ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 90 ADM-21

DIVISION: Family and Children Services

TO: Commissioners of Social Services
Directors of Voluntary Child Caring Agencies

DATE: July 6, 1990

SUBJECT: Foster Care: Medical Services for Children in Foster Care

SUGGESTED DISTRIBUTION:	Directors of Services Children's Services Staff Medical Assistance Staff Staff Development Coordinators
CONTACT PERSON:	Program questions - your Regional Office Director: Albany - John O'Connor, (518) 432-2751; Buffalo - Linda Brown, (716) 847-3145; Metropolitan - Fred Cantlo, (212) 804-1202; Rochester - Linda Kurtz, (716) 238-8200; Syracuse - Jack Klump, (315) 428-3235. Systems-related questions - Gerald Seeley, Bureau of Services Information Systems, 1-800-342-3727, ext. 2-2937. Medical Assistance/C/THP questions - Barbara Meg Frankel, 1-800-342-3715, ext. 3-4054.
ATTACHMENTS:	There are no attachments to this release.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs. 18 NYCRR Parts 357	Soc. Serv. Law & Other Legal Ref.	Manual Ref. C/THP Program	Misc. Ref.
75 ADM-73	76 ADM-5	428	SSL 365-a	Manual	
81 ADM-10	84 ADM-40	441	SSL 366		
84 ADM-4		442	SSL 373-a	1988	
87 ADM-22		447	SSL 398	Model	
88 ADM-40		448		Foster	
		463	Public	Parents	
		507	Health Law	Manual	
		508	Article 27		
				Standards	
			PL 101-239	of Payment	
				Program	
				Manual	

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this directive is to inform you of the provisions of Department regulations which establish comprehensive standards for medical services for children placed in foster care. The regulations establish uniform requirements, consistent with current recommended medical practice, for the content and frequency of medical examinations. They also require documentation and monitoring of medical services through recording of medical service activities in the progress notes of the uniform case record and the entry of medical examination dates into the Child Care Review Service (CCRS).

II. BACKGROUND

New provisions in law, concern for the health status of all foster children, and a rising number of infants coming into foster care with serious health problems have contributed to the realization that the State Department of Social Services must address significant health services issues for children in foster care through new and amended regulations. As a result, standards for medical services for children were revised and promulgated in regulations which became effective on January 13, 1989.

Authority and mandate for such services is clear in the law. Section 366 of the Social Services Law requires that Medical Assistance be provided to an otherwise eligible child under the age of 21 years receiving care away from his or her own home. Medical Assistance is defined by Section 365-a of the Social Services Law to mean, in part, "payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, or result in illness or infirmity...."

Such care includes early and periodic screening and diagnosis of eligible persons under 21 years of age to determine any physical and mental disabilities and to treat such disabilities and conditions. The Child/Teen Health Plan (C/THP) in New York State meets the federal mandate for an Early Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

Further, Section 398 of the Social Services Law, which pertains in part to children in foster care, requires the commissioner of a local district to "provide for expert mental and physical examinations of any such child whom he has reason to suspect of mental or physical disability or disease and pay for such examination from public funds, if necessary" and to "provide necessary medical or surgical care in a suitable hospital...."

Another aspect of medical services, access to the child's medical history, is addressed in Section 373-a of the Social Services Law. Previously this law required the medical history of the child, to the extent available, to be provided to an adoptive or prospective adoptive parent and to the child discharged to his or her own care. Chapter 584 of the Laws of 1988 amended this law to extend provision of such information to foster parents. This change was effective Feb. 1, 1989.

III. PROGRAM IMPLICATIONS

A. Uniform Standards for Medical Services

Authorized agencies are responsible for providing comprehensive medical services for all foster children, for documenting such services, and for maintaining current records. The amended Department regulations now set standards based on currently recommended medical practice, sound casework practice, and required health services supervision.

