SERVICES FOR CHILDREN WITH MENTAL HEALTH AND ANY CO-OCCURRING SUBSTANCE ABUSE TREATMENT NEEDS IN OUT-OF-HOME CARE PLACEMENTS

1. **Purpose.** This operating procedure is applicable in all cases where the Department and its contracted agents are involved in requesting or providing mental health medical screening, including the Comprehensive Behavioral Health Assessment, examination, and treatment, including psychotherapeutic medications for any child placed in out-of-home care by the department or its authorized agent. It is the intent of this operating procedure to fully integrate mental health and/or mental health and co-occurring substance abuse services for children placed into out-of-home care by the Department. This procedure provides standards of care to ensure that children are assessed as to their need for mental health and any co-occurring substance abuse services and provided with individualized treatment and integrated services in support of their safety, permanency and wellbeing. It provides for a system of accessing and tracking referrals and service provision to ensure timeliness and quality of care and to work toward continuous improvement in service delivery and responsiveness. It further provides guidance for making appropriate referrals for residential mental health treatment when needed. Finally, it provides guidance for the required express and informed consent to, or authorization for the provision of psychotropic medications and the medical and psychotropic monitoring that is necessary when such medications are administered.

The operating procedure applies to staff of the Department and its contracted agents. When any of the responsibilities outlined in this procedure are contracted with an individual or entity, the Department will request the contracted provider to submit documentation that its internal operating procedures carry out the intent and purpose of this procedure. Upon approval by the Department, the provider’s operating procedures will be incorporated into the contract. The contracted provider will comply with this operating procedure until its own internal procedures are approved by the Department.

2. **Scope.** This operating procedure is applicable in all cases where the Department and its contracted agent is involved in requesting or providing medical screening, examination, and treatment, including psychotherapeutic medications for any child placed and supervised, in out-of-home care by the department or its authorized agent.

3. **Authority.** Relevant statutory provisions relating to medical screening, examination and treatment of children are as follows:

   a. Section 39.407, Florida Statutes (F.S.), incorporating by reference ss. 394.455(9) and 394.459(3)(a), F.S.

   b. Section 39.304, F.S.

   c. Sections 743.064 and 743 .0645, F.S.

George Sheldon
Secretary
SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

This document supersedes CFOP 155-10 dated August 7, 2008 and CFOP 175-98 dated June 22, 2009. This document combines information found in these CFOPs, updating that information and adding information and guidance on Psychotropic Medications.
Appendix A- CF_MH 1053- COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT REFERRAL
Appendix B- AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
Appendix C- CF-FSP 5338- PARENTAL AUTHORIZATION FOR CONTINUED PROVISION OF
PSYCHOTROPIC MEDICATION UPON A CHILD BEING TAKEN INTO CARE.
Appendix D- CF-FSP 5341- PSYCHOTROPIC MEDICATION INFORMED CONSENT FACILITATION
FORM
Appendix E- CF-FSP 5339- MEDICAL REPORT FOR CHILDREN ON PSYCHOTROPIC MEDICATION
Appendix F- CF-FSP 5340- PSYCHOTROPIC MEDICATION LEGAL REQUEST
Appendix G- CF-MH 1054- THRESHOLD CRITERIA
Appendix H- REFERRAL FOR SUITABILITY ASSESSMENT- SAMPLE LETTER
Appendix I- CF-MH 1055 REFERRAL FOR MENTAL HEALTH SERVICES
Appendix J- CF-MH 1056 STATEMENT OF MEDICAL STABILITY
Appendix K- CF-MH 1057 REFERRAL FOR 9-0-DAY REVIEW FOR SUITABILITY OF SERVICE:
RESIDENTIAL TREATMENT
Appendix L- Process Flow for Psychotropic Medication: Continue At Removal and During First
28 Days
Appendix M- Process Flow for Psychotropic Medication: Continue At Removal and During
First 28 Days
Chapter 1

General

1-1. Context. Children placed in out-of-home care by the Department, or its agent, are at high risk for emotional and co-occurring substance abuse problems because of the trauma of abuse or neglect as well as the necessity of removal from their homes and separation from their families. Through implementing these procedures, the Department will provide children placed in out-of-home care mental health and substance abuse screening, assessment, and timely quality treatment at levels appropriate to the severity of their conditions.

1-2. Guiding Principles. The following principles will direct the planning and delivery of mental health services for children in out-of-home care.

   a. Children placed in out-of-home care by the Department will be screened for mental health treatment and co-occurring substance abuse treatment needs.

   b. If the preliminary screening indicates a potential need for services, a referral for further assessment will be made.

   c. Both the screening and referral for further assessment, if indicated, will be completed within 30 days of the child being placed into out-of-home care by the Department or its agent. If not completed within 30 days, the reasons will be documented in the child’s case file.

   d. Mental health and/or co-occurring substance abuse needs identified through a Comprehensive Behavioral Health Assessment (CBHA) must be considered when developing the child’s case plan.

   e. Case plans will be individualized according to the needs of the child and will emphasize the strengths of the child and, where possible, the family.

   f. The child, family and other individuals important to the child and family will be involved in developing the plan, unless there is reason for non-involvement consistent with the child’s needs, efforts to secure involvement are unsuccessful, or other statutory requirements conflict with involvement.

   g. The case plan will include a description of the mental health and any co-occurring substance abuse needs being addressed and a description of the services to be provided.

   h. As the child’s or youth’s treatment needs change, the case plan will be adjusted accordingly.

   i. The planned mental health services will be implemented within 30 days of identification of the need in the Comprehensive Behavioral Health Assessment (CBHA) or other mental health, substance abuse or developmental disabilities assessment. If a need is identified and services are not initiated within 30 days, the reasons will be documented in the child’s case file.

   j. The mental health and any co-occurring substance abuse services will be provided consistent with the child’s case plan.

   k. The dependency case manager will monitor the results of services to determine whether progress is being made and to detect risk situations and emerging needs or problems and will take steps to address them.
I. As appropriate, needs and stated goals for independent living skills and future personal or adulthood plans will be identified in the case or performance plan, and needed supports and services will be provided accordingly.

m. For all children who are also served by the Department of Juvenile Justice or the Agency for Persons with Disabilities, child specific planning and service delivery will be coordinated between the three agencies.

1-3 Explanation of Terms. As used throughout this operating procedure:

a. “Authorized agent (or designee) of the Department” means an employee, volunteer, or other person or agency determined by the state to be eligible for state-funded risk management coverage, that is assigned or designated by the department to perform duties or exercise powers pursuant to chapter 39, F.S. See, 39.01(9), F.S. For purposes of this operating procedure, licensed shelter and foster parents shall be considered authorized agents of the department. See s. 409.175(14), F.S.

b. “Authorization for Psychotropic Medication Treatment.”

(1) A person who has the power to provide express and informed consent for a child to receive psychotropic medication, as provided by law includes a birth or adoptive parent or a legal guardian.

(2) If a child does not have a birth or adoptive parent or a legal guardian, whose identity or location is known, authorization to treat with psychotropic medication must be pursued through a court order.

c. “Behavioral Health Network (BNET)” means the statewide network of Providers of Behavioral Health Services who serve non-Medicaid eligible children with mental or substance-related disorders who are determined eligible for the Title XXI part of the KidCare Program. This network includes providers who are managed behavioral health care organizations, private and state funded mental health and substance-related disorders provider. The Behavioral Health Network is administered by the Department of Children and Families, Children's Mental Health State Program Office to provide a comprehensive behavioral health benefits package for children with serious mental or substance-related disorders.

d. “Child & Adolescent Needs and Strengths (CANS)” means an assessment tool developed to assist in determining the need and level of intensity and duration of mental health services.

e. “Children’s Functional Assessment Rating Scale (CFARS)” is a tool, developed by the Florida Mental Health Institute, University of South Florida, for standardizing results obtained from psychosocial and other clinical assessment that provides a snapshot of client functioning that is sensitive to change. The CFARS, which must be completed by a Certified CFARS Rater, is used by the Department to report to the Legislature on program and provider treatment effectiveness as measured by client functioning. Detailed information, including the CFARS training course and certification test, is available at the following website: http://outcomes.fmhi.usf.edu/.

f. "Children's Legal Services" (CLS) is a statewide law firm within the Department of Children and Families. The attorneys are employed by the department and represent the State of Florida, acting through the department in its parens patriae role, in fulfilling the duties set forth in Chapter 39, Florida Statutes. Children’s Legal Services duties in representing the State are to ensure the health, safety, and well being of children and the integrity of families when they come into contact with the department as a result of an allegation of abuse, abandonment or neglect. In some parts of the state, Children’s Legal Services contracts with the Attorney General’s Office or the State Attorney’s Office to fulfill the
role of Children’s Legal Services. For purposes of this definition, those contractors are part of Children’s Legal Services.

g. “Child Specific Staffing” means the staffing of a child or youth who is in out-of-home care by a group of people who have child specific information brought together to plan and coordinate mental health and related services to meet the needs of the child in the most appropriate, least restrictive setting in the community. Members of the team should include: the child, unless clinically contraindicated; the child’s parent or legal guardian and other caregiver, such as the foster parent; the child welfare service worker; the child’s therapist and/or behavior analyst; the child’s Individual Education Plan surrogate and others who may have information or services to offer for the child’s service plan.

h. “Comprehensive Behavioral Health Assessment” means an in-depth, detailed assessment of the child’s emotional, social, behavioral, and developmental functioning within the home, school, and community, including direct observation of the child in those settings.

i. “Dependency Case Manager” means an individual who is accountable for service delivery regarding safety, permanency, and well-being for a caseload of children in out of home care.

j. “Designee” is a person, contractual provider or other agency or entity named by the department to perform duties assigned by the Department.

k. “Emergency medical care or treatment” means care or treatment for injury or acute illness, disease or condition, delay of which, within a reasonable degree of medical certainty, would endanger the health or physical well-being of the patient. Licensed physicians, osteopathic physicians, emergency medical technicians and paramedics specified in section 743.064, Florida Statutes, are authorized to provide such treatment to a minor without parental consent if the minor is unable to name his parents or the parents cannot be immediately located by telephone. When applied to the administration of psychotropic medications, these medications may be provided prior to express and informed parental consent or authorization by order of the court, only under the circumstances outlined in s. 39.407(e), F.S., either when a child is an in-patient in a hospital, crisis stabilization unit, of psychiatric inpatient treatment program, or when the prescribing physician certifies in the required signed medical report that delay in providing the medication would more likely than not cause significant harm to the child.

l. “Express and Informed Consent” – consent given voluntarily in writing, by a competent person to the prescribing physician, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of coercion. (As defined by s. 394.455 (9), F.S. and as described in s. 394.459(3)(a)) . Before giving express and informed consent, the following information shall be provided and explained in plain language to the child’s parent or legal guardian, and to the child, if age appropriate:
   the reason for admission or treatment;
   the proposed treatment;
   the purpose of the treatment to be provided;
   the common risks, benefits, and side effects thereof;
   the specific dosage range for the medication, when applicable;
   alternative treatment modalities;
   the approximate length of care;
   the potential effects of stopping treatment;
   how treatment will be monitored; and,
   that any consent given for treatment may be revoked orally or in writing before or during the treatment period by the parent or legal guardian.
m. “Extraordinary Medical Care and Treatment” means care or treatment of a child that is outside of the routine medical and dental care included in the definition of ordinary medical care and treatment, such as any invasive procedures. This includes surgery, anesthesia, administration of psychotropic medications, sterilization, and any other procedures not considered routine and ordinary by objective professional standards or medical care for children.

n. “Independent review” means an assessment by a Qualified Evaluator that includes a personal examination and assessment of the child in residential treatment. The assessment includes evaluation of the child’s progress toward achieving the goals and objectives of the treatment plan, which must be submitted to the court.

o. “Lead Agency” The not for profit or governmental community-based care provider responsible for the provision of support and services for eligible children and their families who have been abused, abandoned, or neglected, through the coordination, integration and management of a local system of supports and services for eligible children and their families.

p. “Least restrictive” means treatment and conditions of treatment that, separately and in combination, is no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or others from physical injury.

q. “Licensed health care professional” means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a nurse licensed under Chapter 464, a physician assistant certified under Chapter 458 or chapter 459, or a dentist licensed under Chapter 466.

