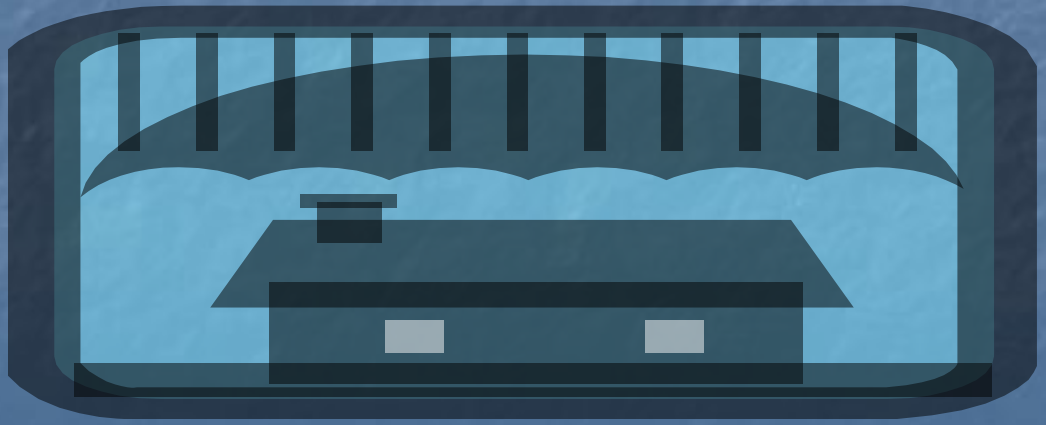
AIFACS Orientation

Umbrella Rule



2960.3000 Foster Family Settings

- Subpart 1. **Purpose and applicability.** Parts 2960.3000 to 2960.3100 establish the minimum standards that a foster family setting must meet to qualify for licensure. Parts 2960.3200 to 2960.3230 contain requirements for foster residence settings. Additional licensing requirements for foster family settings that offer treatment foster care are in parts 2960.3300 to 2960.3340.

- Subp. 4. **Statement of intended use.** The license holder must work with the licensing agency to develop a statement of intended use. The statement of intended use must specify:

  A. the number of children the foster home is licensed for, the age range of children to be placed in the home, and any limitations affecting the placement of children in the home;

  B. whether or not the home will serve as an emergency shelter home, a treatment foster care home, or a home for medically fragile children; and

  C. circumstances when the ratio of one adult to five children does not need to be maintained.

  The statement of intended use must be approved by the licensing agency, but may be modified at any time by agreement between the licensing agency and the license holder to reflect changes that affect the placement of children in the home.

2960.0020 DEFINITIONS.

Subp. 2. **Applicant.** "Applicant" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 3, and a person who has completed and signed an application form. Applicant includes a current license holder who is seeking relicensure or recertification.

Subp. 5. **Basic services.** "Basic services" means services provided at the foster home to the foster child that meets the foster child's basic need for food, shelter, clothing, medical and dental care, personal cleanliness, privacy, spiritual and religious practice, safety, and adult supervision.

Subp. 6. **Caregiver.** "Caregiver" means a person who provides services to a child according to the child's case plan in a setting licensed or certified under parts 2960.0010 to 2960.3340.

Subp. 7. **Case manager.** "Case manager" means the supervising agency responsible for developing, implementing, and monitoring the case plan.

Subp. 8. **Case plan.** "Case plan" means a plan of care for a foster child that is developed by the supervising agency with the child's parents and license holder and monitored by the placing agency.

Subp. 16. **Discipline.** "Discipline" means the use of reasonable, age-appropriate consequences designed to modify and correct behavior according to a rule or system of rules governing conduct.

Subp. 19. **Family.** "Family" means persons related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact.

Subp. 21. **Foster child.** "Foster child" means a person under 18 years of age, a person in special education, or a juvenile under the jurisdiction of a juvenile court who is under 22 years of age and is placed in a foster home.

Subp. 36. **Family or household members.** "Family or household members" has the meaning given in Minnesota Statutes, section 260C.007, subdivision 17.

Subp. 23. **Foster family setting.** "Foster family setting" means the foster home in which the license holder resides.

Subp. 24. **Foster home.** "Foster home" means the dwelling unit used by the license holder to provide foster care to the foster child.

Subp. 25. **Foster parent.** "Foster parent" means an individual licensed under Minnesota Statutes to provide foster care.

Subp. 26. **Foster residence setting.** "Foster residence setting" means a foster home in which the license holder does not reside.

Subp. 27. **License.** "License" means written authorization issued by the commissioner of human services or corrections allowing the license holder to provide foster care service at a foster home for a specified time and in accordance with the terms of the license and the rules of the commissioner of human services or corrections.

Subp. 28. **License holder.** "License holder" means an individual, corporation, partnership, voluntary association, or other organization or entity that is legally responsible for the operation of the foster home that has been granted a license by the commissioner of human services under Minnesota Rules and Minnesota Statutes, chapter 245A, or the commissioner of corrections under Minnesota Statutes, section 241.021, subdivision 2. The duties of the license holder may be discharged by a person designated by the license holder to act on behalf of the license holder.

Subp. 29. **Licensed professional.** "Licensed professional" means a person qualified to complete a diagnostic evaluation, including a physician licensed under Minnesota Statutes, chapter 147, or a qualified mental health professional licensed under Minnesota Statutes, section 148B.18, subdivision 10, or a person defined as a "mental health professional" in Minnesota Statutes, section 245.4871, subdivision 27.

Subp. 30. **Licensing agency.** "Licensing agency" means a county, individual, corporation, partnership, voluntary association, the Department of Corrections, or other organization or entity that recommends licensure of an applicant for a license or license renewal to the state according to parts 9543.0010 to 9543.0150.

Subp. 33. **Placing agency.** "Placing agency" means a private agency licensed according to parts 9545.0755 to 9545.0845 or a county agency that places a child according to parts 9560.0500 to 9560.0670.

Subp. 34. **Psychotropic medication.** "Psychotropic medication" means a medication prescribed to treat mental illness and associated behaviors or to control or alter behavior. The major classes of psychotropic medication are antipsychotic or neuroleptic, antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous classes of medication are considered to be psychotropic medication when they are specifically prescribed to treat a mental illness or to alter behavior based on a foster child's diagnosis.

Subp. 36. **Respite care.** "Respite care" means temporary care of foster children in a licensed foster home other than the foster home the child was placed in.

Subp. 41. **Substitute care.** "Substitute care" means temporary care of foster children inside the foster home by someone other than the foster parent for overnight or longer.

Subp. 45. **Variance.** "Variance" means written permission from the commissioner of human services or corrections for a license holder to depart from a rule standard for a specific period of time pursuant to Minnesota Statutes, section 245A.04, subdivision 9.