Uniform standards for content and frequency of medical examinations follow the recommendations of the American Academy of Pediatrics of the American Medical Association. To assist authorized agencies in implementing the new medical services standards, the regulations:

1. consolidate regulatory references on medical services for foster children in Section 441.22 of Department regulations;

2. clarify and define the roles and responsibilities of local districts, voluntary agencies, foster parents, and medical providers, all of whom are involved in providing medical services for children in foster care;

3. specify responsibility for reporting and monitoring of medical services by authorized agencies;

4. clarify the requirement that Medicaid-eligible foster children be offered C/THP services;

5. provide for follow-up services after discharge from care;

6. list the individuals who must be provided the comprehensive medical history of the child, to the extent it is available.

B. Medical Examinations

Standards ensure that all foster children receive the full range of preventive and primary health care services, including diagnosis and treatment of neglected, chronic or acute medical conditions. The agency responsible for the child's care is also responsible for ensuring that the initial and periodic examination schedule is

followed. Emphasis is on the detection and treatment of any physical or emotional difficulties a child has while in foster care.

C. Informing Foster Parents

Effective casework practice has always included informing foster parents about local agency policies and procedures to be followed in providing medical services for children in their care. Now the law and regulations require that foster parents are provided with the comprehensive health history, to the extent known, of the child placed in their care. Sharing such information is not only required by law, but also enables foster parents to better anticipate the needs of the child in their care and encourages greater involvement in the child's health supervision and treatment plan.

Local agencies are encouraged to review their foster parent manual to be certain it provides foster parents with emergency contacts and procedures in accordance with Section 443.3(p) of Department regulations. (See 88-ADM-40, The 1988 Model Foster Parent Manual.)

In addition, foster care staff, working in cooperation with Medical Assistance staff, need to be well-informed about the range of medical services available in their communities, including psychological services, in order to assist foster parents in formulating a health care plan for the child and to provide appropriate referrals. The local social services district, under Medical Assistance regulations, must keep a list of Medicaid-approved medical providers.

D. Monitoring and Maintaining the Foster Child's Health History File

Documenting the medical services provided and maintaining a health history file for each child in foster care are essential tasks to ensure the child's health needs are met. In addition, oversight and monitoring of the child's medical record by caseworkers, Medical Assistance staff, and supervisors will require ensuring that all items listed for a complete examination have been performed, and that recommendations and referrals for follow-up treatment have been carried out.

E. Medical Services at the Time of Discharge and After Discharge

Since foster children may have less access to medical care after discharge to return home or to independent living, provision is made in the regulations for agencies to assist in the continuation of some medical services for the child. These include discussing with the child's parent or guardian, or with the child discharged to independent living, the importance of continuing medical care. Assistance may also be needed by the family or child in understanding the child's comprehensive health history; the Medical Assistance staff and services caseworker should be knowledgeable and available to provide interpretation and explain recommendations for follow-up

care. Helping the child's family or the child discharged to his or her own care to locate a physician or medical clinic from the district's list of Medicaid providers is the responsibility of the authorized agency at the time of the child's discharge from foster care.

Scheduling comprehensive medical examinations for children prior to discharge to independent living is another agency task in providing medical services. A child returning to care after 90 days have passed is to be considered for health and medical purposes in the same category as a new case and is to receive a comprehensive initial medical examination. While not required, serious consideration should be given to scheduling such examinations when children return to care within 90 days after discharge or after absence without consent, depending on the child's previous history and current condition.

If a child with a goal of independent living is absent without consent, and the case is subsequently closed by the social services district, the agency is not responsible for a final medical examination. Documentation of this situation in the child's health history file is important for possible future case reviews and in the event of the child's return to foster care.

IV. REQUIRED ACTION

A. Disclosure of Health History

According to Social Services Law and Department regulations, the comprehensive health history of a child in foster care must be provided, to the extent known and available, to the following persons:

1. to the receiving agency when the care of the child is transferred from one authorized agency to another for placement;

2. to foster parents at the time the child is placed. If a child is placed on an emergency basis, the health history and medical condition must be immediately provided, to the extent known, and more complete information must be provided as soon as possible, but in all cases within 72 hours.

3. to adoptive parents and prospective adoptive parents*;

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* "Prospective adoptive parents" are persons who have met criteria and standards for adoption through screening and home study as specified in Section 421.16 of Department Regulations, who have indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process described in Section 421.18 of Department regulations.