r. “Mental health case manager” means the person assigned to assist the child in gaining access to and coordinate the needed mental health and related services, including co-occurring substance abuse treatment services, and to work with the child, the Department, and the child’s natural support system to develop and implement the service plan. For purposes of this operating procedure, the term “mental health case manager” is used regardless of whether case management is funded under Medicaid or another funding source.

s. “Ordinary Medical Care and Treatment” means ordinary and necessary medical and dental examinations and treatments. Included in this definition are blood testing, preventive care including ordinary immunizations, tuberculin testing, and well-child care. This does not include surgery, general anesthesia, provision of psychotropic medications, any invasive procedures or other extraordinary medical care and treatment as defined in this operating procedure. (Sec. 743.0645(1)(b), F.S.)

t. “Out-of-Home Care” means the placement of a child, arranged and supervised by the Department of Children and Families or its agent, outside the home of the child’s custodial parent. This includes placement in licensed (i.e., shelter, foster home, group home) and non-licensed (i.e., relative) settings.

u. “Out-of-Home Services” – The array of services provided to children and their families or caregivers for children who are placed outside of their homes.

v. “Person who has the power to consent as otherwise provided by law” includes a natural or adoptive parent, or legal guardian, or any other person specifically granted the power of consent by court order.

w. Point of Contact” (POC) means the person or entity designated by the Circuit’s Substance Abuse and Mental Health Program Office or the Lead Agency as the central point of contact within a
specific geographical area for assisting dependency case manager in accessing mental health services for children in out-of-home settings.

x. Prescribing Practitioner. A physician licensed under Chapter 458 or 459, Florida Statutes, or an advanced registered nurse practitioner licensed under Chapter 464, Florida Statutes.

y. Psychotropic Medication. For purposes of determining the need to seek express and informed consent or a court order and guiding the input of information into the Department’s Florida Safe Families Network (FSFN) data system, psychotropic medication is defined as any chemical substance prescribed with the primary intent to treat disturbances of reality testing, cognitive impairment, mood disorders and emotional dysregulation. The medications include, without limitation, the following major categories:

(1) Antipsychotics;
(2) Antidepressants;
(3) Sedative Hypnotics;
(4) Lithium;
(5) Stimulants;
(6) Non-stimulant Attention Deficit Hyperactivity Disorder medications;
(7) Anti-dementia medications and cognition enhancers;
(8) Anticonvulsants and alpha-2 agonists; and
(9) Any other medication used to stabilize or improve mood, mental status, behavior, or mental illness.

Additionally, for purposes of determining the need to seek express and informed consent or a court order and guiding the input of information into the Department's FSFN system, psychotropic medication for the purposes of this definition includes such medications when used for other medical purposes.

z. “Qualified Evaluator” means a psychiatrist or a psychologist licensed in Florida who has at least three years experience in the diagnosis and treatment of serious emotional disturbances in children and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center. A Qualified Evaluator is a person who meets this definition and is appointed by Agency for Health Care Administration (AHCA) to determine children’s suitability for residential treatment, per s. 39.407, F.S.

aa. “Qualified medical practitioner” means a physician licensed under Chapter 458 or 459, Florida Statutes, or an advanced registered nurse practitioner licensed under Chapter 464, Florida Statutes.

bb. “Residential treatment center” means a program that provides intensive mental health treatment for children with emotional disturbance as defined in s. 394.492(5) or (6), F.S. These programs provide 24-hour staff supervision in a restrictive environment that limits the child’s interaction in the community. Residential treatment centers are currently licensed under either Chapter 65E-9,
Florida Administrative Code (F.A.C.), or Chapter 59A-3, F.A.C. As defined in s. 39.407, F.S., therapeutic group homes are included in the definition of “residential treatment centers.”

cc. “Service plan” means the document developed with the child, the family, and treatment and service program representatives, which addresses the child’s individualized mental health treatment and related service needs, including co-occurring substance abuse needs if indicated, with a goal of maintaining the child in the most inclusive and least restrictive environment possible. The service plan must be consistent with the child’s case plan. Elements of the plan are detailed in s. 394.496, F.S.

dd. “Statewide Inpatient Psychiatric Program” or “SIPP” means those residential mental health treatment programs selected through a request for proposal and contracted by the Agency for Health Care Administration (AHCA) to participate in the Institution for Mental Disease (IMD) waiver.

ee. “Suitability assessment” for residential treatment means a determination by a Qualified Evaluator, who has conducted a personal examination and assessment of the child, that the child meets the criteria for placement in a residential treatment center, pursuant to s. 39.407(6)(c), F.S.

dd. “Therapeutic Group Home” means a 24-hour residential program providing community-based mental health treatment and extensive mental health support services in a homelike setting to no more than 12 children who meet the criteria in s. 394.492(5) or (6), F.S. Unlike the Residential Group Home and Behavioral Health Overlay Services (BHOS) provider whose primary mission is to provide a living environment, the primary mission of the therapeutic group home is to provide treatment of children and youth with serious emotional disturbances.

ff. “Treatment Plan” means that identifiable section of the medical record that depicts goals and objectives for the provision of services with specific treatment environments. The treatment plan shall be developed by a team consisting of individuals with experiences and competencies in the provision of behavioral health services to children as described in subsection 65E-11.002(10), F.A.C.; including if deemed appropriate by the family, the child and family or family representatives; and other agencies, providers or other persons.

1-4. Department/Lead Agency will:

a. Facilitate initial and ongoing training on this operating procedure for all levels of Department and Lead Agency staff and contracted providers of the Lead Agency functions.

b. Monitor to ensure that children in out-of-home care are referred for a Comprehensive Behavioral Health Assessment (CBHA) and, if the assessment is not completed within 24 days of referral to the provider, ensure the reasons are documented in the child’s case file.

c. Monitor the number and timeliness of Lead Agency referrals for Comprehensive Behavioral Health Assessments and their incorporation into the case plan process.

d. Ensure that all children entering out-of-home care, who are not Medicaid eligible when placed into out-of-home care, are qualified for Medicaid, when possible, by working with the child’s caregiver and the economic services office in the area in which the child is placed.

e. Ensure the integration of mental health, substance abuse, and developmental disabilities, service planning into the child’s case planning process.

f. Monitor the dependency case managers’ participation in visiting children in residential treatment centers and in active, timely and appropriate discharge planning.
g. In conjunction with the Region/Circuit SAMH Program Office, develop strategies to maximize the effective use of funding sources, including those of Medicaid, Mental Health, Community Based Care, and support services within the community to meet the mental health and co-occurring substance abuse needs of children in out-of-home care.

h. Work closely with the Circuit SAMH Program Office to identify and resolve any local implementation problems.

I. Monitor implementation of this operating procedure throughout the Lead Agency.

1-5. Point of Contact.

a. Designation. Each Circuit SAMH Program Office or Lead Agency will designate a Point of Contact (POC) to serve as the central point of contact for dependency case managers (DCM) in referring children for comprehensive behavioral health assessments and mental health services, including psychotropic medications.

b. Role. For children in out-of-home care, the Point of Contact provides consultation to dependency case manager in accessing screening for mental health and any co-occurring substance abuse or developmental disorders, professional assessment, and timely, quality treatment at levels appropriate to the severity of children’s conditions. The primary role of the Point of Contact is to serve as a resource to the dependency case manager in ensuring that children are assessed as to their need for mental health, developmental disabilities and/or substance abuse services and provided with individualized treatment and integrated services in support of their permanency goals.

c. Responsibilities. The Point of Contact will:

(1) Serve as a consultant to Community Based Care Lead Agency staff in making timely, appropriate, and effective referrals to mental health, substance abuse, and/or co-occurring substance abuse services in the community.

(2) Assist Community Based Care Lead Agency staff in obtaining clinical case consultations for especially complex cases.

(3) Provide monthly reports to the Circuit’s Community Based Care Lead Agency and SAMH Program Offices, when appropriate, on the number, demographics, timeliness, and status of Comprehensive Behavioral Health Assessments and resulting provision of mental health, substance abuse, or co-occurring mental health and substance abuse related services.

(4) Through sample analysis of all providers’ progress reports or other methods, review service quality, outcomes, and relevance to children’s permanency goals, and report these findings to the circuit SAMH and Community Based Care Lead Agency offices.

(5) Manage the process of referring children for suitability assessments and continued stay reviews.

Chapter 2

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENTS

2-1. Purpose. It is the goal of the Department that all children entering out-of-home care, ages 0-17 who are Medicaid eligible are provided a Comprehensive Behavioral Health Assessment (CBHA). These Medicaid-funded assessments are used to provide specific information about mental health and
related needs, including co-occurring needs and recommendations for services to accomplish permanency planning. The needs identified through the CBHA and the recommendations for services are to be included in the child’s case plan.

2-2. Scope. This section applies to children in out-of-home placements as defined in Section 1-3 of this operating procedure.


2-4. Assessment Goals. As described in the Medicaid Handbook, the goals of the Comprehensive Behavioral Health Assessment are to:

   a. Provide assessment of areas where no other information exists;
   b. Update pertinent information not considered current;
   c. Integrate and interpret all existing and new assessment information;
   d. Provide functional information, including strengths and needs, that will aid in the development of long term and short term intervention strategies to enable the child to live in the most inclusive, least restrictive environment;
   e. Provide specific information and recommendations to accomplish family preservation, re-unification, or re-entry and permanency planning;
   f. Provide data to support the most appropriate placement, when out-of-home care or residential mental health treatment is necessary;
   g. Provide the basis for developing an effective, individualized, strength-based service plan; and,
   h. Provide detailed information on each of the Comprehensive Behavioral Health Assessment components as specified in the Medicaid Community Mental Health Services Coverage and Limitations Handbook.

2-5. Process and Timelines.

   a. The Department is authorized to have the Comprehensive Behavioral Health Assessment performed without authorization from the court and without consent from a parent or legal custodian, per ss. 39.407(1), F.S. Within seven days of the child being placed into an approved out-of-home placement, the child protective investigator or the dependency case manager will forward a completed CF-MH 1053-Comprehensive Behavioral Health Assessment Referral (Appendix A to this operating procedure) and an Authorization for Comprehensive Behavioral Health Assessment (Appendix B to this operating procedure) to request that the Point of Contact refer the child for a Comprehensive Behavioral Health Assessment. Referral guidelines for Comprehensive Behavioral Health Assessment may be found in Medicaid’s Community Mental Health Services Coverage and Limitations Handbook incorporated by reference in Rule 59G-4.050.

   b. Within one working day of receipt of a complete request, the Point of Contact will forward an “Authorization for Comprehensive Behavioral Health Assessment” form to an approved provider and will input the referral data into the Children’s Mental Health Comprehensive Behavioral Health Assessment automated tracking system.
c. The Point of Contact will request that the Comprehensive Behavioral Health Assessment provider complete the summary page of the appropriate Child and Adolescent Needs and Strengths assessment tool to serve as the front page of the completed report.

d. As required in the Medicaid Community Mental Health Services Coverage and Limitations Handbook, within 24 calendar days of receipt of the authorization, the Comprehensive Behavioral Health Assessment provider will complete the assessment and send the report of findings to the Point of Contact. The development of the CBHA shall include information provided by the child’s parents and current care giver when ever possible.

e. Within one working day of receipt of the Comprehensive Behavioral Health Assessment report, the Point of Contact will review the report for quality and completeness and, if acceptable, will forward the report to the dependency case manager. If the report is not complete or does not meet the Medicaid Handbook standards, the Point of Contact will return the report to the provider for revision.

f. The dependency case manager will review the assessment report for any recommendations for behavioral health services and will make appropriate referrals for such services, asking the Point of Contact for consultation if needed. The dependency case manager will also ensure that Children’s Legal Services receives a copy of the assessment at this time.

g. At any point during the assessment process, if the child is determined to have an urgent need for immediate behavioral health treatment, the dependency case manager will seek appropriate services for the child in the community. (A score of 3 in “Risk Behaviors” or “Problem Presentation” areas of the CANS would indicate a high level of urgency for mental health services).

h. The dependency case manager will use the results and recommendations of the Comprehensive Behavioral Health Assessment in developing the case plan, including addressing the child’s and family’s mental health service needs. If the case plan is developed prior to the completion of the comprehensive behavioral health assessment, the use of the assessment in developing, accessing and referring for behavioral health services will be documented in the child’s case file. If the services recommended in the CBHA are not included in the child’s current case plan, the recommendations in the CBHA shall be used to revise the current case plan if necessary. The revised case plan must be filed with and approved by the court.