2960.3020 LICENSING PROCESS.

Subpart 1. **License required.** An individual, corporation, partnership, voluntary association, other organization, or controlling individual must not provide foster care without a license from the commissioner of human services or corrections unless an exclusion specified in this chapter or Minnesota Statutes, section 245A.03, subdivision 2, applies.

Subp. 2. **Application.** Application for a license must be made to the county agency in the county where the applicant resides or to a Minnesota-licensed child placing agency on a form approved by the commissioner of human services. Group foster homes licensed by the Department of Corrections under chapter 2925 and Minnesota Statutes, section 241.021, subdivision 2, as of the adoption of this chapter, may apply to the Department of Corrections for a foster care license according to subpart 12. An application for licensure is complete when the applicant signs the license application and submits all of the information required in this subpart.

Subp. 3. **License does not guarantee placement.** Licensure under parts 2960.3000 to 2960.3340 is not an entitlement, a right, or a guarantee that children will be placed in the foster home. The agency responsible for the child retains the right to choose which licensed foster home is best suited for an individual child in need of foster care placement.

Subp. 4. **License not transferable.** A license under parts 2960.3000 to 2960.3340 is not transferable to another person, entity, or site.

Subp. 5. **Commissioner's right of access.** The commissioner of human services' right of access must be according to Minnesota Statutes, section 245A.04, subdivision 5. The commissioner of corrections must have access to a Department of Corrections licensed foster home according to Minnesota Statutes, section 241.021.

Subp. 6. **Limited licensure.** A license holder may be licensed through only one Minnesota-licensed child placing agency or county social services agency at a time. A license holder must not be licensed at the same time by both the Department of Human Services and the Department of Corrections. A license holder must not simultaneously hold a relative foster care emergency license issued according to Minnesota Statutes, section 245A.035, and a separate foster family setting license issued under this chapter.

Subp. 7. **Notice of changes in household conditions.** The license holder must immediately notify the licensing agency of foster home and foster family or household member changes that effect the terms of the license or the ability of the license holder to provide care to children.

Subp. 8. **Roomers and boarders.** A license holder must not have adult roomers or boarders in the foster home without the licensing agency's approval. Roomers or boarders are subject to an applicant background study according to part 2960.3060, subpart 2.

2960.3030 CAPACITY LIMITS.

Subpart 1. **Maximum foster children allowed.** A foster home must have no more than six foster children. The maximum number of children allowed in a home is eight, including a foster parent's own children. The license holder must maintain a ratio of one adult for each five children.

Subp. 2. **Capacity limits.** The capacity limits in items A to C apply to foster homes.

A. A foster home must have no more than three children who are under two years of age or who are nonambulatory, unless the license holder maintains a ratio of at least one adult present when children are present for every three children under two years of age or children who are nonambulatory.

B. A foster home must have no more than four foster children at one time if any of the children have severe or profound mental retardation, have severe emotional disturbance, or is a person assisted by medical technology.

C. The number of foster children a foster home may accept must be limited based on the factors in subitems (1) to (5):

(1) the license holder's ability to supervise, considering the adult-to-child ratio in the home;

(2) the license holder's training, experience, and skills related to child care;

(3) the structural characteristics of the home;

(4) the license holder's ability to assist children in the home during emergencies; and

(5) the characteristics of the foster children, including age, disability, and emotional problems.

Subp. 3. **Exceptions to capacity limits.** A variance may be granted to allow up to eight foster children in addition to the license holder's own children if the conditions in items A to E are met:

A. placement is necessary to keep a sibling group together, to keep a child in the child's home community, or is necessary because the foster child was formerly living in the home and it would be in the child's best interest to be placed there again;

B. there is no risk of harm to the children currently in the home;

C. the structural characteristics of the home, including sleeping space, can accommodate the additional foster children;

D. the home remains in compliance with applicable zoning, health, fire, and building codes; and

E. the statement of intended use states the conditions for the exception to capacity limits and explains how the license holder will maintain a ratio of adults to children which ensures the safety and appropriate supervision of all the children in the foster home.

2960.3040 FOSTER HOME PHYSICAL ENVIRONMENT.

Subpart 1. **Fire, health, building, and zoning codes.** The foster home must comply with applicable fire, health, building, and zoning codes.

Subp. 2. **Sleeping space.** A foster child must be provided with a separate bed suitably sized for the child, except that two siblings of the same sex may share a double bed. A foster child must not be assigned sleeping space in a building, apartment, trailer, or other structure that is separate from the foster family home or in an unfinished attic, an unfinished basement, or a hall or any other room normally used for purposes other than sleeping. Bedrooms that are used by foster children must have two exits.

Subp. 3. **Space for belongings.** A foster child must have an identified space for clothing and personal possessions with cabinets, closets, shelves, or hanging space sufficient to accommodate clothing and personal possessions.

Subp. 4. **Dining area.** The dining area must be able to accommodate, at one time, all persons residing in the home

2960.3050 FOSTER HOME SAFETY.

Subpart 1. **Inspection by licensing agency.** Prior to licensure, the foster home must be inspected by a licensing agency employee using the home safety checklist from the commissioner of human services. The applicant must correct deficiencies in the foster home which were identified by the agency. The licensing agency may require a health inspection if the foster home's condition could present a risk to the health of a foster child.

Subp. 2. **Fire code inspections required.** If one of the conditions in items A to E exist, the foster home must document inspection and approval of the foster home according to Minnesota Statutes, section 299F.011, and the Uniform Fire Code by the state fire marshal or a local fire code inspector who is approved by the state fire marshal:

A. the foster home contains a freestanding solid fuel heating appliance;

B. the foster home is a manufactured home as defined in Minnesota Statutes, section 327B.01, subdivision 13, and was manufactured before June 15, 1976;

C. the licensing agency identifies a potential hazard in a single-family detached home, or a mixed or multiple-occupancy building;

D. the home is to be licensed for four or more foster children; or

E. the foster home has a foster child sleeping in a room that is 50 percent or more below ground level.

Subp. 3. **Emergency procedures.** The license holder must give the licensing agency a floor plan of the foster home showing emergency evacuation routes. Emergency procedures must include a plan for care of children, evacuation, temporary shelter, and gathering at a meeting place to determine if anyone is missing. The plan must specifically address the needs of children whose behavior increases the risk of having a fire. The foster parent must give the emergency procedures to the agency, and the foster parent and licensing agency must review the emergency procedures during relicensure.