4. to parents or guardians at the time of discharge of the child from foster care, including all medical treatment during the time in foster care;

5. to the child himself or herself at the time of discharge to independent living;

6. to the child's physician or medical provider in order to facilitate care and treatment for the child.

PLEASE NOTE: Results of HIV testing and presence of HIV-related illness must be included in medical records of children in foster care, and such information must be given to all the above persons. However, redisclosure of this information by those persons to other persons is forbidden by law without signed informed consent or official written authorization. The following warning statement must be given to all persons to whom the confidential HIV information is disclosed:

> "This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure."

In order to facilitate foster care and adoptive placements while ensuring compliance with the law and regulations governing confidentiality of information related to HIV infection and AIDS, persons applying to become foster or adoptive parents should be asked by the agency at the time of application if they wish to consider fostering or adopting a child with HIV disease. If the response is negative, then no child known to be HIV-infected should be considered for placement in those homes. If the response is positive, then the agency may suggest a child with HIV disease to prospective adoptive parents and may place HIV-infected children in such foster homes. It is essential that the caseworker make a diligent effort to ascertain from the foster or prospective adoptive parents their attitude toward and capacity for caring for an HIV-infected child prior to placement; in no case should a foster parent or prospective adoptive parent be surprised with such information following a placement if that information is known at the time of placement. Nor should persons with a casual and general interest in adoption or foster care be provided with HIV-related information about a particular child.

However, when the agency is certain that the foster parents and prospective adoptive parents are willing to accept such children, the complete medical history, including HIV-related information, must be provided to them.

B. Medical History Documentation and Record Keeping

For each child in foster care the authorized agency caring for the child must maintain a continuing individual medical history in the uniform case record. If the child-caring agency is a voluntary agency, copies of additions to the medical history file must be forwarded to the social services district which has ultimate responsibility for the child's welfare whenever a significant change occurs in a child's health status or treatment, but in no case later than the next six month case review and reassessment.

Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.

Locally established written procedures must ensure that social services district foster care staff provide any medical or health-related information in the uniform case record as requested by the Medical Assistance and C/THP Units of the agency. Such cooperative communication procedures are necessary to assure that all medical service requirements for the child are met.

The comprehensive health history of each child must include, but is not limited to, the following, where known:

1. hereditary conditions or diseases;

2. drugs or medications taken by the child's mother during pregnancy;

3. immunizations received by the child (type and dates);

4. medications dispensed to the child;

5. allergies exhibited by the child;

6. results of diagnostic tests and evaluations, including developmental and psychological tests, given to the child;

7. results of laboratory tests, including tests for HIV;

8. names and addresses of the child's health/medical provider(s);

9. follow-up or continuing treatment provided to, or still needed by, the child;

10. medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, mechanical breathing supports, eyeglasses, hearing aids).

In addition, the following forms and notices must be included in the health history section of the uniform case record:

1. Past medical records of the child. Diligent effort must be made to obtain records of any previous medical, psychological, or dental treatment of the child placed in foster care. Prior to accepting a child into care, or within 10 days after admission, a request must be made to the child's parent or guardian for written authorization for release of the child's past medical records. In the absence of parental consent, the local social services commissioner is authorized to sign the request for release of such records. Written requests with attached release authorization for the child's treatment history and records must be sent to known medical providers who have treated the child.

2. Form DSS 711, Child's Medical Record, or copies of a comparable medical record form. Some agencies prefer to provide an alternative form, and many physicians have designed forms for their own use. Any such forms are acceptable as long as they record the results of the initial and periodic medical examinations given the child. Form DSS 711 is available from NYSDSS Forms and Publications or through your local social services district office.

3. Form DSS 704, Medical Report on Mother and Infant. This form must be submitted to the appropriate hospital or physician with a request for all pre-natal and birth information available for each pre-school child placed in foster care. A consent release (see B.1.) must be attached. Diligent effort must be made to obtain such information, and all such information received, in whatever form, should be attached to Form 704 and retained in the case file.

