

Chapter HSS 37

INFORMATION TO BE PROVIDED TO FOSTER PARENTS

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HSS 37.01 Authority and purpose. This chapter is promulgated under the authority of s. 895.485 (4) (a), Stats., to specify the kinds of information about all foster children that the child's placing agency is to provide to the child's foster parent, treatment foster parent or family-operated group home parent, in order to maintain and promote the health, safety and welfare of the foster child and of the foster parent, treatment foster parent or family-operated group home parent and their other family members and to ensure that foster parents can be as effective as possible in providing appropriate care for the foster child because they have received full information about the child from the placing agency.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

HSS 37.02 Applicability. (1) **SCOPE.** Except as provided in sub. (2), all requirements contained in this chapter shall be met by all agencies authorized under s. 48.57 or 48.61, Stats., to place children in foster care.

(2) **EXCEPTION.** (a) A placing agency may make an exception to the provision of any kind of information required under this chapter provided that:

1. The information is confidential, the agency does not have access to the information and the agency has made a reasonable effort to obtain the information through appropriate releases of information; or

2.a. The exception does not jeopardize the health, safety or welfare of the foster child, the foster parent, the treatment foster parent or the family-operated group home parent or the community; and

b. The information is not critical to the success of the placement and related treatment or services or the purposes described in s. HSS 37.01.

(b) Any exception made by a placing agency to a requirement under this chapter shall be documented in detail and included in the narrative section of the child's case record. The documentation shall include the specific information that was not provided to the foster parents, the reasons for not providing the information, the name of the agency representative who made the decision to not provide that information, the date the decision was made and written approval by that person's supervisor.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

HSS 37.03 Definitions. In this chapter:

(1) "Allegation" means a charge or statement made by any party regarding a foster child or the child's family which is known to the agency and which has not been proven or for which there is no known substantiating evidence or support, but does not include:

(a) An interpretation of information made by a professional individual involved in the child's treatment;

(b) Any charge or statement which, in whole or in part, formed the basis for the child's removal from his or her home; or

(c) In the case of a delinquent, any additional charges read into the record at the time of adjudication.

(2) "AODA" means alcohol or other drug abuse.

(3) "CAN" means child abuse or neglect.

(4) "Child's family" means, unless otherwise indicated, the child's biological or adoptive family.

(5) "CHIPS" means a child in need of protection or services as defined in s. 48.13, Stats.

(6) "Department" means the Wisconsin department of health and social services.

(7) "Family-operated group home" means a facility which is providing care and maintenance for 5 to 8 children and is operated by one or more persons required to be licensed under s. 48.625, Stats., who do not operate another group home and do not operate the home for a corporation or agency.

(8) "Foster child" means a child placed for care and maintenance in a foster home by the department, a placing agency or a court.

(9) "Foster home" means any facility operated by a person required to be licensed under s. 48.62 (1) (a) or (b), Stats., that provides care and maintenance for no more than 4 foster children unless all of the children are siblings, or any family-operated group home licensed under s. 48.625, Stats.

(10) "Foster parent" means a person licensed under s. 48.62 (1) (a) or (b), Stats., with primary responsibility for the care and supervision of foster children placed in his or her home, or a parent in a family-operated group home licensed under s. 48.625, Stats.

(11) "Information" means data relating to the medical, physical, mental or emotional condition of a child or the child's family that has been gathered for the purposes of assessing, adjudicating, placing, treating or providing services to the child. "Information" does not include allegations, except as provided in s. HSS 37.04 (3).

(12) "Placing agency" means the public or private agency authorized under s. 48.57 or 48.61, Stats., to place children in foster care.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

HSS 37.04 Information to be provided to foster parents. (1) (a) A placing agency shall enter on a face sheet and checklist included as Appendices A and B to this chapter all available information about a foster child that is called for by the face sheet and checklist or indicate on the face sheet or checklist that specific information was provided in some other form, such as in another document or verbally.

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(b) A placing agency shall make a reasonable attempt to gather any information required on Appendices A and B that the agency does not possess.

(2) Unless an exception has been made and documented under s. HSS 37.02 (2), a placing agency shall provide to a foster child's prospective or actual foster parents all available information included on the face sheet and checklist included as Appendices A and B to this chapter.

(3) An allegation regarding the foster child or the child's family shall not be provided to the foster parents unless the placing agency determines that, if substantiated, the allegation would have a significant impact on the health, safety or welfare of the foster child or the foster parents or the foster child's or foster parents' family or on the success of the placement and related services.

