURE)	DATE
The information contained in this form has been explained to me to my satisfaction and I give my assent to the above-named foster care agency to administer the above named psychotropic medication to me as indicated above.			
PRINTED NAME OF CLIENT	CLIENT SIGNATURE		DATE

Foster Care Agency Designee Consent for Psychotropic Medication

FOSTER CARE AGENCY		PROGRAM NAME	
AGENCY CONTACT NAME	TITLE	CONTACT PHONE NUMBER	CONTACT EMAIL ADDRESS
NAME OF CHILD			DATE OF BIRTH
PRESENTING PROBLEM(S)			
PRIMARY PSYCHIATRIC DIAGNOSES (DSM-5)			
SOCIAL AND ENVIRONMENTAL FACTORS (V or Z Codes)			
PROPOSED MEDICATION AND DOSE RANGE		SPECIFIC TARGET SYMPTOMS	
EXPECTED BENEFITS		RISKS/POSSIBLE UNTOWARD EFFECTS	
IS THERE A BLACK BOX WARNING ON THIS MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPECIFY: _____		IS THIS MEDICATION FDA-APPROVED FOR THE PATIENT'S CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO AND FOR THE PATIENT'S AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ESTIMATED DURATION/LENGTH OF TREATMENT			
Using this form, consent may be requested for one alternative medication to be prescribed if above medication is not effective. Signature on this form <u>does not</u> indicate consent to prescribe both medications simultaneously beyond the period of cross-titration.			
PROPOSED <i>ALTERNATE</i> MEDICATION AND DOSE RANGE		TARGET SYMPTOMS	
EXPECTED BENEFITS		RISKS/POSSIBLE UNTOWARD EFFECTS	
IS THERE A BLACK BOX WARNING ON THIS MEDICATION? <input type="checkbox"/> NO <input type="checkbox"/> YES (SPECIFY): _____		IS THIS MEDICATION FDA-APPROVED FOR THE PATIENT'S CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO AND FOR THE PATIENT'S AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CURRENT NON-PSYCHOPHARMACOLOGICAL TREATMENT MODALITIES			
NON-PSYCHOPHARMACOLOGICAL TREATMENT MODALITIES BEING CONSIDERED			
REQUEST SUBMITTED BY (printed name of psychiatrist)	SIGNATURE OF PSYCHIATRIST (or authorized prescriber)		DATE
The information contained in this form has been explained to me to my satisfaction. Permission is hereby granted to provide the above-named psychotropic medication(s) to the above-named child as indicated.			
EXECUTIVE DIRECTOR OR DESIGNEE	TITLE	EXECUTIVE DIRECTOR OR DESIGNEE SIGNATURE	DATE
The information contained in this form has been explained to me to my satisfaction and I give my assent to the above-named foster care agency to administer the above named psychotropic medication to me as indicated above.			
PRINTED NAME OF CLIENT	CLIENT SIGNATURE		DATE