4. Progress Notes. Form DSS-3306 is the official cover sheet for progress notes in the uniform case record. Any comparable form may be used to record information summarizing medical/health history-related activities. Activities which must be noted include the dates of medical and dental appointments, examinations and services, a record of referrals, follow-up activities, and transportation provided by the authorized agency. It is not necessary to summarize the child's medical record or results of examinations since the examination record forms must be retained in the same file.

5. Consent forms. At the time a child is placed in foster care voluntarily, the agency must request during the admission process, or within 10 calendar days after admission, an

authorization in writing from the child's parent or guardian for medical or psychological assessment, examination, and treatment, and for emergency medical or surgical care in case the parent or guardian cannot be located at the time the care is necessary.

At the same time, request must be made to the parent(s) for authorization for release of medical records from providers who have previously treated the child.

In cases of involuntary placement involving an abused, abandoned, or neglected child, if parental consent is not available, the local social services commissioner may provide both written authorizations for treatment and for release of medical records. According to Section 383-b of Social Services Law, "the local commissioner of social services or the local commissioner of health may give effective consent for medical, dental, health and hospital services for any child who has been found by the family court to be an abused child or a neglected child, or who has been taken into or kept in protective custody or removed from the place where he is residing, or who has been placed in the custody of such commissioner."

In all cases the signed consent forms must be retained in the uniform case record with other items on the child's health history.

6. Family planning notices to foster parents. A copy must be kept in the child's health history file to indicate that the required notice of family planning services has been sent within 30 days of placement to all foster parents caring for children 12 years of age or older. This notice, which must also be sent annually to such foster parents, informs them of the availability of social, educational, and medical family planning services for the adolescent as is required by section 463.2 of Department regulations.

7. Notice of family planning services directly to adolescents (optional). If the local social services commissioner has approved a district-wide plan to make an offer directly to all foster care adolescents within his or her jurisdiction of family planning services, then a copy of the information provided to the child must be retained in the health history file. The availability of such services may be discussed orally with the young person, but must also be offered in writing. A policy to make such direct offers of services is a local option, but the established policy must have district-wide implementation.

8. Notice of C/THP services. Within 60 days of entry into foster care of a Medicaid-eligible child, the local department of social services must notify in writing the foster parents, or the institution, group residence, group home, or agency boarding

home of the availability of Child/Teen Health Plan (C/THP) services. A copy of the notice must be kept in the child's health history file. This written notice must also be provided to the caretakers of the child at least annually as required by Section 508.4(a) of Department regulations.

9. Child Care Review Service (CCRS). Data related to the foster child's appointments for medical, psychological, and/or dental examinations and treatment must be entered into the Child Care Review Service (CCRS) system in a timely manner. The dates and types of exams must be entered in order to track required timeframes for both the initial and periodic examinations. This computerized record will serve as an administrative tool to cue workers for scheduling purposes. It is not intended as a sanctionable requirement, but may be used for future reviews and reports.

C. The Initial Medical Examination

1. Each child entering foster care must be given an initial comprehensive medical examination no later than 30 days after admission. This requirement also applies to children returning to foster care after a period of 90 days following discharge, trial discharge, or absence without consent.

> EXCEPTION: The initial comprehensive medical examination may be waived if the child has been given such an examination within 90 days prior to admission into foster care, records are obtained to document the examination, and the child's health status does not warrant a second comprehensive examination.

2. The initial comprehensive medical examination is optional when a child returns to care within 90 days after discharge, trial discharge, or absence without consent. However, in making such a decision, a careful assessment should be made of the child's previous history and current condition. Such an examination is also optional when a child is transferred from one agency to the care of another agency.

3. For each foster child's initial medical examination, the local social services district or voluntary agency is responsible for:

a. scheduling the examination for the child or assisting the foster parent to schedule within the required timeframe;

b. offering to provide or arrange for transportation as needed;

c. providing the physician with the child's available medical history at the time of the exam or as soon thereafter as possible;

d. ensuring that the physician is familiar with the requirements for a comprehensive examination (see IV.E.);

e. ensuring that the examination is completed in those situations when the foster parent assumes responsibility for scheduling and taking the child to the examination without the caseworker;

f. ensuring that the results of the initial examination and any referrals for follow-up care are retained in the child's health history file in the uniform case record. The date of the initial examination must be entered into the Child Care Review Services (see V.A.).