Chapter 3
Medical and Mental Health Treatment

3-1 Purpose: It is the goal of the department that all children entering out-of-home care receive the mental health, substance abuse, and developmental disabilities services that they need to help them live a safe and successful life. To accomplish that goal all children in out of home care will receive the screenings, assessments and treatment needed to accomplish this goal.

3-2 Scope: This section applies to children in out-of-home placements as defined in Section 1-3 of this operating procedure.

3-3 Authority: Sections 39.407 and 743.0645, F.S.

3-4. Screening for mental health & co-occurring substance abuse services,

   a. There is statutory authority for the department to have children medically screened without parental or guardian consent and without a court order. Child Protective Investigators (CPI) or
dependency case managers must seek medical screening for children entering out-of-home care within 72 hours of removal.

b. Such medical screening shall be performed by a licensed health care professional and shall be to examine the child for injury, illness and communicable disease, including need for immunization.

c. The Department also has statutory authority to consent to medical care and treatment related to the suspected abuse, abandonment or neglect of the child, as well as to emergency medical care and treatment for a child who, as a result of the medical screening, is determined by a licensed health care professional to be in need of medical treatment. This authority shall only be used if the parent or guardian is available but refuses to consent to the necessary treatment and a court order cannot reasonably be obtained within the time frame deemed necessary by the licensed health care professional for the treatment to be given. In such an instance, a court order shall be obtained and placed in the child’s record as soon as reasonably possible following the treatment.

d. The Department may also consent to necessary medical treatment for the child if a parent or legal custodian is unavailable, his or her whereabouts cannot be reasonably ascertained, and it is after normal working hours for the court. Again, a court order shall be obtained authorizing the medical treatment and placed in the child’s record as soon as reasonably possible.

e. When children come into physical custody of the department for placement in shelter care, when ordinary and necessary medical treatment is necessary and the situation is not an emergency, the dependency case manager shall attempt to obtain consent from the parent or guardian. Finding no resolution there, the dependency case manager will attempt to obtain a Court order with assistance of Children’s Legal Services. If no Court order can be readily obtained and the attending physician determines that treatment is essential for the well-being of the child, the attending physician can provide the treatment while the dependency case manager is in the process of obtaining the Court order or parental consent as soon as possible.

f. The dependency case manager shall document attempts to obtain parental consent/seek a Court Order in Florida’s Safe Family Network (FSFN).

g. In situations involving a child in the physical custody of the department for placement in shelter care, when ordinary and necessary medical treatment, including immunizations, is necessary and the situation is not considered an emergency, the protective investigator shall:

(1) Make and document a reasonable attempt to obtain consent from the parent or legal guardian;

(2) If the parent or legal guardian cannot be located, obtain a court order if the services of the court are available; or,

(3) If the court is not available and the treatment procedure is essential for the child’s well-being, give consent for necessary medical treatment and obtain court authorization, or parent, legal custodian, or legal guardian consent, as soon as reasonably practicable and place it in the child’s case file.

(4) If the parent, legal custodian or legal guardian refuses to consent, a court order shall be obtained unless the condition is deemed an emergency. The court should be notified of the treatment and the position of the parent, legal custodian or legal guardian regarding consent, at the first available opportunity.

h. Nothing in section 39.407, Florida Statutes, releases the parent, legal custodian, or legal guardian from their obligation to pay for medical treatment even though they have not consented to the
treatment. The parent, legal custodian, or legal guardian can be court ordered to reimburse the department as well as other service providers for the cost of the services. The necessary information shall be obtained so that every effort can be made to secure reimbursement.

i. In no case shall the Department, or any authorized agent of the department, give consent to sterilization, abortion, or termination of life support.

3-5. Medical/Mental Health Treatment Procedure for a child who has been committed to the custody of the Department.

   a. An authorized agent of the Department has the authority to consent to ordinary medical care and treatment as well as emergency medical care and treatment for a child whose parents’ rights have terminated.

   b. An authorized agent of the Department has the authority to consent to ordinary and necessary medical care for a child, when the parent or legal guardian cannot be contacted and has not expressly objected to the department’s providing the consent. The agent’s attempt to contact the parent shall be documented in the child’s record.

   c. The Department has no authority to consent to any extraordinary medical care or treatment, unless the necessary care or treatment is an emergency.

   d. To the greatest extent possible, the dependency case manager will attempt to obtain parental consent for all procedures and will initiate treatment without parental consent only in cases where parental permission cannot be obtained. If the parent or legal guardian refuses to consent to treatment for the child, a Court order shall be sought unless it is an emergency.

   e. The dependency case manager shall document attempts to obtain parental consent/seek a Court Order in Family Safe Florida Network (FSFN).

3-6. Specialized Therapeutic Foster Care

   a. Specialized Therapeutic Foster Care is a Medicaid-funded program of intensive mental health treatment provided in specially recruited foster homes. The program is designed to provide the supervision and intensity of programming required to support children with moderate to severe emotional and/or behavioral problems and to avoid the need for admission to an inpatient psychiatric hospital or residential treatment center.

      (1) Specialized therapeutic foster homes must be licensed under Chapter 65C-13, Florida Administrative Code, and no more than two children requiring this level of care, in addition to the foster parents’ own children, may be placed in a home except when a child has a sibling and it is necessary to keep them together. Approval for the over-capacity placement of a child’s siblings must be approved in writing by the Regional Administrator or the Chief Executive Officer of the Community Based Lead agency in accordance with 65C-13.032(3), F.A.C.

      (2) The level of Therapeutic Foster Care refers to the level of supervision and training of the foster parents and the intensity of program supports needed to treat the child. Level I homes are for children who are seriously emotionally disturbed, with treatment needs such that one foster parent must be available 24 hours a day to respond to crises. Level II homes are for children with more severe emotional and/or behavioral problems, requiring a higher degree of structure, support and clinical services. There must be one non-working parent present in a Level II foster home.
(3) A child specific multidisciplinary team, consisting of a representative of the Circuit SAMH Program Office, Community Based Care Lead Agency, and the area Medicaid office, must assess whether the child requires specialized therapeutic foster care services and must determine the level of services required. The team must review each child’s status to re-authorize services no less than every six months. Specific policy and procedures are outlined in Chapter 2, Section 3, of Medicaid’s “Community Mental Health Services Coverage and Limitations Handbook.”

b. Therapeutic Foster Care provides mental health services for children with emotional and behavioral disturbances living in a foster family home. Each home is managed by trained foster parents who provide specialized care for children needing a therapeutic setting. Each home must be licensed under Chapter 65C-13, Florida Administrative Code, and supervision of the child’s treatment is provided by mental health professionals. The child and family receive support services as necessary. In this program, the therapeutic foster parent is considered the key therapeutic agent. Typically, each home is licensed to serve one or two children.

Chapter 4

Psychotropic Medications

4-1. Purpose. The purpose of this chapter is to delineate the requirements for express and informed consent to, or court authorization to provide psychotropic medications to children placed in out-of-home care by the Department, and the administration and monitoring of these medications.

4-2. Scope. This section applies to all children in out-of-home placements as defined in Section 1-3 of this operating procedure.


4-4 Documentation. Section 39.407(3)(c), F.S., requires the doctor to submit a signed Medical Report prior to the provision of psychotropic medication to children in the legal custody of the department. The dependency case manager shall provide the prescribing physician with Form CF-FSP 5339- Medical Report for Children o Psychotropic Medication (appendix E to this CFOP), prior to the child’s evaluation, whenever possible, and prior to the provision of the psychotropic medication except when the child is placed into a hospital, crisis stabilization unit or psychiatric residential treatment center. CF-FSP 5339 shall serve as the signed Medical Report, and will provide the documentation of the parent’s express and informed consent, when given by the parent. The final page of the form need only be completed by the consultant child psychiatrist when required by Section 5-4 of this Operating Procedure. Required documentation in FSFN will be discussed in each subsection, where appropriate.

4-5 Special requirements for Children ages birth through five. There is a mandatory consultation that a prescribing physician must have with the University of Florida child psychiatrist on contract with the Department through the MedConsult Program. This consultation, described in Chapter 5, must be completed, in addition to the requirements in this Chapter, for the prescription of medications to any child birth to five unless the child was prescribed the medication when brought into shelter care, or unless the child is placed into a hospital, crisis stabilization unit or psychiatric residential treatment center. The final page of CF-FSP 5339 shall be completed by the consulting child psychiatrist when this review is required pursuant to this subsection and Chapter 5, herein. This subsection does not apply when the prescribed medication meets the definition of a psychotropic medication as previously defined herein, but is prescribed for a non-psychotherapeutic purpose, such as a seizure disorder or other medical treatment.

4-6 The Lead Agency may satisfy the requirements of 4-5 by contracting with a local board certified child and adolescent psychiatrist to provide pre-consent consultations as long as they are provided within the requirements of the pre-consent consultation as defined in Chapter 5 of this CFOP. This
locally contracted board certified child and adolescent psychiatrist may also provide a second opinion instead of a pre-consent consultation.

4-7. Authority to provide psychotropic medications to children in out-of-home placements.
The general rule for the authorization of all psychotropic medication to a child placed in out-of-home care by the Department, is that prior to the provision of psychotropic medication the Department or its contracted agent must have either documented proof of parental express and informed consent for the medication whenever the parent’s rights have not been terminated, or a court order authorizing the provision of the medication. When parental rights have been terminated, or the identity or whereabouts of the parent is unknown, or the parent refuses to provide express and informed consent to the provision of the prescribed psychotropic medication, then the court must enter an order authorizing the provision of the medication, prior to it being provided to the child. There are exceptions to this general rule; for emergency administration of medication, in a hospital or other residential setting and when the prescribing physician determines the immediate administration of the medication is necessary; and, when a child comes into care and is already taking prescribed medication. These exceptions are discussed below.

a. The Department or its contracted agent is required to assist the prescribing physician to obtain express and informed consent from the child’s parent or legal guardian, unless parental rights have been terminated, and must take steps to include the parent in the child’s consultation with the physician. If the child’s parent or legal guardian attends the appointment, and/or speaks with the physician who prescribes the child psychotropic medication, the parent or legal guardian is able to give express and informed consent. This consent shall be recorded in FSFN and shall also be documented in the CF FSP 5539-Medical Report for Children on Psychotropic Medications (hereafter called “Medical Report.”)¹ No motion for authorization of psychotropic medication will be necessary when the parent has provided express and informed consent. However, the Medical Report must be submitted to the Court, as a separate filing, or attached to the first Judicial Review Social Study Report filed after the parent’s consent to the medication.

1) At a minimum, these efforts to assist the physician to obtain express and informed consent from the child’s parent or legal guardian shall include the following and shall be documented in FSFN and reported in the Medical Report:

i. Attempts to invite the parent or legal guardian to the doctor’s appointment and to offer the parent transportation to the appointment, if necessary.

ii. Attempts to contact the parent or legal guardian by phone shall be made as soon as feasibly possible upon learning of the recommendation for psychotropic medication by the prescribing physician, if they were not present at the appointment, and specific information for how and when to contact the physician shall be provided.

iii. All written information concerning the prescription shall be sent to the parent or legal guardian’s last known address, if they were not present at the appointment to receive it.

iv. All phone calls and written communication to the parent or legal guardians concerning the prescription of the psychotropic medications shall be documented.

v. Facilitation of transportation arrangements to appointment and/or telephone calls between the parent or legal guardian and the prescribing physician shall be made and documented.

¹ Florida law requires that the prescribing physician sign a written medical report. DCF created the Medical Report for Children on Psychotropic Medications, CF-FSP 5291, to function as that required prescribing physician’s signed medical report, as well as to document express and informed parental consent, when given.
b. If the parent or legal guardian attends the appointment, speaks with the physician who prescribes the child psychotropic medication, and the parent or legal guardian declines or refuses to give consent to provision of the medication, the parent’s decision needs to be documented on in Section 11: Informed Consent by Parent or Guardian of the Medical Report, where the parent would normally sign for consent.