Subp. 4. **Pets.** A foster home serving children less than six years of age must not keep reptiles, chickens, or ducks as pets. A foster home serving children six years of age and older that keeps reptiles, chickens, or ducks as pets must require a thorough hand washing following the handling of the animal, its food, and anything the animal has touched. Pets in family residences must be immunized and maintained as required by local ordinances and state law

2960.3060 LICENSE HOLDER QUALIFICATIONS.

Subpart 1. **Experience.** The prospective license holder must agree to cooperate with the licensing agency and:

A. have at least the equivalent of two years of full-time experience caring for or working with the issues presented by the children they will care for, whether they are the license holder's own children or other children;

B. agree to receive training in child care and development as needed in order to meet the individual needs of the children placed in the foster home;

C. be related to the child needing foster care; or

D. be an important friend with whom the child has resided or had significant contact.

Subp. 2. **Background study.** A license holder and individuals identified in Minnesota Statutes, sections 241.021 and 245A.04, subdivision 3, must submit to a background study.

A. Background checks conducted by the Department of Human Services must be conducted according to Minnesota Statutes, section 245A.04, subdivision 3.

B. Background checks conducted by the Department of Corrections must be conducted according to Minnesota Statutes, section 241.021, subdivision 6.

Subp. 3. **Personal characteristics of applicants.** The applicant must comply with the requirements of items A to G.

A. The applicant must be at least 21 years old at the time of application.

B. The applicant and household members must provide a signed statement which indicates that they are receiving all necessary medical care, do not pose a risk to the child's health, and are physically able to care for foster children and indicate any limitations the applicant and household members may have.

C. The applicant and adult household members must sign a statement that they have been free of chemical use problems for the past two years.

D. The applicant must help the licensing agency obtain at least three letters of reference that provide information about the license holder's support system, the observed license holder's interactions with children, and the ability of the license holder and foster family to accept different points of view.

E. The applicant must help the licensing agency get previous foster care studies completed on the applicant by any other agency to which the applicant has applied for foster care licensure.

F. The licensing agency must make a determination as to whether a prospective license holder and foster parent can provide appropriate structure and is suitable to be licensed if a prospective license holder or foster parent has had either of the following:

(1) a child for whom the applicant is legally responsible was removed from the applicant's home and placed in foster care, a correctional facility, or a residential treatment center for severe emotional disturbance under Minnesota Statutes, chapter 260C, within one year prior to the date of application; or

(2) the applicant has a child in voluntary foster care under Minnesota Statutes, section 260C.212, subdivision 8, 260C.193, 260C.201, or 260C.205.

G. The licensing agency may consult with a specialist in such areas as health, mental health, or chemical dependency to evaluate the abilities of the applicant to provide a safe environment for foster children. The licensing agency and the specialist must evaluate each applicant individually. The licensing agency must request a release of information from the applicant prior to assigning the specialist to evaluate the applicant. The licensing agency must tell the applicant why it is using a specialist to evaluate the applicant.

Subp. 4. **Home study of applicant.** The applicant must cooperate with a home study conducted by the licensing agency. At a minimum, there must be one in-home interview and documented interviews with all household members over seven years of age. The home study must be completed using the commissioner of human services' designated format. The applicant must demonstrate the ability to:

A. provide consistent supervision, positive and constructive discipline, and care and training to contribute to the foster child's well-being;

B. understand the licensing agency's programs and goals;

C. work within agency and state policies;

D. share responsibility for the foster child's well-being with the foster child's social worker, school, and legal parents;

E. actively support the foster child's racial or ethnic background, culture, and religion, and respect the child's sexual orientation;

F. accept the foster child's relationship with the child's family and relatives and to support visitation and family reunification efforts;

G. have a current network of support that may include extended family, and neighborhood, cultural, and community ties that the applicant can use to strengthen the applicant's abilities, and for support and help;

H. meet the foster child's special needs, if any, including medical needs, disabilities, or emotional disturbance;

I. deal with anger, sorrow, frustration, conflict, and other emotions in a manner that will build positive interpersonal relationships rather than in a way that could be emotionally or physically destructive to other persons; and

J. nurture children, be mature and demonstrate an ability to comply with the foster child's care plan, and meet the needs of foster children in the applicant's care.

2960.3070 FOSTER PARENT TRAINING.

Subpart 1. **Orientation.** A nonrelative foster parent must complete a minimum of six hours of orientation before admitting a foster child. Orientation is required for relative foster parents who will be licensed as a child's foster parents. Orientation for relatives must be completed within 30 days following the initial placement. The foster parent's orientation must include items A to E:

A. emergency procedures, including evacuation routes, emergency telephone numbers, severe storm and tornado procedures, and location of alarms and equipment;

B. relevant laws and rules, including, but not limited to, chapter 9560; Minnesota Statutes, chapters 245A, 260, and 260C; and Minnesota Statutes, section 626.556; and legal issues and reporting requirements;

C. cultural diversity, gender sensitivity, culturally specific services, cultural competence, and information about discrimination and racial bias issues to ensure that caregivers will be culturally competent to care for foster children according to Minnesota Statutes, section 260C.212, subdivision 11;

D. information about the role and responsibilities of the foster parent in the development and implementation of the case plan and in court and administrative reviews of the child's placement; and

E. requirements of the licensing agency.

Subp. 2. **In-service training.** Each foster parent must complete a minimum of 12 hours of training per year in one or more of the areas in this subpart or in other areas as agreed upon by the licensing agency and the foster parent. If the foster parent has not completed the required annual training at the time of relicensure and does not show good cause why the training was not completed, the foster parent may not accept new foster children until the training is completed. The nonexclusive list of topics in items A to Z provides examples of in-service training topics that could be useful to a foster parent:

A. cultural competence and transcultural placements;

B. adoption and permanency;

C. crisis intervention, including suicide prevention;

D. sexual offender behaviors;

E. children's psychological, spiritual, cultural, sexual, emotional, intellectual, and social development;

F. legal issues including liability;

G. foster family relationships with placing agencies and other service providers;

H. first aid and life-sustaining treatment such as cardiopulmonary resuscitation;

I. preparing foster children for independent living;

J. parenting children who suffered physical, emotional, or sexual abuse or domestic violence;

K. chemical dependency, and signs or symptoms of alcohol and drug abuse;

L. mental health and emotional disturbance issues;

M. Americans with Disabilities Act and Individuals With Disabilities Education Act;

N. caring for children with disabilities and disability-related issues regarding developmental disabilities, emotional and behavioral disorders, and specific learning disabilities;

O. privacy issues of foster children;

P. physical and nonphysical behavior guidance, crisis de-escalation, and discipline techniques, including how to handle aggression for specific age groups and specific issues such as developmental disabilities, chemical dependency, emotional disturbances, learning disabilities, and past abuse;

Q. birth families and reunification;

R. effects of foster care on foster families;

S. home safety;

T. emergency procedures;

U. child and family wellness;

V. sexual orientation;

W. disability bias and discrimination;

X. management of sexual perpetration, violence, bullying, and exploitative behaviors;

Y. medical technology-dependent or medically fragile conditions; and

Z. separation, loss, and attachment.

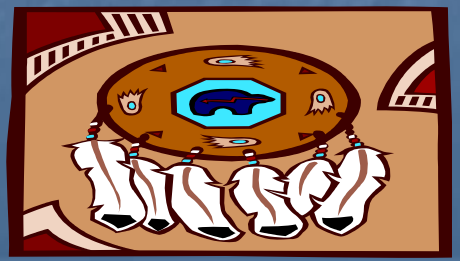
Subp. 3. **Medical equipment training.** Foster parents who care for children who rely on medical equipment to sustain life or monitor a medical condition must meet the requirements of Minnesota Statutes, section 245A.155.