D. Periodic Medical Examinations

1. Every child in foster care must receive complete periodic individualized medical examinations on a continuing schedule. The required foster care periodic schedule is the same as that required by the Child/Teen Health Plan (C/THP) and follows the recommendation of the American Academy of Pediatrics of the American Medical Association. It is a standard for basic health care for all children, but each child's health care needs beyond this basic care must be met on a case-by-case assessment.

Examinations must follow current recommended medical practice and cover the requirements listed in IV. E. below. Agencies must ensure that children are examined according to the following schedule:

Age 0-1 year: 2-4 weeks / 2-3 months/ 4-5 months / 6-7 months / 9-10 months

Age 1-6 years: 12-13 months / 14-15 months / 16-19 months / 23-25 months / 3 years / 4 years / 5 years

Age 6-21 years: 6-7 years / 8-9 years / 10-11 years / 12-13 years / 14-15 years / 16-17 years / 18-19 years / 20 years

2. Every foster child 3 years of age or older must have an annual dental examination by a dentist and must be provided with any other dental care as needed.

3. Authorized agencies must inform foster parents that assistance is available in scheduling appointments and providing or arranging for transportation to medical providers.

4. Records on the results of such examination, referrals for follow-up care, and casework activities related to scheduling these examinations must all be kept in the uniform case record as items in the child's health history file. Dates of such examinations must be entered into the Child Care Review Service system in a timely manner to maintain current information.

E. Contents of Comprehensive Medical Examinations

Medical examinations must take into account the age, environmental background and development of the child and must include the following:

1. a comprehensive health and developmental history;

2. a comprehensive unclothed physical examination;

3. an assessment of the child's immunization status and the provision of immunizations as necessary;

4. an appropriate vision assessment;

5. an appropriate hearing assessment;

6. laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;

7. dental screening and/or referral. All children up to age three should have their mouths examined at each medical examination and, where appropriate, should be referred for dental care. All children three years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed; and

8. observation for child abuse and maltreatment which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment.

These requirements follow current medical guidelines developed by the American Academy of Pediatrics.

F. Follow-Up Services

Agencies must ensure that follow-up health care is provided or arranged for each foster child as needed or recommended by the child's physician. Staff must consult with medical and other appropriate professionals and the child's foster parents regarding health services necessary to meet the child's needs. Written procedures must be developed locally to ensure that foster care services and Medical

Assistance staff, including Child/Teen Health Plan staff, cooperate and communicate in regard to their shared responsibility for follow-up services.

Following each comprehensive medical examination, agency staff must:

1. review the child's medical examination record form to determine whether the physician recommended further treatment, referrals, medications, or other follow-up care;

2. contact the medical provider as appropriate to obtain necessary information on follow-up care and treatment;

3. offer assistance to the foster parent(s) in arranging for follow-up care and transportation as necessary;

4. in cases requiring ongoing medical care, encourage the medical provider to contact the agency caring for the child concerning follow-up, referrals, missed appointments, or other important information.

G. Discharge from Foster Care

1. When a child is discharged from foster care, the comprehensive health history of the child must be provided:

a. to the child's parents or guardian if the child is released to their care; or

b. to the child himself or herself if the child is discharged to independent living.

2. Prior to final discharge agency staff must:

a. assist the parent(s) and/or child with interpretation of the health history;

b. discuss with the child's parents or the child to be discharged to his or her own care the importance of periodic medical assessments, follow-up treatments, and any medications prescribed by the physician;

c. discuss with the child's parents or the child to be discharged to his or her own care the availability of Child/Teen Health Plan (C/THP) services and eligibility for Medicaid;

d. assist the child's parents or the child to find a physician or medical provider organization in an appropriate

location through referrals and/or medical provider lists which must be maintained by social services Medical Assistance units;

e. make diligent effort to obtain the name and address of the child's post-discharge medical provider in order to provide the child's comprehensive health history to that provider.

3. Prior to discharge to independent living, a child must be given a comprehensive medical examination unless such an examination has been provided within one year of the date of discharge.