(4) Any allegation provided by the placing agency to the foster parents as information regarding a foster child shall be recorded in the child's case record along with justification for providing that information.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

HSS 37.05 Timing of providing information. When information about a child that is included in Appendices A and B to this chapter becomes known to the placing agency, the placing agency shall provide that information to the foster parents. If the information is known prior to the foster parents' agreement to the placement of the child or the actual placement of the child, the information shall be provided prior to the agreement or actual placement. Information not available to the placing agency prior to the foster parents' agreement to the placement or the actual placement shall be provided to the foster parents within 7 working days after the placing agency's receipt of the information or, if the placing agency determines that the information obtained is of critical importance to the health, safety or welfare of the foster child or the foster parents, within 3 working days after receipt of the information.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

HSS 37.06 Confidentiality. (1) At the time that any information regarding a foster child is first provided to the foster parents by the placing agency, the placing agency shall inform the foster parents of all confidentiality requirements mandated under state or federal law, including the requirements under ss. 48.396, 48.78, 48.981 (7), 51.30, 118.125, 146.025, and 146.82, Stats., and any placing agency policy, and penalties which may be imposed for violating the rights to confidentiality of the foster child and the foster child's family.

(2) The placing agency providing information about a foster child may require that the information and any related documents be maintained by the foster parent in a manner which would prohibit access to the information by the foster child, any other foster children or any other party whose access to the information is prohibited.

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95.

APPENDIX A
FACE SHEET
FOR CHILD IN FOSTER CARE

Date of Placement: / /

Child's Name: _____	Nickname(s): _____
DOB: <u> </u> / <u> </u> / <u> </u>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: _____
Cultural Identification (as indicated by child if old enough): _____	
Height: _____	Weight: _____ lbs.
Religious Preference (of child or family): _____	
Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): _____	

Child's Social Worker With Whom Foster Parent Will Have Contact:	
Name: _____	Title: _____
Agency: _____	
Agency Secondary Contact (if social worker not available): _____	
Telephone: Regular Hours: () _____	After Hours: () _____

Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s):
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS:
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors?
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a:

- Voluntary Placement
 Court-ordered Placement

Medical Assistance #: _____

Insurance Company (if any): Name _____

Telephone: () _____

Policy #: _____ Group #: _____

Physician: _____ Type: _____

Address: _____

Telephone: () _____

Dentist: _____

Address: _____

Telephone: () _____

Other Health Specialists/Therapists

Name: _____ Telephone: () _____

Specialty: _____

Name: _____ Telephone: () _____

Specialty: _____

Preferred Hospital: _____

(Note: Use of hospital may be dictated by insurance company/plan)

Is foster parent expected to participate in therapy with the child? Yes No

Name of Child's (Check most appropriate one)	<input type="checkbox"/> Birth Mother: <input type="checkbox"/> Stepmother: <input type="checkbox"/> Adoptive Mother:
Address: _____	
Telephone: () _____	
Name of Child's (Check most appropriate one)	<input type="checkbox"/> Birth Father: <input type="checkbox"/> Stepfather: <input type="checkbox"/> Adoptive Father:
Address: _____	
Telephone: () _____	
Child's Siblings:	
Name: _____	DOB: / / Phone: () _____
<input type="checkbox"/> At home <input type="checkbox"/> Out of home (where: _____)	
Name: _____	DOB: / / Phone: () _____
<input type="checkbox"/> At home <input type="checkbox"/> Out of home (where: _____)	
Name: _____	DOB: / / Phone: () _____
<input type="checkbox"/> At home <input type="checkbox"/> Out of home (where: _____)	
Significant Extended Family Members (Name, Phone and Relationship):	
Legal Custodian: _____	
Relationship: _____	
Address: _____ Phone: () _____	
GAL / Legal Counsel: _____	
Address: _____	
Telephone: () _____	
*Guardian ad litem	

Significant individuals who may be having contact with the child:

<u>Name</u>	<u>Phone</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Individuals whose contact with the child is forbidden or restricted
(e.g., supervised visitation)

<u>Name</u>	<u>Relationship</u>	<u>Type of Restriction</u>	<u>Rationale (e.g., court order, parents' wishes)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Should you have any questions about contacts, please call the child's social worker.)

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))

<u>Type (FH, GH, RCC/CCI, hospital, etc.)</u>	<u>Name</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Attending or Will Attend: _____
Telephone: () _____ Grade: _____
Is child enrolled in a special education program? ____ Yes ____ No
If yes, what type: _____
Contact Person: _____

Day Care or Respite Provider(s)

Phone: () _____

Phone: () _____

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)? Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

- | | | |
|--|---|---|
| <input type="checkbox"/> Birth certificate (copy),
if available | <input type="checkbox"/> Medical records/summary | * <input type="checkbox"/> Social history/summary |
| * <input type="checkbox"/> Court order | <input type="checkbox"/> Permission to operate
hazardous machines | <input type="checkbox"/> Social Security Card |
| * <input type="checkbox"/> Court report/summary | <input type="checkbox"/> Placement Agreement | * <input type="checkbox"/> Summary of social/
psychiatric
evaluations |
| * <input type="checkbox"/> Dental records/summary | * <input type="checkbox"/> School academic
records/summary | <input type="checkbox"/> Summary of mental
health treatment |
| <input type="checkbox"/> Information on child's
specific diagnosis and/or
disability | <input type="checkbox"/> School and community
activity permissions | |
| <input type="checkbox"/> MA card | <input type="checkbox"/> Signed medical release
for emergency health
care | |

* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.