2960.3080 PLACEMENT, CONTINUED STAY, AND DISCHARGE.

Subpart 1. **Placement criteria.** Foster care placement is governed by the statement of intended use developed by the licensing agency and the license holder. The license holder may decline to accept a foster child without a stated reason. The requirements of parts 2960.0510 to 2960.0530 do not apply if the foster home serves as an emergency shelter home.

Subp. 2. **Screening.** The license holder must cooperate with the placing agency to ensure that the child's needs are identified and addressed.

Subp. 3. **Child's property.** The foster child must be allowed to bring personal possessions, as agreed upon between the child, the child's parent, the placing agency, and the license holder, to the foster home and must be allowed to accumulate possessions to the extent the home is able to accommodate them.



Subp. 4. **Information about foster children.** Before placement or within five days following placement, the placing agency shall give the license holder written information in items A to K about the child:

A. the child's placement history summary;

B. name and nicknames;

C. date of birth;

D. gender;

E. name, address, and telephone number of the child's parents, guardian, and advocate;

F. race or cultural heritage of the child, including tribal affiliation, if any;

G. description of the child's presenting problems, including medical problems, circumstances leading to placement, mental health concerns, safety concerns including assaultive behavior, and victimization concerns;

H. description of assets and strengths of the child and, if available, related information from the child, child's family, including siblings, and concerned persons in the child's life;

I. name, address, and telephone number of the contact person for the last educational program the child attended, if applicable;

J. spiritual or religious affiliation of the child and the child's family; and

K. information about the child's medication and diet needs and the identities of the child's recent health care providers.

The child's placing agency shall update the information in items A to K as new information becomes available.

Subp. 5. **Cooperation required.** The license holder must cooperate with the child's placing agency according to items A and B.

A. The license holder must provide basic services to the child.

B. The license holder must cooperate with the child's case manager and other appropriate parties to develop and implement the child's case plan during the child's stay in the foster home. The license holder shall cooperate in the following areas:

(1) identify and share information, if appropriate, with persons who are directly involved in the child's treatment plan and tell those persons about major treatment outcomes the child will achieve while in the home, including attaining developmentally appropriate life skills that the child needs to become functional in the community;

(2) report the child's behaviors and other important information to the placing agency and others as indicated in the child's case plan;

(3) recommend changes in the child's case plan to the case manager if needed;

(4) give the placing agency additional significant information about the foster child as it becomes known;

(5) facilitate the child's school attendance and enroll the child in a local school district or, if appropriate, the child's district of residence;

(6) provide a child with timely access to basic, emergency, and specialized medical, mental health, and dental care and treatment services by qualified persons; and

(7) maintain a record of illness reported by the child, action taken by the foster parent, and the date of the child's medical, psychological, or dental care.

Subp. 6. **Foster child services.** The license holder must:

A. work with the child's placing agency and child's parents to develop a plan to identify and meet a foster child's immediate needs. The license holder must collaborate with the placing agency to provide the basic services to the child;

B. encourage age-appropriate activities, exercise, and recreation for the foster child;

C. seek consultation or direction from the placing agency if issues arise that cannot be resolved between the license holder and the foster child;

D. explain house rules and tell the foster child about the license holder's expectations about behavior, the care of household items, and the treatment of others; and

E. know the whereabouts of the child in the license holder's care. The license holder must be guided by the case plan or court order in determining how closely to supervise the child. The license holder must immediately notify the placing agency if the child runs away or is missing.

Subp. 7. **Foster child diet.** A foster child must be provided food and beverages that are palatable, of adequate quantity and variety, served at appropriate temperatures, and have sufficient nutritional value to promote the child's health. If the child has a medically prescribed diet, then the license holder must provide the diet as ordered by a physician or other licensed health care provider.

Subp. 8. **Discipline.** The license holder must consider the child's abuse history and developmental, cultural, disability, and gender needs when deciding the disciplinary action to be taken with the child. Disciplinary action must be in keeping with the license holder's discipline policy. The discipline policy must include the requirements in items A and B.

A. Children must not be subjected to:

(1) corporal punishment, including, but not limited to: rough handling, shoving, ear or hair pulling, shaking, slapping, kicking, biting, pinching, hitting, throwing objects at the child, or spanking;

(2) verbal abuse, including, but not limited to: name calling; derogatory statements about the child or child's family, race, gender, disability, sexual orientation, religion, or culture; or statements intended to shame, threaten, humiliate, or frighten the child;

(3) punishment for lapses in toilet habits, including bed wetting or soiling;

(4) withholding of basic needs, including, but not limited to: a nutritious diet, drinking water, clothing, hygiene facilities, normal sleeping conditions, proper lighting, educational services, exercise activities, ventilation and proper temperature, mail, family visits, positive reinforcement, nurturing, or medical care. However, a child who destroys bedding or clothing, or uses these or other items to hurt the child's self or others, may be deprived of such articles according to the child's case plan;

(5) assigning work that is dangerous or not consistent with the child's case plan;

(6) disciplining one child for the unrelated behavior or action of another, except for the imposition of restrictions on the child's peer group as part of a recognized treatment program;

(7) restrictions on a child's communications beyond the restrictions specified in the child's treatment plan or case plan, unless the restriction is approved by the child's case manager; and

(8) requirements to assume uncomfortable or fixed positions for an extended length of time, or to march, stand, or kneel as punishment.

B. The license holder:

(1) must not require a child to punish other children;

(2) must follow the child's case plan regarding discipline;

(3) must not use mechanical restraints or seclusion, as defined in part 2960.3010, subpart 38, with a foster child;

(4) must ensure that the duration of time-out is appropriate to the age of the child; and

(5) must meet the requirements of part 9525.2700, subpart 2, item F, regarding the use of aversive or deprivation procedures with a foster child who has mental retardation or a related condition.

Subp. 9. **Visitation and communication.** The license holder must follow the visitation and communication plan in a foster child's case plan, which was developed by the placing agency and child's parents, or required by court order. In the absence of a case plan or court order regarding visitation, the license holder must work with the placing agency and the child's parents to jointly develop a visitation plan.