1) When the parent declines or refuses to provide consent, the dependency case manager shall consult with CLS to ensure that the court is informed of the parent’s objections to the prescribed medication and the prescribing physician’s reasons for the continued need to provide the medication in spite of the parent’s objections. If the prescribing physician continues to recommend the medication after considering the parent’s concerns and objections, CLS shall file a motion within one business day. (In the event the parent objects to the medication, and the prescribing physician concurs with the parent’s decision, no further action by the department is required.)

c. Whenever the parental rights of the parent have been terminated, the parent’s location or identity is unknown or cannot reasonably be ascertained, or the parent refuses to consider the request to provide express and informed consent, the dependency case manager must obtain the completed Medical Report from the prescribing physician. Within three business days of receiving the Medical Report from the prescribing physician, the dependency case manager must submit this Report to CLS, together with Form CF FSP 5341- Psychotropic Medication Informed Consent Facilitation Form (Appendix C to this CFOP), documenting all their efforts to obtain the parent’s consent and a Request for Legal Action to obtain a court order authorizing the administration of the prescribed medication. When it has received all the required documentation, CLS shall file the motion and notice all parties. CF FSP 5340- Psychotropic Medication Legal Request (Appendix F to this CFOP), may be used as the request for legal action form.

d. When a child who is taken into custody is taking psychotropic medications at the time the child is removed from the home, the Child Protective investigator (CPI) is required to determine the information concerning the prescription medication that the child is taking. The CPI must seek immediate authorization from the parent to continue providing the medication to the child, and should request the parent sign the "Parent's Authorization to Continue Providing Psychotropic Medication" form CF FSP 5338 Parental Authorization for Continued Provision of Psychotropic Medication upon a Child Being Taken into Care (Appendix C to this CFOP). To continue providing the medication to the child without a prior court order, in addition to the parent’s authorization, either: the medication must be in its original container, be clearly marked as a prescription for the child in question, and the prescription must be current; or a qualified medical practitioner must confirm that the medication is the child’s prescription and that the prescription is current. The information on the container or as verified by the qualified medical practitioner will be used to provide the initial documentation in FSFN.

If all the above conditions are met, except that the parent does not provide authorization, the medication may be continued to be provided to the child as prescribed for the child’s wellbeing, but only until the shelter hearing. When the medication is continued without parental authorization, the Department must notify the parent that the medication is being provided. The child’s record must include the reason parental authorization was not initially obtained, and an explanation of why the medication is necessary for the child’s well-being.

If the child’s parent or care giver states that the child is on a prescription medication but there is not a container clearly marked with the needed information, or if there are several medications in the bottle, and a qualified medical practitioner is unable to confirm the identity of the medications and that the medications belong to the child and that the prescriptions are current,
then the CPI will check with the prescribing physician, if possible, or another physician at the 72 hour physical to determine if the child is currently prescribed a psychotropic medication and receive the dosing information and new prescription. This information must be entered into FSFN and can be used to request the court’s authorization to continue the medication in the shelter order.

e. Unless there is parental authorization, medication can only be continued without a court order until the date of the shelter hearing. To continue administering the medication beyond the date of the shelter hearing, the CPI or dependency case manager must: have a determination from a physician licensed under chapter 458 or chapter 459, Florida Statutes, that the child should continue the psychotropic medication and provide to any information it has in support of its request to continue the medication in writing to CLS. CLS must file a motion requesting continuation of the medication to be heard at the shelter hearing. The motion must indicate that a physician has advised that the child should continue the medication and provide any other information to the court in its possession in support of the request. The Court’s shelter order to continue the medication is valid only until the arraignment hearing on the petition for dependency or for 28 days following the date of removal, whichever occurs first. If the DCM is unable to contact the prescribing physician prior to the shelter hearing the information on the medication bottle can be used as proof of the intent of the prescribing physician to continue the medication until medical advice can be obtained by the DCM.

f. To continue any psychotropic medication to a child beyond the date of the arraignment hearing or 28 days following the date of removal, whichever occurs first, the child must be evaluated by a physician to determine whether it is appropriate to continue the medication. The dependency case manager or CPI shall follow the directions in subsections 4-5(a) and (d) of this Operating Procedure to assist the physician in obtaining express and informed parental consent, and shall provide the Medical Report to the physician for completion. This Medical Report must be provided to CLS in sufficient time prior to the deadline for filing the Petition for Dependency, to allow CLS to also file a Motion seeking court authorization for the psychotropic medication if the parent does not sign the consent section of the Report.

g. Psychotropic medications may be administered in advance of a court order, upon admission of a child to any hospitals, Crisis Stabilization Units (CSU) or Psychiatric Residential Treatment Center. Within three (3) working days after the medication is initiated, a motion for Court authorization must be filed by CLS. To ensure CLS has sufficient information for the motion, the dependency case manager must obtain a Medical Report signed by a treating physician in the facility, and provide this to CLS, within two (2) working days after the medication is initiated. The dependency case manager shall follow the procedures outlined in this Chapter to assist the physician to obtain the express and informed consent of the child’s parent.

h. Psychotropic medications may also be administered in advance of a parent’s consent or authorization by court order when the child’s prescribing physician certifies, in the Medical Report that delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child. In this situation, the Medical Report must provide the specific reasons why the child may experience significant harm and the nature and extent of the potential harm. CLS must file a motion requesting continuation of the medication, along with the Medical Report, and provide copies of both to the court, the child’s guardian ad litem, and all other parties within 3 working days after the department begins providing the medication to the child. CLS shall schedule the motion to be heard at the next regularly scheduled court hearing, or within 30 days after the date of the prescription, whichever occurs sooner. If any party objects to the department’s motion, the court shall hold the hearing within 7 days.

i. The parent must be notified as soon as possible after the treatment is initiated.
j. The assigned dependency case manager is responsible for ensuring that the child’s caregivers are fully informed about the medication, possible side effects, and the proper administration, based on information provided by the prescribing physician.

k. The dependency case manager will be responsible for securing a new consent or court order if there are any changes in medication, including dosage. The dependency case manager shall inform CLS of any changes in medication, and shall provide CLS a copy of the amended Medical Report, if a court order is required.

l. All administered psychotropic medications will be entered into FSFN by the dependency case manager within 3 business days of the parental consent or Court approval of the medication, unless one of the conditions exists that allow provision of the medication prior to consent or court authorization. In those cases the medications will be entered into FSFN within 3 business days of beginning the medication. A case note will be put in FSFN to explain why there is no parental express and informed consent or court order, as described in “h” and “l” above, at the time the medication is entered into FSFN and will indicate the deadline for securing the necessary post-administration court authorization. Updates, including changes in dosage or physician prescribed cessation of the medication will be added to FSFN within the same timeframe.

m. The dependency case manager or other designee will attend medication reviews as required by the prescribing physician and/or agency.

n. Psychotropic medications will be administrated by designated caregivers only.

o. The designated caregiver administrating the psychotropic medication will have received training on medication management and will record the administration of these medications when given. The Lead Agency is responsible to provide medication management training to designated care givers or ensure that it has been provided.

p. If a child on psychotropic medication is removed from a foster placement and placed in another home, it is the responsibility of the dependency case manager transporting the child to obtain the current medication(s) in the original container with original labeling and any additional written prescriptions and dosage information and transport to the new placement.

q. If it is age appropriate and the child is able to understand the risks and benefits of the prescribed medication, the dependency case manager should also facilitate the prescribing physician to obtain the child’s verbal consent to the medication. It is the physician’s responsibility to inform the child as clearly as possible and as fully as is appropriate. The dependency case manager should always attempt to ensure that the physician fulfills this responsibility but the child’s failure to understand or consent is not, by itself, sufficient to prevent the administration of a prescribed medication. If the child refuses to consent to the psychotropic medication the dependency case manager will request that CLS request an attorney ad litem be appointed for the child.

r. Whenever the child, child’s parent (if parental rights have not been terminated) or caregiver requests the discontinuation of the psychotropic medication, and the prescribing physician refuses to order the discontinuation, the dependency case manager should advise CLS of this request. CLS may file a motion with the court requesting discontinuation, pursuant to s. 39.407(3)(d)1, F.S.

s. Whenever a child in out-of-home care is receiving psychotropic medications, whether pursuant to express and informed consent by the parent, or as authorized by an order of the court, the department shall fully inform the court of the child’s medical and behavioral status at
each subsequent Judicial Review hearing, and shall furnish copies of all pertinent medical records concerning the child which have been generated since the previous court hearing, including the Medical Report.

4-7 Requests for second opinions

a. The dependency case manager may make a referral for a second medical opinion through the Lead Agency at any time.

b. When any party files a motion requesting that the court order the department or its contracted agent to secure a second medical opinion, or on its own motion, the court may require the department or its contracted agent to obtain a second opinion within a reasonable timeframe as established by the court. The department or its contracted agent will make an appointment for the second opinion within one working day of the court’s order.

4-8 Use of the MedConsult Line program.

The MedConsult line is a contract with the University of Florida, School of Psychiatry to provide medical consultation on psychotropic medication treatment decisions for children in out-of-home care or enrolled in BNET. Use of this service is voluntary for all requesting parties.

a. This service is open to any prescribing physician, dependency case worker, parent (unless parental rights have been terminated), foster parent, minor, relative/non-relative care giver, GAL, judge, parent of a child enrolled in the Behavioral Health Network (BNET) or BNET Liaison who is working with a child in out-of-home care or enrolled in BNET.

b. The MedConsult Line program also provides a mandatory pre-consent review process for all psychotropic medications prescribed to children between the ages of birth through five (5) years, prescribed specifically for psychotherapeutic purposes, when the children are in out-of-home care. The pre-consent review process is described in Chapter 5.

c. The Lead Agency may satisfy the pre-consent consultation requirement by contracting with a local psychiatrist to provide pre-consent consultations as long as they are provided within the requirements of the pre-consent consultation as defined in Chapter 5 of this CFOP. This locally contracted board certified child and adolescent psychiatrist may also provide a second opinion. When a second opinion is provided it will take the place of the required pre-consent consultation.

4-8 Parental and caregiver Involvement.

a. When authorization to provide psychotropic medications is provided by order of the court, because the location or identity of the child’s parent is unknown, or the parent refuses or declines to provide consent, the dependency case manager must continue to try to involve the parent in the child’s ongoing treatment planning, and shall continue to facilitate the parent’s express and informed consent to the provision of any new medications or dosages.

b. The dependency case manager shall provide and update to the child’s caregivers the information contained in the physician’s medical report. This information is to include:
   - An explanation of the nature and purpose of the treatment;
   - The recognized side effects, risks and contraindications of the medication;
   - Drug-interaction precautions;
- Possible side effects of stopping the medication; and
- How the treatment will be monitored.

4-9 Medical Monitoring. Psychotropic drugs are very powerful, and can have severe and sometimes life-threatening side effects, particularly on children.

a. It is necessary that the dependency case manager timely comply with the doctor’s recommended medical screenings and evaluations for the child, and report the results to CLS and the prescribing physician.

b. It is necessary that the dependency case manager monitor any side effects, risks, contraindications of the medication, and drug-interaction precautions, by discussing these issues with the child, if age appropriate, and the child’s caregiver. Any information that calls into question the child’s health and safety shall immediately be brought to the attention of the prescribing physician.

Chapter 5

PRE-CONSENT REVIEW FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION FOR PSYCHOTHERAPEUTIC TREATMENT FOR CHILDREN FROM BIRTH THROUGH AGE 5 IN OUT OF HOME PLACEMENT

5-1. Purpose. This chapter describes the process for obtaining a pre-consent review prior to administration of psychotropic medication for psychotherapeutic treatment for children from birth through age 5 who are in out-of-home placement.

5-2. Scope. This chapter is applicable for all children from birth through age five (5) who are in the custody of the department in out-of-home care and who, following medical evaluation, are found to be in need of psychotropic medication therapy for psychotherapeutic treatment. This Chapter does not apply when the psychotropic medication is prescribed solely for medical treatment, including but not limited to seizure disorders.

5-3. References. Relevant provisions relating to use of psychotropic medication for children are as follows:

a. Section 39.407, Florida Statutes, Medical, psychiatric, and psychological examination and treatment of child; physical or mental examination of parent or person requesting custody of child.

b. Department of Children and Families legal Opinion 09-01.