4. When a child is freed for adoption and is to be discharged from foster care to adoptive placement, a comprehensive medical examination must be provided unless such an examination has been given within 6 months prior to the adoptive placement.

V. SYSTEMS IMPLICATIONS

A. CCRS Reporting

1. To provide administrative assistance in the monitoring of required periodic medical examinations, local agencies must report to CCRS that the required medical examinations have been performed.

When the medical exam has been completed, the following CCRS activity code must be entered for each child in the prescribed manner:

H100 - MEDICAL EXAM PERFORMED. The activity date is the date the medical exam was done. There are no modifiers required. The entry of the H100 activity will release/suppress all prior cues for examinations that may not have been performed.

2. Within one year prior to the anticipated date of discharge for a child with a permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only, a medical examination is necessary. When the PPG of 03 or 10 is entered on the assessment service plan, districts should also enter the anticipated completion date for the permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only. In the future, a cue/notice will be generated six months prior to the anticipated completion date for any child with a PPG of 03 or 10 to assist districts in monitoring this requirement.

B. CCRS Caseload Report

To assist agencies in the management of medical exams for children in foster care, two additional cues/notices will appear on the CCRS Caseload Report. The cues are A660 - Medical Exam Due and C660 - Medical Exam Overdue. These cues will be generated for the following situations:

1. When the child is placed in foster care, the initial medical examination cue will be generated from the movement activity (M910), placement in care, reported to CCRS.

2. When the child has been absent from foster care for 91 days or more, the initial medical exam cue will be generated when the movement activity, "return to care," is reported to CCRS.

PLEASE NOTE: The movement activities must be reported to CCRS in the month in which they occur in order for the cues to be displayed on the appropriate month's report.

3. Periodic cues based on the date of birth of the foster child will be generated based on the schedule detailed in section IV. D, Periodic Medical Examinations, in this Directive.

C. Conversion

Six months from the effective date of this Directive, districts must have completed the following actions:

1. Entry of all appropriate H100 - Medical Exam Performed codes into CCRS activities. Only the most recent exam should be reported.

2. For each child with a PPG of 03 or 10, enter the anticipated completion date for the PPG.

VI. ADDITIONAL INFORMATION

A. Medical Assistance Eligibility

Local social services departments must determine Medical Assistance eligibility when a child is placed in foster care. Medical Assistance eligibility for children placed in foster care who are not eligible for and in receipt of Title IV-E foster care maintenance payments must be determined as described in 75 ADM-85 and 81 ADM-10. In accordance with 81 ADM-10, a child's Medical Assistance eligibility must be determined as a separate household of one, and must be based solely on the child's own income and resources and on the amount of support the parents contribute. The child's Medical Assistance eligibility level equals the foster care rate or the Medicaid level for a household of

one, whichever is higher. Children who are eligible for and in receipt of Title IV-E foster care maintenance payments are automatically eligible for Medical Assistance. (See 84 ADM-4.) Furthermore, all children who are eligible for Medical Assistance are entitled to receive Child/Teen Health Plan (C/THP) services.

B. Costs of Medical Examinations

Costs of medical examinations for all those children who are eligible for Medical Assistance, if not included in a voluntary agency's per diem child caring rates, will be paid through MMIS. Costs of examinations for children who are not eligible for Medical Assistance should be paid by the local district and claimed on Schedule K as federally non-participating (FNP) on line 4a or 4b, whichever is applicable.

C. Allocation of Program Costs

Appropriate reporting and allocation of program costs should follow directions specified in the Standards of Payment for Foster Care of Children Program Manual.

D. Annual Establishment of Medicaid Rates for Child Care Agencies

The Department will, on an annual basis, review agency reports of costs incurred in the delivery of medical services to children in care in order to determine the per diem rates for the subsequent year. Rates will be based on reasonable costs incurred in comparison to programs of similar type and geographic location, trended forward to reflect changes in prices for similar medical services.

VII. EFFECTIVE DATE

The effective date of the actions required by this Directive is August 1, 1990, retroactive to January 13, 1989, the date the regulations concerning medical services to children in foster care became effective.

Joseph Semidei
Deputy Commissioner
Division of Family and
Children Services