Subp. 10. **Complaints and grievances.** The license holder must work with the licensing agency to develop written complaint and grievance procedures for foster children. The procedures must meet at least the following requirements:

A. the agency or license holder must tell the child and the child's parent or legal representative about the complaint and grievance procedures and upon request give the child or the child's parent or legal representative a copy of the procedures and any forms needed to complain or grieve;

B. the license holder must notify the placing and licensing agency about a written complaint or grievance and the resolution of the complaint or grievance; and

C. a license holder's response to a complaint or grievance that alleges abuse or neglect must meet the requirements of the Maltreatment of Minors Act, Minnesota Statutes, section 626.556.

Subp. 11. **Discharge.** The license holder must work with the child's placing agency to ensure a planned discharge and compliance with Minnesota Statutes, section 260C.212, subdivision 3. Before an unplanned discharge, the license holder must confer with other interested persons to review the issues involved in the decision. During this review process, which must not exceed 30 days, the license holder must determine whether the license holder, treatment team, if any, interested persons, and the child can develop additional strategies to resolve the issues leading to the discharge and to permit the child an opportunity to continue to receive services from the license holder. If the review indicates that the decision to discharge is warranted, the reasons for it and the alternatives considered or attempted must be documented. A child may be temporarily removed from the foster home during the review period if the child is a danger to self or others. This subpart does not apply to a child removed by the placing authority or a parent or guardian.

2960.3090 RESPITE AND SUBSTITUTE CARE FOR FAMILY SETTINGS.

Subpart 1. **Notice requirements.** In nonemergency situations, the license holder, parent, and placing agency must agree on respite care and substitute care arrangements within ten working days prior to the use of respite care or substitute care or must agree on respite care according to an ongoing written agreement. In an emergency that may require the use of respite or substitute care, the license holder must notify the placing agency of the emergency as soon as possible. The license holder must notify the placing agency when respite care or long-term substitute care is being provided.

Subp. 2. **Qualifications of long-term substitute caregiver.** A substitute caregiver must:

A. be at least 18 years of age;

B. have completed a background study within the past 12 months;

C. have no statutory or rule disqualification;

D. if providing more than 30 cumulative days of substitute care in a 12-month period:

(1) submit a signed statement attesting to good health and being physically able to care for foster children; and

(2) have at least six hours of training or 20 hours of experience in caring for children with the particular needs of the foster children to be cared for; and

E. provide documentation of medical equipment training on the equipment used to care for the foster child from an appropriate training source.

Subp. 3. **Short-term substitute caregiver.** As used in parts 2960.3000 to 2960.3340, "short-term substitute care" means less than 72 hours of continuous care for a child. A short-term substitute caregiver does not have to meet the requirements of subpart 2. However, the foster parent and the placing agency must agree that the short-term substitute caregiver is able to meet the needs of the foster child. The short-term substitute caregiver must provide documentation of medical equipment training on the equipment used to care for the foster child from an appropriate training source.

2960.3100 RECORDS.

Subpart 1. **Foster care license records.** The license holder must cooperate with the licensing agency to ensure the agency has the following records:

A. a copy of the application for licensure signed by the applicant;

B. a license holder agreement form supplied by the Department of Human Services which is signed by the applicant and the agency;

C. reports and signed statements from specialists, and signed statements from the license holder, the license holder's children, and other household members concerning the physical health of the license holder, the license holder's children, and other household members;

D. a current completed commissioner's home safety checklist (D.S.-644) plus a written report from the fire marshal on any specific fire hazards, if required;

E. the prelicensing home study and supporting documentation;

F. references obtained through the licensing process;

G. a documented annual evaluation of the licensed foster home, conducted jointly by the license holder and the licensing agency, including, at a minimum:

(1) a review of all foster placements in the past year and an assessment of the impact and outcomes of the placement on the child, child's family, license holder, and development and implementation of the case plan;

(2) a review of any comments, suggestions, or concerns raised by placing agencies and an assessment of implications for training and foster home policies or procedures;

(3) a review of any grievances, their outcomes, and an assessment of implications for training and foster home policies or procedures;

(4) a review of the ability of the license holder to care for children; and

(5) the development of a plan for the next year's foster care training and development;

H. documentation for any rule variance from this chapter; and

I. a record of training received by the license holder and staff, if any, and foster parents, including a list of training on medical equipment used to sustain life or monitor a medical condition.

Subp. 2. **Foster child records.** The license holder must keep a record for each foster child in care. The record must include the child's medical records, which includes records of illnesses and medical care provided to the child; grievance records, including documentation of the grievance resolution; and other documentation as required by the child's case plan.

F.A.Q

Q. WHAT IS THE DATA PRACTICES ACT?

Q. WHAT DEFINES MALTREATMENT?

Q. WHAT IS CHIPS?

Q. WHAT IS AN ADMINISTRACTICE REVIEW?

Q. WHAT IS TERMINATION OF PARENTAL RIGHTS?

Q. WHAT IS VOLUNTARY PLACEMENT?

Q.WHAT IS A VOLUNTARY PLACEMENT AGREEMENT?

Q. WHAT IS A HOLD HEARING?

Q. WHAT IS AN ARRAIGMENT?

Q. WHAT IS A PRE-TRIAL CONFERENCE?

Q. WHAT HAPPENS AT THE TRIAL?

Q. WHAT IS A GUARDIAN AD LITEM?

Q. WHAT IS THE INDIAN CHILD WELFARE ACT?

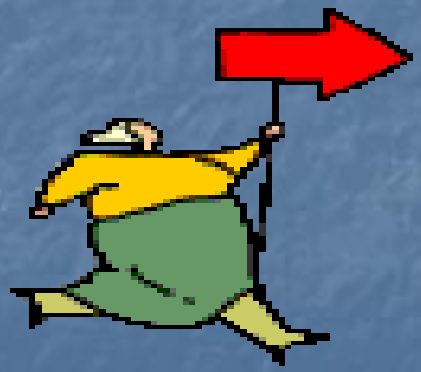
Q. WHAT IS INVOLUNTARY OR COURT-ORDERED PLACEMENT?