5-4. General Statement. A mandatory pre-consent review by a child psychiatrist, contracted by the department, will be obtained prior to prescription of a psychotropic medication for psychotherapeutic treatment for any child between the ages of birth through five (5) years who is in the custody of the department in out-of-home care. The final recommendation of the consultant child psychiatrist is intended to be used by the person who has legal authority to consent for extraordinary medical treatment or the judge who is providing the court order for treatment with a psychotropic medication. For medications that are generally considered psychotropic medications but are being prescribed by a physician for general medical treatment, such as treatment for seizure disorder, this usage shall be exempted from the mandatory pre-consent consultation process.

5-5. Pre-Consent Review Procedure.
a. Completion of the pre-consent review process for psychotropic medication to be prescribed for a child in out-of-home care is the responsibility of the child’s dependency case manager.

b. The case manager will complete the sections of the Medical Report, CF FSP 5339, as designated, prior to the child’s psychiatric evaluation.

c. The case manager will coordinate a psychiatric evaluation for the child, will take the child to the prescribing practitioner’s office for the evaluation, and will request the prescribing practitioner to complete the Medical Report form (CF-FSP 5339) during the time of the child’s evaluation.

d. The case manager will electronically send (by facsimile or e-mail) the completed Medical Report form (CF-FSP 5339) to the contracted consultant child psychiatrist within one (1) business day of the child’s office visit.

e. The Department’s contracted consultant child psychiatrist will review the Medical Report and document the consultant psychiatrist’s review and recommendations form within one (1) business day of receipt of the plan and electronically send (by facsimile or e-mail) the completed last page to the case manager that day. If further information is needed or the consultant does not concur with the prescribing practitioner’s treatment plan, the consultant will contact the prescribing practitioner by telephone to discuss the treatment plan. If the consultant is unable to obtain the information needed to provide a completed review, the consultant will note that inability on the form.

f. The case manager will electronically send (by facsimile or e-mail) the completed last page of the Medical Report to the prescribing practitioner the day it is received.

g. The case manager will deliver the fully completed Medical Report to the Children’s Legal Services (CLS) attorney. If the parent or legal guardian has not consented to the administration of the prescribed psychotropic medication, the CLS attorney shall file the motion for court authorization for psychotropic medication treatment within one business day.

h. If the individual responsible for providing consent, or the judge responsible for providing the court order for treatment, has questions regarding the Medical Report or the consultant child psychiatrist’s recommendations, the case manager will facilitate a conversation between the physician and the parent/legal guardian or judge to assist in fully answering the questions raised.

i. The case manager will file a copy of the Medical Report in the child’s Department record and provide a copy to the CLS attorney.

j. If the psychotropic medication treatment identified in the Medical Report does not yield expected results, and if the prescribing physician prescribes any alternate psychotropic medications, the pre-consent review process identifying a new medication treatment plan will begin again as described in paragraphs 5a through i above.

Chapter 6

RESIDENTIAL MENTAL HEALTH TREATMENT

6-1. Purpose. This chapter provides the process for assessing and, if needed, placing children that are in out-of-home care into residential treatment centers, including therapeutic group homes. The process is consistent with Section 39.407, F.S., which provides the statutory requirements for such placements. Such placements must be carefully planned and should be considered only when a child has not been responsive to mental health treatment in the community and less restrictive treatment interventions are not currently appropriate or available. Residential treatment shall not be used for emergency
placements; children or youth experiencing an acute psychiatric crisis should be referred to the local Baker Act receiving facility for emergency screening and stabilization.


6-3. Threshold Criteria.

a. Before a child can be referred for a suitability assessment, the dependency case manager will review the child’s current condition with the child’s mental health case manager in relation to specific threshold criteria (see Appendix C to this operating procedure). The purpose of this internal review is to determine if the Department believes the child has an emotional disturbance severe enough to require the intensity and restrictiveness of treatment in a residential treatment center.

b. Resources that should be sought in reviewing the child’s current condition are:

   (1) Current evaluations or assessments;
   (2) Reports from the family, foster family, school, and the child’s current placement;
   (3) The results of recent case staffing(s);
   (4) Staff observations of the child; and,
   (5) Reports from mental health treatment, substance abuse and/or co-occurring mental health and substance abuse providers who worked with the child in the community or in less restrictive residential treatment settings, such as Specialized Therapeutic Foster Care to determine what previous interventions were attempted, what interventions worked, did not work, and why

c. Each child being considered for referral for a suitability assessment must meet one or more of the Children’s Functional Assessment Rating Scale (CFARS) problem severity ratings in Section B of Appendix C, and one or more of the following situations, as described in Section A of Appendix C:

   (1) Comprehensive treatment in the least restrictive settings has been ineffective.
   (2) The child’s psychiatric condition is so severe that treatment can not be safely attempted in the community.

6-4. Suitability Assessment. If it is determined that the child meets the threshold criteria:

a. The dependency case manager will prepare the referral packet (Appendices C, D, and E), including all required attachments, obtain the signatures of the immediate supervisor and next level supervisor, and forward the packet and all attachments to the Point of Contact. The dependency case manager will simultaneously notify the Children’s Legal Services that a Suitability Assessment has been requested so that Children’s Legal Services can file notice with the court and all Parties, including the child’s guardian ad litem and attorney, if appointed. The dependency case manager shall provide the child’s guardian ad litem and attorney, if appointed, the opportunity to meet with the child before the child’s appointment with the Qualified Evaluator, and shall facilitate the opportunity for the child’s guardian ad litem and attorney, if appointed, to discuss the child’s suitability with the qualified evaluator prior to the written assessment.

b. The Point of Contact will review the referral packet to ensure that it is complete and, within two working days, will fax the cover memo (Appendix D to this operating procedure) and the three-page referral form (Appendix E), minus the attachments, to AHCA’s contracted provider or Qualified Evaluator.
c. Within two working days of receiving the referral from the Point of Contact, AHCA’s contracted provider is required by contract to:

(1) Designate a Qualified Evaluator;
(2) Schedule the child’s appointment with the Qualified Evaluator; and,
(3) Notify the Point of Contact of the name, address, and phone number of the selected Qualified Evaluator and the date and time of the appointment at least three working days before the appointment.

d. Immediately upon notification from AHCA’s contracted provider, the Point of Contact will:

(1) Notify the dependency case manager of the appointment;
(2) Confirm that the dependency case manager, or the child’s foster parent or another adult who knows the child well, will transport and accompany the child during the appointment; and,
(3) At least one working day before the appointment, ensure that the completed packet, including all required attachments, is delivered to the office of the Qualified Evaluator.

e. The Qualified Evaluator, after completing the evaluation and suitability assessment, will submit the report and any supporting information to AHCA’s contracted provider for approval. This report must include written findings that the child has been provided with a clinically appropriate explanation of the nature and purpose of the recommended treatment.

f. After approving the report, AHCA’s contracted provider sends the report to the Point of Contact, who will forward the report to the dependency case manager and to the Circuit SAMH Office. The report of the findings will be forwarded within 14 working days of receipt of the referral.

g. The Point of Contact will provide a copy of the suitability assessment report to the CLS attorney who will provide it to the court and all parties, including the guardian ad litem and attorney ad litem, if assigned.

h. If, at any point during the suitability assessment process, the child or family member appears to have an urgent need for immediate mental health services, the dependency case manager will access appropriate mental health services in the community, requesting assistance as needed from the Point of Contact.

6-5. Actions Following Suitability Determination.

a. If the Qualified Evaluator determines the child does not require placement in a residential treatment center, the Point of Contact will offer to assist in developing a plan for necessary treatment and support services for the child in the community.

b. If the Qualified Evaluator determines the child does need treatment in a residential treatment center and the decision is made to place the child into a residential treatment center or hospital, the dependency case manager will:

(1) Immediately notify Children’s Legal Services.
(3) Meet with the Circuit SAMH Program Office/ Point of Contact to identify less restrictive placement options, services and supports for the child as an alternative to residential treatment in the event the court orders that the child be placed in a less restrictive placement.

c. Upon notification from the child’s dependency case manager, the CLS attorney will file a motion for placement of the child with the court and notify the child’s guardian ad litem and attorney, if assigned, and all other parties. This motion shall include a statement as to why the child is suitable for this placement, why less restrictive alternatives are not appropriate, and the written findings of the qualified evaluator. This motion shall also state whether all parties, including the child, are in agreement with the decision. CLS shall ensure the court sets the matter for a status hearing within 48 hours, excluding weekends and holidays, and shall provide timely notice of the date, time and place of the hearing to all parties and participants, except that the child’s attorney or guardian ad litem shall notify the child of the date, time and place of the hearing. If, at the status hearing, any party disagrees with the recommended placement, then the matter shall be heard by the court within 10 working days.

d. If the Qualified Evaluator’s written assessment indicates that the child requires immediate placement in a residential treatment center or hospital and that such placement cannot wait for a court hearing, then the child may be placed, pending a hearing, unless the court orders otherwise.

e. Upon the filing of the motion for placement, the Department will provide timely notice of the date, time, and place of the status hearing to all parties and participants.

f. If the motion for placement of the child into residential treatment is approved by the court during the status hearing, the dependency case manager, the Point of Contact and the SAMH Office will coordinate the placement of the child.

g. If the child, or any other party, disagrees with the placement of the child into residential treatment, a placement hearing will be requested. The dependency case manager will assist Children’s Legal Services staff in preparing for the placement hearing.

h. If the court approves the motion for placement of the child into residential treatment and if resources are immediately available for placing the child in a residential treatment center:

   (1) The Circuit SAMH Program Office will in consultation with Community Based Care Lead Agency, select a residential treatment center, in most instances a Statewide Inpatient Psychiatric Program (SIPP) in the Circuit, designed to meet the child’s identified treatment needs and follow the approval and placement process required for the placement selected.

      (a) If SIPP is selected, submit a complete referral package to the SIPP that includes, at a minimum, Appendix G, Appendix I with all attachments, Appendix J and the suitability assessment of the Qualified Evaluator.

      (b) Follow-up with the SIPP provider to ensure that prior authorization is being requested from AHCA’s contracted provider of SIPP utilization management.

      (c) Upon notification from the SIPP that the child has been authorized for admission, notify the Point of Contact, the dependency case manager and AHCA’s contracted provider for independent evaluations of the child’s admission, the date of admission, and the name, address and phone number of the facility.

      (d) If authorization is denied, reconsideration may be requested per the process outlined in AHCA’s “Utilization Management Procedures for Statewide Inpatient Psychiatric Program” manual.
Upon notification from the Circuit SAMH Program Office that the child will be placed in the SIPP/residential treatment center, the dependency case manager will:

(a) Immediately notify Children’s Legal Services attorney who will in turn notify the guardian ad litem, the attorney ad litem, if assigned, and the court of the child’s placement in the residential treatment center.

(b) Provide the facility with a copy of the court order that currently authorizes administration of psychotropic medications.

(c) Provide the facility with the appropriate legal consent to treatment and a copy of the court order approving placement of the child, if available.

(d) Prepare the child for the placement, including describing the facility and its program and explaining the nature and purpose of the treatment.

(e) Ensure that the child has suitable clothing and arrange in advance with the residential treatment center for the child to bring allowable personal possessions.

(f) Inform the child’s parents of the child’s status and the SIPP placement arrangements.

(g) Give the child and the residential treatment center the name and phone number of the dependency case manager and supervisor, including an after-hours contact for urgent situations, and the phone number of the child’s foster parents, parents and/or other relatives that the child has permission to contact unless contraindicated, as well as the guardian ad litem and child’s attorney, if one has been appointed.

(h) Monitor the child’s safety, care, and treatment while in the residential treatment center by maintaining regular contact with the child and the child’s treatment team, including monthly visits with the child.

(i) In coordination with the residential treatment center, facilitate regular contacts between the child and the significant people in the child’s life.

(j) Work closely with the facility and relevant resources in the community toward a timely and appropriate discharge plan.

(k) Follow through to ensure appropriate treatment and support services are provided to the child and family upon discharge.

i. If the court denies the motion to place the child into a residential treatment facility or orders the placement of the child in a less restrictive setting during a 90-day review hearing, the dependency case manager will consult with the Point of Contact and the Circuit SAMH Program Office to coordinate the referral and placement of the child into the least restrictive setting that is best suited to meet the child’s needs.

j. If the child cannot be placed immediately in a residential treatment center, the Circuit SAMH Program Office will:

(1) Ensure that a case manager is designated to develop, implement, and monitor a service plan for the child that is integrated into the child’s case plan.
(2) Enter the child’s name onto the area’s waitlist for the purpose of providing needed services.