APPENDIX B

CHECKLIST FOR CHILD IN FOSTER CARE

	Yes	No	NK *	If "Yes", please comment
1. Previous hospitalizations				
a. Was anesthesia used?				
b. Problems with anesthesia?				
2. Previous serious illnesses or injuries				
3. Has child had any other medical tests (e.g., CAT Scan, EEG, MRI)?				
4. Taking any medication including birth control pills or the use of birth control devices which require a prescription or other involvement of a physician? (If "Yes", name of medication, dosage, reason, prescription or over the counter, how given, by whom, who prescribed).				
5. immunizations (Indicate date(s))				Dates (s)
DPT (infants)(Diphtheria, Pertussis, Tetanus)				
Polio (type: TOPV-Oral or IPV-Injectable)				
MMR (Measles, Mumps, Rubella)				
Flu				
Pneumonia				
Hepatitis B				
6. Significant biological family medical history: (e.g., cancer, heart problems)				
7. Medical needs				
Apnea monitor				
Gastrostomy				
Tracheotomy				
Ventilator				
Heart monitor				
Other (specify)				
8. Degenerative disorder				
9. Allergies, including animals, insect bites/stings, soap, wool, food, drugs, milk. (If "Yes", to what, symptoms, treatment)				
10. Child has or ever had the following: (If yes, date child had it)				Date(s)
7-day Measles				
3-day German Measles				
Chicken Pox				
Rubella				
Mumps				

(continued on next page)

* NK = Not Known At This Time

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	Yes	No	NK *	If "Yes", please comment
Whooping Cough				
Scarlet Fever				
Strep Throat				
Impetigo				
Lice				
Worms				
Sexually Transmitted Disease				
Hepatitis B				
Polio				
Pneumonia				
Mononucleosis				
Scabies				
Other				
11. Current dental problems				
Braces or retainers?				
Bridges or dentures?				
Last dental exam date? _____				
12. Appetite above or below normal				
Balanced diet				
Unusual eating patterns/habits (e.g., large sugar intake, no vegetables)				
13. Abdominal Concerns				
Has had an ulcer or heartburn				
Child regularly uses Tums or other antacid				
Frequent nausea or vomiting				
Child drinks caffeinated coffee or cola. How much per day?				
Has had "yellow jaundice" or liver disease				
Gets abdominal pain				
Child uses laxatives. How often?				
Becomes constipated or gets diarrhea				
Has had blood in stool recently				
Special diet needs (religious, medical, philosophical, vitamin/mineral supplements, etc.)				
14. Anorexia/bulimia/other eating disorders. Ever had treatment?				

* NK = Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
15. Headaches				
Migraine				
16. Coordination or balance problems/dizziness				
Has had serious head injury or loss of consciousness				
Numbness or loss of strength in hand, arm or leg				
Any trouble with swallowing or speaking				
17. Has had a seizure				
Has had epilepsy				
Type and frequency of seizures				
How to respond				
Controlled or uncontrolled				
Ever hospitalized for seizures				
Ongoing medicines for seizures				
18. Does child wear glasses? If yes, for how long?				
Last eye exam (date, Dr.'s name)				
Blurred or double vision				
Contact lenses				
19. Has hearing problem				
Ringing in ears				
Discharge or infection in ears				
Tube(s) in ears				
20. Blocking of nose, discharge, post-nasal drip				
Nose bleeds				
Persistent hoarseness				
21. Treatment for skin trouble, rashes, hives, acne, or breaking out				
22. Has had bursitis, sprain or dislocation of bone or joint				
Cramps or pain in legs				
Backaches				
Arthritis				
23. Thyroid problems				
24. Child has had test for AIDS/HIV (If yes, date: _____)				Results:
25. Child has had test for Hepatitis (If yes, (date: _____)				Results:

* NK = Not Known At This Time

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	Yes	No	NK *	If "Yes", please comment
26. Chest pain or discomfort/heart concerns				
Asthma or wheezing				
Cough, phlegm, bronchitis				
Has coughed up blood				
Smoke? If yes, how long? How much?				
TB skin test. If yes, when? Results?				
Heart trouble				
Rheumatic Fever				
Has had electrocardiogram (EKG)				
Has had chest X-ray. If yes, when was last one?				
Heart murmur				
High or low blood pressure. Last check up?				
Irregular heart beat				
Shortage of breath				
Swollen ankles				
How many pillows does child sleep on?				
27. Urinary or prostate problems/Gall bladder				
Incontinence, urine or fecal				
Bleeding or burning when urinating				
Abnormally frequent urination				
Has had kidney or gall bladder stone				
28. Anemia				
29. Blood problems				
30. Cancer, leukemia, or other malignancy				
31. History of abusing or not taking prescribed medications				
32. Alcohol use or abuse				
33. Other drug use or abuse				
AODA treatment				
34. Is child menstruating?				
Child understands menstruation				
Child's periods are normal				
Excessive cramping or pain				
PMS symptoms				
Medication for cramps. If yes, what medication?				

(continued on next page)

* NK = Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Bleeding or discharge other than when menstruating				
Has had a "yeast" infection				
Has had a "Pap" test. If yes, when? Why? Abnormal results?				
35. Child has physical or developmental disabilities				
If yes, what type of disability?				
Autism				
Blindness				
Cerebral Palsy				
Deafness				
Dyslexia				
Emotional Disturbance				
Epilepsy				
Fetal Alcohol Effect				
Fetal Alcohol Syndrome				
Mental Retardation				
Muscular Dystrophy				
Neurological Impairment				
Physical Impairment				
Other (specify):				
Restrictions on Activities (e.g., lifting, driving, riding bikes)				
Special equipment (e.g., cane, walker, wheelchair)				
36. Considering the age of the child, his/her abilities are are not appropriate for:				
Bathing				
Feeding				
Toileting				
Dressing				
Learning				
Receptive Language				
Mobility				
Danger Awareness				

(continued on next page)

* NK = Not Known At This Time

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	Yes	No	NK *	If "Yes", please comment
Social/Emotional Functioning				
Capacity for Independent Living				
Other (specify):				
37. Limitations in verbal skills. (If yes, also check a or b below)				
a. Child is non-verbal				
b. Child has very limited verbal skills				
38. History of behavioral or emotional problems				
39. History of treatment for behavioral or emotional problems at a clinic or hospital				
40. Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below)				
Depression				
Anxiety				
Mood swings				
Suicide attempts				
AODA				
Mental Health				
41. Has the child ever:				
Felt hopeless or depressed				
Had unexplained crying spells				
Planned or attempted suicide				
Had peculiar or bizarre thoughts				
Had trouble eating or sleeping (either too much or too little)				
Had an excess of energy or activity				
Felt like hurting him/her self				
Displayed reckless or dangerous behavior				
Heard things no one else around him/her heard				
Shown inappropriate emotions (reactions that didn't make sense in the situation).				
Assaulted anyone physically (if yes, who, how recently, and how severely).				
Assaulted anyone sexually (if yes, who, how recently, and how severely).				
Assaulted or abused animals				

* NK = Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
42. Child has had any of the following problems at home or in the community.				
Withdrawing socially (doesn't want to be around other people)				
Lying or stealing				
Arguing or fighting with peers or siblings				
Clinging excessively to a parent, teacher or other person				
Problems with police				
Setting fires				
Refusing to follow instructions from parents or obey house rules, etc.				
43. Child ran away in past. (If yes, answer below)				
For how long?				
From where did child run?				
Where did child go?				
How was child returned? (Voluntarily, law enforcement, social worker?)				
Why did child run?				
Did/does child run alone or with others?				
44. Child has had any of the following problems at school				
Poor grades				
Difficulty making friends				
Suspensions from school				
Fighting or arguing with peers or teachers				
Frequent lying or stealing				
Frequent truancy (including cutting classes)				
45. Child has trouble sleeping. If yes, answer below:				
Child takes sleeping pills. If yes, how often?				
General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe:				

* NK = Not Known At This Time

	Yes	No	NK •	,if "Yes", please comment
46. Child has fears/phobias. If yes, answer below: Darkness Animals Cars Loud noises Heights Water (e.g., swimming pools, baths, lakes) Weather (e.g., wind, thunder, storms) Other (specify)				
47. Child has a history of making abuse allegations against care providers				

• NK = Not Known At This Time

The information included herein and the form have been shared with the foster parent. The foster parents have been made aware of the laws regarding confidentiality and the limitations on sharing any of this information with individuals or agencies not involved in the case of this child and/or his/her parents.*

Signature of Staff Person Providing Information

Date

Signature of Foster Parent

Date

Signature of Foster Parent

Date

(Two copies should be made and signed. Foster parents should keep one copy in the child's file, and the placing agency should keep one copy in the child's case record.)

* In accordance with ss. 48.396, 48.78, 48.981(7) and other relevant sections of Wisconsin Statutes.