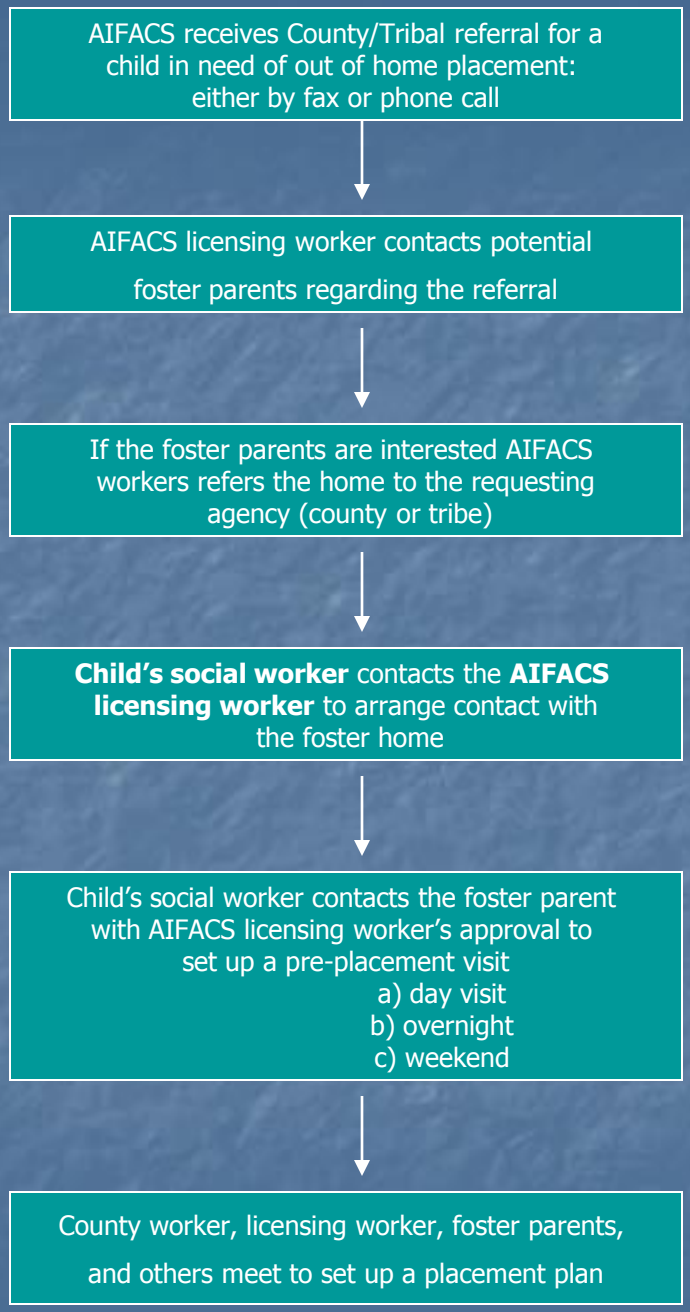
Q. WHAT IS LEGAL CUSTODY?

Q. WHAT IS THE ADOPTION PROMOTION AND STABILITY ACT (APSA)?

Q. WHAT IS THE MINNESOTA INDIAN FAMILY PRESERVATION ACT?

Steps to the Referral and Placement Process




AIFACS receives County/Tribal referral for a child in need of out of home placement: either by fax or phone call
AIFACS licensing worker contacts potential foster parents regarding the referral
If the foster parents are interested AIFACS workers refers the home to the requesting agency (county or tribe)
Child's social worker contacts the **AIFACS licensing worker** to arrange contact with the foster home
Child's social worker contacts the foster parent with AIFACS licensing worker's approval to set up a pre-placement visit
a) day visit
b) overnight
c) weekend
County worker, licensing worker, foster parents, and others meet to set up a placement plan

Responsibilities Of Foster Parents To The Children In Their Care

1. Medical and Dental

2. Therapy

3. Family visitation

4. Be available for monthly visits with placing agency and AIFACS staff

5. Documentation
    a) calendar
    b) notebook
    c) incident reports

6. Communication with:
    a) County/tribe
    b) AIFACS
    c) School
    d) Doctors/Therapist
    e) Biological family

7. Training
    a)24 hours required yearly
    b) $200.00 yearly budget per foster home for extra training
    c) AIFACS offers training on monthly basis
    d) AIFACS maintains a library of training materials including books, cds, tapes and videos

Foster Child Minimum Clothing Standard

Infants (0-1 Year Old)
7-10 outfits
7 onesies or t-shirts
1 pair of shoes
1 coat appropriate for season, including snow pants, cap, scarf, and mittens if winter discharge
1 comb or hairbrush
Any gifts given to the child while in foster care
1 duffel bag or suitcase
1 diaper bag containing:
1 bottle
1 blanket
1 bib
1 unopened can of formula
6 disposable diapers

1-11 years Olds
7 underpants
7 pair of socks
5 tops
5 pants/shorts
2 pairs of shoes
2 sleepwear
1 outfit for special occasions
1 coat appropriate for season, including snow pants, cap, scarf, and mittens if winter discharge
1 toothbrush
1 book bag for school-aged children
1 comb or hairbrush
Any gifts given to the child while in foster care
1 duffel bag or suitcase

12-14 years Olds
7 underpants
7 pair of socks
5 tops
5 pants/shorts
2 bras (girls)
2 pairs of shoes
2 sleepwear
1 sweatshirt
1 outfit for special occasions
1 coat appropriate for season, including snow pants, cap, scarf, and mittens if winter discharge
1 toothbrush
1 book bag
1 comb or hairbrush
Any gifts given to the child while in foster care
1 duffel bag or suitcase

15-18 years Olds
7 underpants
7 pair of socks
5 tops
5 pants/shorts
2 bras (girls)
2 pairs of shoes
1 sweatshirt
1 outfit for special occasions
1 coat appropriate for season, including snow pants, cap, scarf, and mittens if winter discharge
1 toothbrush
1 book bag
1 comb or hairbrush
Any gifts given to the child while in foster care
1 duffel bag or suitcase

Self Care For Foster Parents

1. Documentation:
   -to protect against allegations

2. Use of respite care

3. Training/Support Groups

4. Communication
   a) AIFACS worker
   b) County/Tribal worker
   c) School personnel
   d) Therapist/medical provider

5. Use of Community Resources

NO! NOT! NEVER!

Infants May NOT Be

- Left in the care if another foster child
- Left to cry without checking on them
- Allowed to in the car without a car seat
- Left in a car alone, even briefly

Toddlers May NOT Be

- Left in the tub unsupervised, even briefly
- Left in the yard unsupervised, even briefly
- Allowed to ride in a car without a car seat
- Left in a high chair unattended, even briefly
- Left in a bathroom or kitchen unattended, even briefly
- Left to care for a younger child, even briefly
- Out of your sight in a public setting
- Left in a car alone, even briefly

School Aged Children May NOT Be

- Left in a car alone, even briefly
- Allowed to ride in a car without a seatbelt
- Allowed easy access to chemicals or medical products
- Left to care for a younger children
- Alone in the home overnight
- Left alone in a store or mall
- Left alone with other children at home or in public
- In the park without adult supervision