(3) Monitor, through the mental health data system, to ensure the child is receiving the needed mental health services.

6-6. Discharge Planning.

a. Before a child is admitted to a residential treatment center, the dependency case manager will coordinate the development of an initial discharge plan that at a minimum identifies:

(1) The individual or family or program that the Community Based Care Lead Agency anticipates will be providing a home for the child following discharge. Because this may not be firmly established at the time of admission to the facility or may be subject to future court approval, contingency plans should also be discussed with the child and included in the initial discharge plan.

(2) Services that will be offered to the child’s identified future caregiver during the placement and following discharge. These services should be designed to prepare the caregiver to work effectively with the child and ensure stability in the discharge environment.

(3) Potential step-down treatment programs in the community that may be explored, depending on the intensity of the child’s needs for continued structured treatment at the time of discharge. Such programs might include a therapeutic foster home, Specialized Therapeutic Foster Care at Level 1 or 2, or a specially recruited foster home that has been trained through the area’s Behavior Analyst Services Project.

b. While the child is in the facility, the child’s designated case manager and/or the dependency case manager will communicate regularly with the child, the child’s family/caregiver, the facility’s treatment team and the Lead Agency placement unit to plan for the child’s discharge. The discharge plan will be finalized at least 30 days prior to the child’s projected discharge date.

c. As soon as the child’s future caregiver is identified, the dependency case manager will work with the facility to facilitate phone calls, visits, and home visits with the caregiver and to address any issues identified by the child, the caregiver, or facility staff to ensure a successful discharge.

6-7. Reviews and Reports.

a. Section 39.407(6), F.S., requires certain reports and reviews for children in the Department’s custody who are placed into residential treatment centers or hospitals. It is imperative that Circuits track compliance with these requirements and ensure timely receipt and distribution, including requirements for filing reports with the court. Each Circuit will develop its own operating procedures for ensuring compliance.

b. The following reports and reviews are required for placements made under Section 39.407(5), F.S., to hospitals licensed under Chapter 395, F.S., or residential treatment centers, including therapeutic group homes, licensed under Chapter 65E-9, F.A.C

(1) **10-Day Report.** Subsection 39.407(5) (e), F.S., requires that:

(a) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director’s designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the Department, and to the guardian ad litem, and submitted to the Point of Contact and Community Based Care Lead Agency Service Worker.
(b) The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child’s foster parents must be involved to the maximum extent consistent with the child’s treatment needs.

(c) The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured.

(d) A copy of the plan must be provided to the child, to the guardian ad litem, the CLS attorney and to the child’s dependency case manager.

(2) **30-Day Report**. Subsection 39.407(5) (f), F.S., requires that:

(a) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child’s placement in the program. The residential treatment program must determine whether the child is receiving benefit towards the treatment goals and whether the child could be treated in a less restrictive treatment program.

(b) The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem, the Department, and to the dependency case manager.

(c) The Department must submit the report to the court through the CLS attorney. The report must include a discharge plan for the child.

(d) The residential treatment program must continue to evaluate the child’s treatment progress every 30 days thereafter and must include its findings in a written report submitted to the Department and the dependency case manager.

(e) The Department, through the CLS attorney, must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child’s progress towards achieving the goals specified in the individualized plan of treatment.

(3) **90 Day Reviews**.

(a) AHCA’s contracted provider will direct one of its registered Qualified Evaluators to conduct the 90-day independent reviews, for children in Department custody in facilities licensed under Chapter 395, F.S. and 65E-9, F.A.C.

(b) The Circuit will provide ongoing notification to AHCA’s contracted provider of all children in Department custody placed in these facilities to ensure that the reviews are scheduled timely. Appendix E will be used to authorize access to the child by the Qualified Evaluator for these reviews.

(c) Subsection 39.407(5) (g) and (h), F.S., requires that:

1. The court must conduct a hearing to review the status of the child’s residential treatment plan no later than three months after the child’s admission to the residential treatment program.

2. An independent review of the child’s progress towards achieving the goals and objectives of the treatment plan must be completed by a
Qualified Evaluator and submitted to the court before its three-month review.

3. For any child in residential treatment at the time a judicial review is held pursuant to s. 39.701, the child’s continued placement in residential treatment must be a subject of the judicial review. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the Department to place the child in the least restrictive setting that is best suited to meet his or her needs.

4. After the initial 3-month review, the court must conduct a review of the child’s residential treatment plan every 90 days.

c. Florida Supreme Court Rule 8.350 requires the court to review the status of the child’s residential treatment plan no later than 3 months after admission to the residential treatment facility and every 3 months thereafter, until the child is placed in a less restrictive setting. The dependency case manager will provide a copy of the child’s 90-day review, completed by the Qualified Evaluator, to the child’s guardian ad litem and the Children’s Legal Services attorney so they can provide the court, and all other parties, with a copy at least 72 hours prior to the child’s review hearing.

6-8. Visitation.

a. Within three working days of placement in a residential treatment center, the dependency case manager will contact the child, by phone or in person, and the facility’s treatment staff to assure the program is meeting the child’s needs.

b. The dependency case manager will visit the child at least monthly while the child is in the placement to monitor the child’s condition and progress and will document the visits through Florida Safe Families Network (FSFN). During the visit, the dependency case manager will ensure that services are being provided that address all domains of a child’s life and document that in the case record.

c. If the child is placed out of Circuit, the Lead Agency will formally request the receiving Circuit to visit the child at least monthly, document the visits through FSFN, and provide the home Circuit with regular written updates on the child’s adjustment and condition.

6-9. Out-of-State Placements Prohibited. It is the policy of the Department that the Circuit will not approve or participate in funding out-of-state placements for mental health treatment of children. The only exception that may be considered must meet the following conditions:

a. The Community Based Care Lead Agency reunification plan is for the child to join a family who lives in the other state.

b. The home study is complete and approved.

c. Funding is for a transitional period not to exceed three months.

d. The Circuit Administrator has provided prior written approval of the placement.

e. A copy of the Circuit Administrator’s approval letter is sent to the Chief of Children’s Mental Health in the SAMH Central Office.
4-11. Relinquishing Custody. It is the policy of the Department that parents or other custodians must not be compelled nor encouraged to relinquish custody of their children to the Department in order to access mental health services for their child. No family should have to place their child into the Department’s custody in order to receive treatment, nor should any suggestion ever be made to a family or to a court to do so.
Comprehensive Behavioral Health Assessment Referral

Please complete this form and forward it to the Point of Contact along with the Authorization for Comprehensive Behavioral Health Assessment form.

Child’s Name: ___________________________ Sex: _______ D.O.B. ___________ Race: ___________
SSN #: ________________________________
Name of Caregiver: ________________________ Phone #: __________________
Address of Caregiver: ____________________________
School Child Attends: __________________________
Reason for Shelter: (Abuse, Neglect, Abandonment) ________________________________

Name of Parents: ____________________________ Phone/Cell/Pager #: ______________
Name(s) of siblings: 1. ____________________ Location: __________________________
   2. ____________________ Location: __________________________
   3. ____________________ Location: __________________________
Preliminary Goal: (Reunification, adoption, expedited termination of parental rights) ________________________________
What services and with whom are services currently provided to the child/family: ________________________________

Prior reports to DCF (date, findings, indications) ________________________________
Has there been any identified mental illness in child/family?: ________________________________
Has there been any identified alcohol or other drug use with the child/family?: ________________________________

Please provide the Following Department Information:

CW/CBC Counselor/Investigator: ____________________________ County: ____________ Phone #: ____________
CW/CBC Supervisor: ________________________________ Phone Number: __________________
CW/CBC Contact Person: ____________________________ Phone Number: __________________

CF-MH 1053, Jan 2004
AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

This is to certify that

Child’s Name ___________________________ Date _____________

Medicaid Number ________________

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment (W1059) as outlined in the Medicaid Community Mental Health Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by ___________________________ (provider)

_________________________ Date

Circuit SAMH Representative

AND

_________________________ Date

Circuit Community Based Care Lead Agency Representative

OR

_________________________ Date

Juvenile Justice Representative

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT FOR CHILD IN SHELTER

This is to certify that

Child’s Name ___________________________ Date of Referral _____________

Medicaid Number ________________ Shelter Name ___________________________

Shelter Address ___________________________

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment (W1059) as outlined in the Medicaid Community Mental Health Services Coverage and Limitations handbook. The behavioral health comprehensive assessment will be provided by ___________________________ (provider)

_________________________ Date

Circuit Community Based Care Lead Agency Representative

to be placed in recipients (child’s) medical record

July 2000
PARENTAL AUTHORIZATION FOR CONTINUED PROVISION OF PSYCHOTROPIC MEDICATION
UPON A CHILD BEING TAKEN INTO CARE.

This Form must be completed by the Child Protective Investigator for all cases where a child removed from his or her home under s. 39.401, F.S., and the child is currently prescribed and taking any psychotropic medication for any reason. This completed form must be submitted to CLS as part of the CLS Psychotropic Medication Packet immediately upon completion.

I ___________________________ (Print Child Protective Investigator Name) certify that the following information concerning the psychotropic medications listed in this form is accurate at the time I removed the child from the home under s. 39.401, F.S.:

☐ Upon removing the child from the child's home, I took the psychotropic medications listed in this document into custody. This medication is in its original container, and is a current prescription for the child or ☐ the prescription was confirmed by _____________________, a qualified medical practitioner, on ______________________ (date)______.

Section 1:
Child’s Name: ________________________ DOB: ________________________
Child’s Height: _________ Child’s Weight: ______________
Mother (if rights not terminated): ________________ Phone: ___________ Email: ________________
Father (if rights not terminated): _________________ Phone: ___________ Email: ________________

I ____________________________(Print name of parent or legal guardian) certify that my child _____________________(print child’s full name) is currently prescribed and taking the listed medications and by my signature I am giving authorization to the Department of Children and Families to continue to provide the listed medications and continue any listed behavioral health services.

Signature of Parent: ____________________________ Date: _______________

Section 2: (Note: This Section only needs to be completed if a parent does not authorize continuing this medication by signing above.)

☐ Parental authorization to continue the psychotropic medications listed in this document was not obtained, because:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

☐ I have contacted the physician identified as the child’s prescribing physician _________________ or another physician
_______________ and he/she advised me that continuing this medication is necessary for the child’s well-being, because:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

☐ I notified the child’s parent that the psychotropic medication listed in this document is being provided to the child.

☐ The following additional information supports the request for the shelter order to include authorization to continue the psychotropic medication listed in this document:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Signature of Child Protective Investigator: ____________________________ Date: _______________

CF- FSP 5338 Aug 2009 Appendix C to CFOP 155-10/175-40
PSYCHOTROPIC MEDICATION INFORMED CONSENT FACILITATION FORM

This Form must be completed by the Case Manager for all cases where a child in out-of-home care is seeing a physician for the purposes of assessing a need for a prescription of psychotropic medication for any reason. This completed form must be submitted to CLS with the CLS Psychotropic Medication Packet immediately upon completion.

I ___________________________ (Print Case Manager Name) certify that I have taken the following steps necessary to facilitate the inclusion of a parent or guardian, whose parental/guardian rights are intact, in the child’s consultation with the prescribing practitioner:

Section 1:

☐ I successfully contacted the following parent or guardian advising them of an appointment with a physician regarding the prescription of psychotropic medication to their child in out-of-home care. If parent or guardian is unable to be contacted, skip to Section 3.

Name of parent or guardian contacted: ____________________________________ Date of contact: ________________

AND

☐ I provided the parent or guardian with the following information regarding the appointment with the physician:

☐ Phone Conference Information: Name of physician ____________________

Phone Number ____________________

Date/Time to Call ____________________

OR

☐ Face-to-Face Meeting Information: Name of physician ____________________

Address ____________________

Date/Time ____________________

☐ Transportation Information (Describe efforts made to assist parent/guardian with transportation to appointment with physician):

_______________________________________________________________________________________

AND

Section 2:

☐ Parent agreed to attend the face-to-face meeting with the physician or to call the physician.

OR

☐ Parent refused to attend the face-to-face meeting with the physician or to call the physician.

Section 3:

☐ The parent or guardian of the child is unknown and, as a result, informed consent will not be obtained.