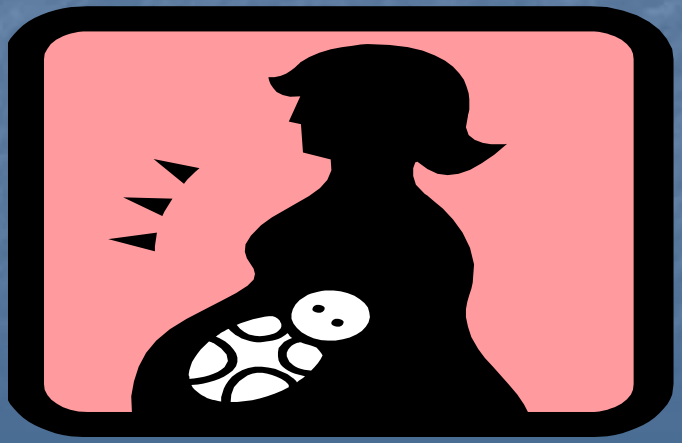
Teenagers May NOT Be

- Allowed to ride in a car without a seatbelt
- Left alone overnight
- Allowed to spend the night with a friend without their social worker's permission
- Left to care for younger children when you are unsure of their capabilities
- Left to select music, movies, video games, or surf the internet without supervision
- Allowed to spend the day alone without you know specifically where they are

Complaints F.A.Q

- Q. WHY ARE FOSTER PARENTS SO SUSCEPTIBLE?
- Q. WHERE DO COMPLAINTS COME FROM?
- Q. WHAT IS THE FIRST THING THAT NEEDS TO BE DETERMINED WHEN A COMPLAINT IS MADE ABOUT A FOSTER HOME?
- Q. WHAT IS MALTREATMENT?
- Q. IF THE COMPLAINT MEETS THE CRITERA TO BE INVESTIGATED THROUGH CHILD PROTECTION, MAY MY LICENSING SOCIAL WORKER DO THE INVESTIGATION?
- Q. WHAT IS THE ROLE OF MY LICENSING SOCIAL WORKER DURING THE AN INVESTIGATION BY CHILD PROTECTION?
- Q. WHAT ARE THE POSSIBLE OUTCOMES OF A COMPLAINT THAT IS INVESTIGATED BY CHILD PROTECTION?
- Q. WHY DOES IT SOMETIMES TAKE SO LONG BETWEEN THE TIME I AM NOTIFIED THAT THERE IS A COMPLAINT AND WHEN THE INTERVIEW TAKES PLACE?
- Q. HOW AM I NOTIFIED ABOUT THE DETERMINATION OF A MALTREATMENT COMPLAINT?
- Q. WHAT HAPPENS TO THE RECORDS ABOUT THESE COMPLAINTS?
- Q. IF A COMPLAINT DOES NOT MET THE CRITERIA TO BE INVESTIAGTED BY CHILD PROTECTION, WHAT HAPPENS TO THE COMPLAINT?
- Q. WHAT ARE THE POSSIBLE OUTCOMES OF A COMPLAINT THAT INVOLVES LICENSING VIOLATIONS?
- Q. WHAT INFORMATION ABOUT A LICENSING COMPLAINT IS KEPT IN MY LICENSING FILE?
- Q. WHAT IS A CORRECTION ORDER?
- Q. WHAT ARE THE OTHER POSSIBLE NEGATIVE LICENSING RECOMMENDATIONS?
- Q. IF I AM NOTIFED THAT CHILD PROTECTION HAD MADE A DETERMINATION THAT NO MALTREATMENT EXISTS, WHY MAY I STILL GET A CORRECTION ORDER OR OTHER NEGATIVE LICENSING ACTION FROM LICENSING?
- Q. IS ANY OF THE COMPLAINT MATERIAL PUBLIC INFORMATION?

Fetal Alcohol Spectrum Disorder



What is Fetal Alcohol Syndrome/Effects?

Fetal Alcohol Syndrome is a combination of physical and neurological birth defects caused by prenatal exposure to alcohol.

To be diagnosed with this, children must show effects in three different areas:

- evidence of facial morphology (small, wide set eyes, flat face, thin upper lip, etc.)
- evidence of growth retardation both in size and weight
- evidence of central nervous system damage (small head, poor fine and gross motor control, hyperactivity, etc.).

There are also a number of physical difficulties that are sometimes associated with FAS, including

- heart defects
- cleft palate
- sight
- hearing defects

Facts about FAS/FAE

- FAS is the leading known cause of mental retardation.

- FAS/FAE produces irreversible physical and mental damage.

- Behavioral problems of FAE children can be as severe as those of FAS children.

- FAS/FAE crosses all socio-economic groups and effects all races.

- Costs for one FAS child is estimated to be $2 million over a lifetime.

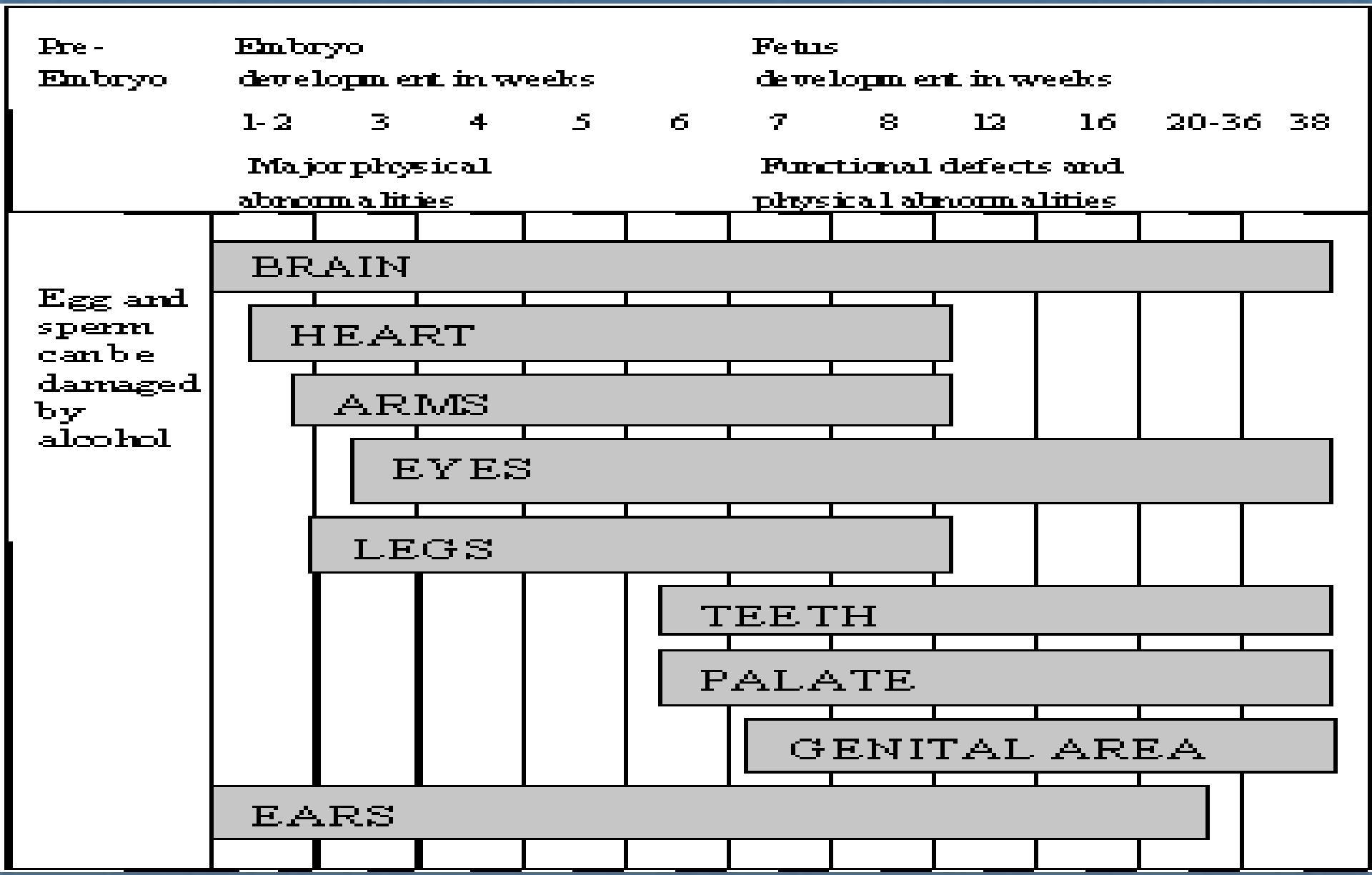
- FAS/FAE costs the American taxpayer more than $321 million every year.