OR

☐ I was unsuccessful in my attempts to advise a parent or guardian of an appointment with a physician regarding the prescription of psychotropic medication to their child in out-of-home care. I took ALL of the following steps to attempt to contact the parent or guardian:

☐ I sent written information concerning the need of the parent/guardian to provide express and informed consent for the prescription of psychotropic medication to their child to the last known address of the parent or guardian on the following occasion:

1) ____________________________________

AND

☐ I called the parent or guardian at the last known telephone/cell number and left messages when possible to ensure parental awareness of the need to provide express and informed consent for the prescription of psychotropic medication (s) on the following occasions:

1) ____________________________________

2) ____________________________________

3) ____________________________________

4) ____________________________________

Signature of Case Manager: __________________________________________ Date: ________________

CF-FSP 5341 Aug 2009 Appendix D to CFOP 155-10/175-40
Thank you for your work with children in the foster care system. For many of our children, the provision of quality psychiatric services is a crucial component in strengthening their families and helping them achieve stability as children and success as young adults. Your expertise and professionalism are both greatly appreciated and greatly needed.

The legislature has recognized the commitment and dedication of physicians working in the system by creating an evidentiary rule that allows this medical report to be admitted into evidence without in-court testimony from the doctor. Balancing against that relaxed rule, however, is a list of certain information that must be in every medical report. If that information is not present, the Court cannot accept the medical report. Therefore, you are strongly encouraged to fill out this medical report as completely as possible and to note when a question is not applicable.

Beyond just their parents, children in the child welfare system have multiple other parties responsible for their interests and well-being. As such, you may receive inquiries from Children's Legal Services (DCF Legal), the guardian ad litem, or the Court. To minimize the need for such inquiries, please use this medical report as a chance to answer any foreseeable questions or concerns that a lay person interested in the welfare of the child might have. You are strongly encouraged to append any additional information that supports or explains your diagnosis and prescription.

Overview of the Psychotropic Medication Authorization Process

This is a legal document which may be filed with the court. As a physician, you have particular responsibilities in the prescribing and administration of psychotropic medications. Below are some guidelines:

1. Prior to assessing the child, the dependency case manager will provide you with a completed Referral Form for Psychotropic Medication, along with pertinent medical information on the child, which you are required to review. (§ 39.407 (3))

2. According to Florida law, the prescribing physician shall attempt to obtain express and informed consent from the child’s parent or legal guardian. The dependency case manager will facilitate the parent’s inclusion in the child’s consultation with you. (§ 39.407(3)(a))

3. You will evaluate the child, discuss the medical report with the parent or legal guardian, and fill out the Medical Report with the child’s proposed medication profile.

4. If a parent or legal guardian of the child gives express, informed consent to the medication, no court authorization is required. The parent or legal guardian and you will complete Section 10 of this document. Neither the foster parent nor the dependency case manager can give consent.

5. The child cannot receive any psychotropic drug until authorization has been provided through express and informed consent or court order, unless you certify that a delay in providing a prescribed psychotropic medication will more likely than not cause significant harm to the child.

You do not have to appear for the court hearing unless the court needs additional information and orders you to appear or a party subpoenas you to appear. Again, we greatly value your service to children and stand ready to help in any way we can. If you have any questions at all, please do not hesitate to contact the agency’s clinical director: ________________________________.
# Medical Report for Children on Psychotropic Medication

(to be completed by the physician)

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<tr>
<th>Requesting Physician's Name:</th>
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<tr>
<td>Office Visit Address:</td>
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<td>Date/Time of Office Visit:</td>
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## SECTION 1: CHILD'S INFORMATION

<table>
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<th>Child's Name:</th>
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<td>Child's Date of Birth:</td>
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## SECTION 2: INFORMATION RECEIVED BY PHYSICIAN.

Briefly list any persons consulted, tests performed, or documents reviewed in conjunction with this child’s evaluation.

Received *Psychotropic Medication Referral Form* from Case Manager? □ yes □ no

## SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS.

List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medication profile. Please provide the Axis diagnosis if known.
SECTION 4: RECOMMENDED SERVICES, OTHER TREATMENTS. List any psycho-social services, medical or psychiatric follow-ups, or treatments the child should receive in conjunction with this medication profile including a recommended schedule.

SECTION 5: FOR CHILDREN AGES BIRTH-5. Name and contact information of consultant child psychiatrist, the date the pre-consent review was conducted, and the final recommendation of the consulting psychiatrist.
SECTION 6: PROPOSED MEDICATION PROFILE

This report requests authorization for ONLY the below-listed psychotropic medications. All prior authorization for psychotropic medications will be voided by this medical report. Therefore, please list the child’s complete proposed psychotropic medication profile below.

Note: Mark the A/C/D column appropriately for (A) adding a new medication to be authorized, (C) continuing a medication the child is currently taking or will be taking prior to court authorization, or (D) discontinuing a medication the child is currently taking. If discontinuing, please include the discontinuation plan under “expected length of treatment.”

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<thead>
<tr>
<th>A/C/D</th>
<th>MEDICATION NAME</th>
<th>START DOSE</th>
<th>DOSAGE RANGE</th>
<th>TARGET SYMPTOMS</th>
<th>SIDE AFFECTS CAREGIVER SHOULD MONITOR</th>
<th>TITRATION PLAN / EXPECTED LENGTH OF TREATMENT</th>
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(Please cross out any unused lines.)

Please also list any non-psychotropic medications known to you that the child is currently taking: ________________________________

___________________________________________________________________________________________________________
SECTION 7: CERTIFICATION IF SIGNIFICANT HARM:

I, the physician, have reviewed all medical information concerning this child provided to me by DCF/CBC and/or the child’s caregivers, and certify that a delay in providing the prescribed psychotropic will more likely than not cause significant harm to the child:

(1) _______ (Initial here) I find that it is more likely than not that any delay in taking this medication would cause significant harm to this child. I recognize that this finding statutorily pre-authorizes the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. The Department must then notify all parties within 3 working days, and must seek a court order at the next court hearing or within 30 days.

Delay in taking the psychotropic medication(s) will more likely than not harm the child for one or more of the following clinical conditions:

_______ (Initial here) The child is deemed a clear and present danger to himself/herself.

_______ (Initial here) The child is deemed a clear and present danger to others.

_______ (Initial here) The child’s behavior is deemed so chaotic, disorganized and/or impulsive that, without immediate psychotropic medication intervention, the child’s current school or placement will likely be disrupted and the child will be forced to move to another living or educational setting.

Please provide detailed explanation of the nature and extent of harm the child will likely experience:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

(2) _______ (Initial here) This child is currently in a hospital, crisis stabilization unit, or psychiatric residential treatment center. I recognize that this finding statutorily pre-authorizes the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. A court order must then be sought within 3 working days.

SECTION 8: DRUG INFORMATION

By law, medical information covering the recognized side effects, risks, contraindications, drug-interaction precautions, and possible effects of stopping FOR EACH MEDICATION LISTED IN THIS PROPOSED MEDICATION PROFILE must be attached to this medical report. Medical reports without such information attached cannot be filed with the court.


Please attach the appropriate information for all psychotropic medications in the child’s proposed medication profile. (Non-psychotropic medications need not have information attached.)

_______ (Initial here) I have provided a copy of the attached medical information to the child, if age appropriate, and to the child’s caregiver. I have also discussed this information with the child, if age appropriate, in age-appropriate terms, and with the child’s caregiver.
SECTION 9: SUPPLEMENTAL INFORMATION. Please write below or attach any supplemental information that might explain or support this medical report.

SECTION 10: SIGNATURE OF PHYSICIAN

By signing this document, I am certifying that I have reviewed all medical information concerning the child which has been provided, and I am certifying that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child’s diagnosed medical condition, as well as the behaviors and symptoms the medication, and its prescribed dosage, is expected to address.

____________________________________________________  License: __________
(Print Name)                                             

Emergency Contact Telephone Number of Physician
SECTION 11: INFORMED CONSENT BY PARENT OR GUARDIAN

To be completed by parent or guardian in consultation with the physician.

By signing this section I am certifying that I am a parent or guardian of the above-named child, and that the physician has explained to me each of the following (initial each):

- the reason for treatment;
- the proposed treatment;
- the purpose of the treatment to be provided;
- the common risks, benefits, and side effects of the treatment;
- the specific dosage range for the medication;
- alternative treatment modalities;
- the approximate length of care;
- the potential effects of stopping treatment;
- how treatment will be monitored.

Further, by signing this section I am certifying the following (initial each):

- The physician has fully answered all of my questions about this medical report.
- I understand that I am not required to consent to this medical report. The Department may after consultation with the prescribing physician, seek court authorization to provide the psychotropic medication to the child.
- I understand that any consent given for medical report may be revoked orally or in writing before or during the treatment period by a person who is legally authorized to make health care decisions on behalf of the child, and the Department will then be required to obtain a court order to continue the child on the medication.

_______________________________________  _________________________
Signature of parent or guardian  Relationship to Child

____________________
Date

________________________________________
Print Name
DATE: ____________________________

TO: ______________________________
ATTORNEY: ________________________

FAX #: ____________________________
JUDGE: ___________________________

FROM: ____________________________
PROVIDER: ________________________

CELL PHONE #: ____________________
FAX #: ____________________________

CHILD’S NAME: ____________________
DOB: ______________________________

CASE NUMBER: ____________________

Is the child already taking the requested medication? □ Yes □ No __________:___________________

When did the child start taking the medication? ____________________________________________

List ALL other known medications/street drugs and the current dosages (if not attached):
__________________________________________________________________________________
__________________________________________________________________________________

Describe IN DETAIL the symptoms/behaviors that suggest the need for medication (do not just recite the diagnosis):
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Who reported these symptoms? ________________________________________________________

When were these symptoms first noticed? ________________________________________________

Is the child in therapy? □ Yes □ No How often does the child attend therapy? ____________

Therapist information: ________________________________________________________________

Has the therapist been consulted regarding the need for medication? □ Yes □ No
Mother’s name: _____________________________________________________________________

Was she consulted? □ Yes □ No If no, why not? ______________________________________

Does she agree to meds? □ Yes □ No If no, why not? ______________________________________

Father’s name: _____________________________________________________________________

Was he consulted? □ Yes □ No If no, why not? ______________________________________

Does he agree to meds? □ Yes □ No If no, why not? ______________________________________

What is the name of the person who was notified about the medication and treatment plan?
_________________________________________________________________________________

When is the next medication management appointment? ________________________________

Name of the doctor doing medication management: ____________________________________

Please ensure that the Doctor’s medical statement/psychotropic medication treatment plan is attached

Case Manager’s Signature ___________________________ Date _______________________

Supervisor’s Signature ___________________________ Date _______________________

CF-FSP 5340, August 2009                             CFOP 155-10/175-40
Threshold Criteria

Each child being considered for referral for a suitability assessment must meet one or more of the conditions described in Sections A and one or more of the CFARS problem severity ratings in Section B. The CFARS ratings in Subsection B-1 should be provided also, but they should be considered only as supplementary risk factors or functional impairments related to the child’s serious emotional disturbance as described in Section B. This form will be completed by the Community Based Care Lead Agency Service Worker with assistance from the child’s mental health case manager.

A. Attempts to treat child in the community: (check all that apply)

☐ A comprehensive service plan developed by a multidisciplinary team was implemented. A case manager coordinated the provision of the services, and the services were not successful in treating the child’s condition; and/or

☐ The child was placed in a Specialized Therapeutic Foster Home program or other community-based therapeutic setting for treatment and the placement was not successful in treating the child’s condition; and/or

☐ The child’s condition is so severe and the situation so urgent that treatment can not be safely attempted in the community.

B. Serious emotional disturbance: Insert the number ratings from the most recent CFARS and attach the CFARS two-page summary sheets. A rating of 7 or above on one or more of the following areas generally indicates a child with a serious emotional disturbance.

_____ DEPRESSION (unipolar, dysthymia, bipolar)

_____ ANXIETY (panic attacks, obsessive-compulsive disorders)

_____ THOUGHT PROCESS (schizophrenia, psychotic disorders, hallucinations)

_____ TRAUMATIC STRESS (intrusive thoughts, hyper-vigilance)

_____ DANGER TO SELF (recent suicidal gestures or attempts, head-banging)

B-1: Supplementary information: Insert the number ratings from the most recent CFARS and attach.

_____ DANGER TO OTHERS

_____ COGNITIVE PERFORMANCE

_____ HYPERACTIVITY

_____ MEDICAL/PHYSICAL

_____ SUBSTANCE USE

_____ INTERPERSONAL RELATIONSHIPS

_____ BEHAVIOR IN “HOME” SETTING

_____ ADL FUNCTIONING

_____ SOCIO-LEGAL

_____ WORK OR SCHOOL

_____ SECURITY MANAGEMENT NEEDS
Referral for Suitability Assessment – Sample Letter

DATE:

TO:  (Agency for Health Care Administration contracted provider)

FROM:  (Single Point of Access), Circuit ________

Attached is a referral on behalf of (child’s name) ________________ to determine if:

1. This child has an emotional disturbance serious enough to require residential mental health treatment,
2. The child is reasonably likely to benefit from the residential treatment, and,
3. All available treatment options less restrictive than residential treatment have been considered and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

I have reviewed the attached referral information for completeness and am requesting that you provide me with the name, phone number and mailing and street address of the Qualified Evaluator you have selected to perform the assessment. Upon receiving that information, I will immediately send to the Qualified Evaluator the entire referral packet, including attachments, for review before the suitability assessment appointment.

Please ask the Qualified Evaluator to call __________________________, the child’s Community Based Care Lead Agency Child Welfare Service Worker, at (____) ____-______ to schedule the appointment, to give directions to the Evaluator’s office, and to confirm transportation arrangements to the appointment.

Please provide a copy of your findings and any additional supporting information to me at the following address:____________________________________________________

____________________________________________________

I will then share the report with the Community Based Care Lead Agency Child Welfare Service Worker who will inform the guardian ad litem and the court. If you have any questions about the referral, please call me at (____) ____-______.
REFERRAL FOR MENTAL HEALTH SERVICES

☐ COMMUNITY MENTAL HEALTH SERVICES  ☐ MENTAL HEALTH CASE MANAGEMENT  ☐ RESIDENTIAL MENTAL HEALTH SERVICES

Child information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #:</td>
<td>Gender: ☐ Male ☐ Female</td>
</tr>
<tr>
<td>Medicaid ID #:</td>
<td>Race/ethnicity:</td>
</tr>
<tr>
<td>Current school:</td>
<td>Current grade:</td>
</tr>
</tbody>
</table>

Legal Status (as reported in FSN):

Parent or legal guardian information: (This is the biological or adoptive parent or relative or other adult appointed by the court as legal guardian, not the DCF staff, foster parent, or shelter):

<table>
<thead>
<tr>
<th>Name of parent or legal guardian:</th>
<th>Mailing address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street address:</td>
</tr>
<tr>
<td>Daytime phone:</td>
<td>Directions:</td>
</tr>
<tr>
<td>Evening phone:</td>
<td></td>
</tr>
</tbody>
</table>

Child’s current living arrangement: Complete this section if child is not living with the parent or legal guardian.

<table>
<thead>
<tr>
<th>Name of current caregiver:</th>
<th>Daytime phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evening phone:</td>
</tr>
<tr>
<td>Type of setting:</td>
<td>Mailing address:</td>
</tr>
<tr>
<td>☐ Shelter ☐ Foster home ☐ Group home</td>
<td></td>
</tr>
<tr>
<td>☐ Therapeutic foster home ☐ Therapeutic group home</td>
<td></td>
</tr>
<tr>
<td>☐ Residential treatment center ☐ Acute hospital</td>
<td></td>
</tr>
<tr>
<td>☐ Crisis unit ☐ Psychiatric hospital ☐ Detention</td>
<td></td>
</tr>
<tr>
<td>☐ Other (specify) ________________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Street address:</td>
</tr>
<tr>
<td></td>
<td>Directions:</td>
</tr>
</tbody>
</table>

Community Based Care Lead Agency Child Welfare Service Worker: Complete this section if child has a Community Based Care Lead Agency Service Worker; if not, place “N/A” next to “name.”

<table>
<thead>
<tr>
<th>Name:</th>
<th>Mailing address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>Pager or cell phone #:</td>
<td>E-mail address:</td>
</tr>
<tr>
<td>Supervisor name:</td>
<td>Supervisor phone #:</td>
</tr>
</tbody>
</table>

Summary of permanency or transition plan goals for the child:

CF-MH 1055, Jan 2004
Guardian Ad Litem: Complete this section if child has a Guardian Ad Litem; if not, place “N/A” next to “name.”

<table>
<thead>
<tr>
<th>Name</th>
<th>Mailing address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone #</th>
<th>Pager or cell phone #</th>
<th>E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Juvenile Probation Officer: Complete this section if child has a Juvenile Probation Officer; if not, place “N/A” next to “name.”

<table>
<thead>
<tr>
<th>Name</th>
<th>Mailing address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
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<tr>
<th>Phone #</th>
<th>Pager or cell phone #</th>
<th>E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child’s mental health information:

<table>
<thead>
<tr>
<th>Current prescribed medications</th>
<th>Current DSM-IV diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug name</td>
<td>Axis I.</td>
</tr>
<tr>
<td>Dosage &amp; frequency</td>
<td>Axis II.</td>
</tr>
<tr>
<td>Dates used</td>
<td>Axis III.</td>
</tr>
<tr>
<td></td>
<td>Axis IV.</td>
</tr>
<tr>
<td></td>
<td>Axis V. (GAF):</td>
</tr>
<tr>
<td></td>
<td>Prescribing physician name &amp; phone #:</td>
</tr>
<tr>
<td></td>
<td>Diagnosing professional’s name &amp; phone #:</td>
</tr>
</tbody>
</table>

Reason for referral for treatment: In your own words, describe the child’s need for mental health services. Please describe specific behaviors the child is exhibiting.

Desired treatment outcomes: In your own words, describe the results you want for the child from receiving mental health treatment.

Summary of discharge plan: (include specific caregiver and living arrangements):
Required documents attached: Check all the documents that are attached. If not available, please explain why.

- Threshold criteria (Appendix A to CFOP 155-10)
- Comprehensive Behavioral Health Assessment
- Most recent CFARS (completed by the mental health professional working with the child)
- Previous mental health treatment (types of services/facilities, dates of admission & discharge, outcomes)
- Shelter petition, shelter order, or foster care order
- Pre-Disposition Summary
- Case plan
- Individual Educational Plan and/or 504 Plan
- Multidisciplinary service plan, including outcomes
- Summary of foster care placement(s) (List child’s foster care placement(s), reasons moved, and dates.)
- Summary of Juvenile Justice involvement (List delinquency charges, dispositions, and dates.)
- Department consent for treatment
- Parent or legal guardian consent for psychotropic medication or court order
- Statement of Medical Stability (Appendix F to CFOP 155-10) – for referrals to SIPPs
- Other – attached (please describe): _____________________________________________________________

Additional comments or information regarding this child’s referral:

Return the completed form and attachments to:

Complete the following section only for children being referred for a suitability assessment for possible treatment in a residential treatment center/hospital or therapeutic group home:

We, the undersigned, believe that ____________________________, a child in the custody of the Department of Children and Families, has a severe emotional disturbance and may need residential treatment, pursuant to Section 39.407, Florida Statutes.

Community Based Care Lead Agency Child Welfare Service Worker

___________________________________________________ Date: _____/_____/____

Community Based Care Lead Agency Supervisor:____________________________________________________ Date: _____/_____/____

Next level supervisor:________________________________________________________ Date: _____/_____/____

I certify the referral form and packet for suitability assessment are complete:

__________________________________________________________ Date:_____/_____/____

Single Point of Access

Copy to:
STATEMENT OF MEDICAL STABILITY

Child’s Name: _________________________________    Date of Birth: _______________

Social Security #: ___________________________

I, ______________________________________________, have examined the above child and have determined that he or she is currently in good physical health with no acute or chronic conditions requiring extensive medical treatment, and the need for medical care, other than routine, is not anticipated.

__________________________________________ __________________
Health Care Provider’s Signature Date

**PLEASE ATTACH A COPY OF THE PHYSICAL EXAM THAT HAS BEEN DONE WITHIN THE LAST 30 DAYS**
REFERRAL FOR A 90-DAY REVIEW FOR SUITABILITY OF SERVICE: RESIDENTIAL TREATMENT

DIRECTIONS:
This review is required for children placed in a 395 or a 65E-9 licensed facility that are in the custody of the Department of Children and Families (DCF). The time frame for completion of the suitability assessment is 70-75 days after admission and every 90 days thereafter. Each child in the custody of the Department placed in this type of facility is subject to a judicial review of treatment pursuant to F.S., 39.407. The authorization section within this document serves as a release from the Department to allow the designated Qualified Evaluator access to the child for a face-to-face interview and to the child’s clinical record for a record review.

Please complete this form and fax it to the attention of the QEN Coordinator at First Health Services of Florida: 800-639-8982.

Referring Circuit: ___________________________    Today's Date: ________________

SINGLE POINT OF ACCESS

NAME:
ADDRESS 1:
ADDRESS 2:
CITY/STATE/ZIP:
PHONE:    FAX:

CHILD’S NAME | SSN | MEDICAID # | DOB

FACILITY WHERE THE CHILD IS PLACED

NAME:
ADDRESS 1:
ADDRESS 2:
CITY/STATE/ZIP:
PHONE:    FAX:

SIPP REFERRED?  ☐ Yes  ☐ No    DATE OF SAMHIT: _______________________

LAST REVIEW DATE: _______________________

CF-MH 1057, Jan 2004
AUTHORIZATION OF SUITABILITY ASSESSMENT BY A QUALIFIED EVALUATOR

Pursuant to Section 39.407(5)(g)2., Florida Statutes, Dr. ________________________________, a Qualified Evaluator contracted by First Health, Inc., is authorized to have access to the child, to members of the child’s treatment team and to the child’s clinical records for the purpose of producing a report to the Department of Children & Families. The Qualified Evaluator is a Florida-licensed psychiatrist or psychologist with at least three years' experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents. The Department will submit to the dependency court the Qualified Evaluator’s report, which will summarize the child’s progress toward achieving the goals and objectives of the individualized treatment plan that is on file with the court.

Authorization beginning date: ____/____/____ (valid for 90 days)

If there are any questions about this authorization, please contact me at (____) ____-______.

Thank you for your cooperation.

Sincerely,

________________________________________
(name)

________________________________________
(title)

Substance Abuse & Mental Health Office
Circuit _____
Process Flow for Psychotropic Medication: Continue At Removal and During First 28 Days

1. Need
   - May Need To Continue Psychotropic Medication

2. Determine / Confirm
   - Physician Seeks Express And Informed Consent To Continue Psychotropic Medication
   - May Order Additional Medical Consultation If Parent/Legal Guardian Requests

3. Obtain
   - Follow Court Order To Taper Or Immediately Discontinue Medications

4. Authorize / Notify / Document
   - Authorize/Administer
   - Please Note Legal Guardian Authorization Obtained
   - Document In Record Reason If Parent’s Authorization Not Obtained

5. Seek / Notify / Document
   - Administer Medication
   - Notify Court Of Medical Status
   - Follow Action Steps Indicated During Staffing

6. Authorize
   - Authorizes To Continue Up To 28 Days, Arraignment?

7. Follow / Hold
   - Follow Physician’s Directions For Discontinuing Medication

8. Administer
   - Administer Medication

9. Inform Seek / Notify / Evaluate
   - Objection To Motion? (File Within 2 Working Days)

10. Recommend / Follow
    - Negotiate/ Follow

11. Seek
    - Conduit case staffing to assess recommendation for medication based on physician’s documentation (Include Children’s Legal Services)

12. Obtain
    - Document Express & Informed Consent
    - Notify Court Of Medical Status

13. Notify / Document
    - Complete And File Motion For Continuing Medication At Same Time As Dependency Petition (Return Medical Report
    Notify Within 48 Hours All Parties That Motion Has Been Filed

14. Object
    - Objection To Motion? (File Within 2 Working Days)

15. Hold
    - Court Holds Hearing

16. Authorize / Follow / Hold
    - Court Authorizes Medication

17. Follow
    - Follow Physician’s Recommendations For Medication And Treatment

18. Administer
    - Ensure Caregiver Receives Information To Appropriately Administer Medication
Process Flow for Psychotropic Medication: Initiate or Change While Child Is In Care

6. REPORT

- Medical Report
- If Child ≤ 5 Or Under, Conduct Pre-consent Review

7. COMPLETE /