- No amount of alcohol consumption during pregnancy is known to be safe.

- Of FAE Individuals between the ages of 12 and 51:
  - 95% will have mental health problems
  - 55% will be confined in prison, drug or alcohol treatment centers or a mental institution
  - 60% will have "disrupted school experience"
  - 60% will have trouble with the law
  - 52% will exhibit inappropriate sexual behavior

- Of FAE individuals between 21 and 51:
  - 82% will not be able to live independently
  - 70% will have problems with employment
  - More than 50% of males and 70% of females will have alcohol and drug problems

Impact of Alcohol Use of the Developing Fetus

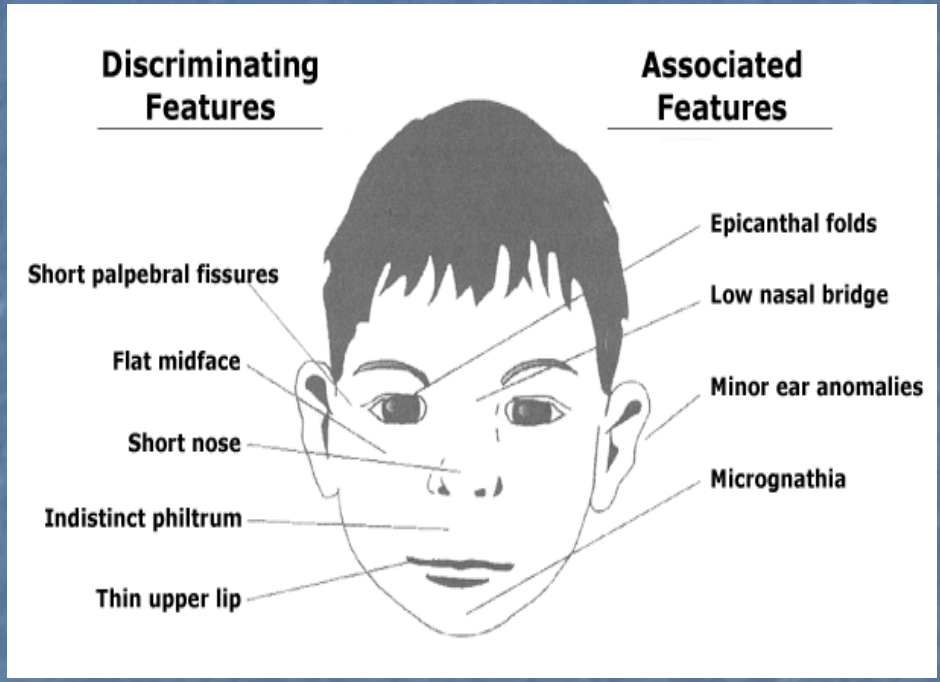


Physical Characteristics Related to FAS/FAE

Facial Appearance

So what features make a child "look" like a child with FAS? The following facial features are associated with FAS.

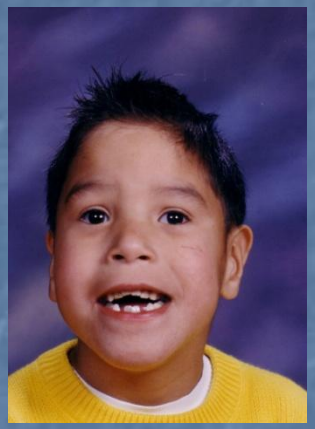
- Nearsightedness
- -Short eye slits (short palprebral fissures)
- -Droopy eyelids (epicanthal folds)
- -Widely spaced eyes
- -Crossed eyes
- -Short, upturned nose
- -Low and/or wide bridge of the nose
- -Thin upper lip
- -Smooth or flat area between the nose and lip (indistinct philtrum)
- -Flat midface
- -Small, underdeveloped jaw (micrognathia)

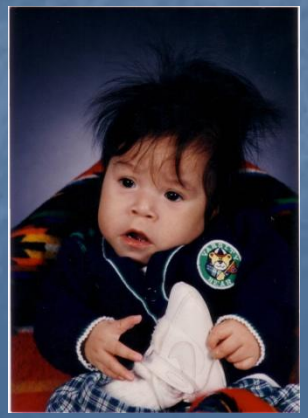


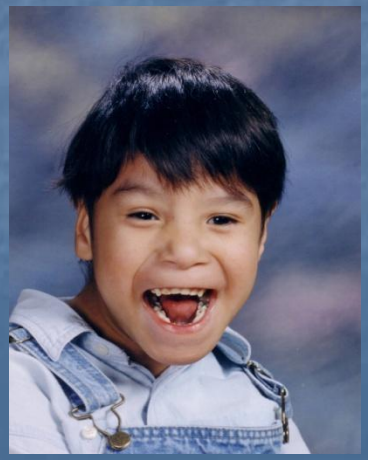
•The facial characteristics of FAS are sometimes not as noticeable at birth and are less obvious in adolescence and adulthood. The facial anomalies will be the more noticeable between the ages of 2-10 years

Other physical features related to FAS/E include:

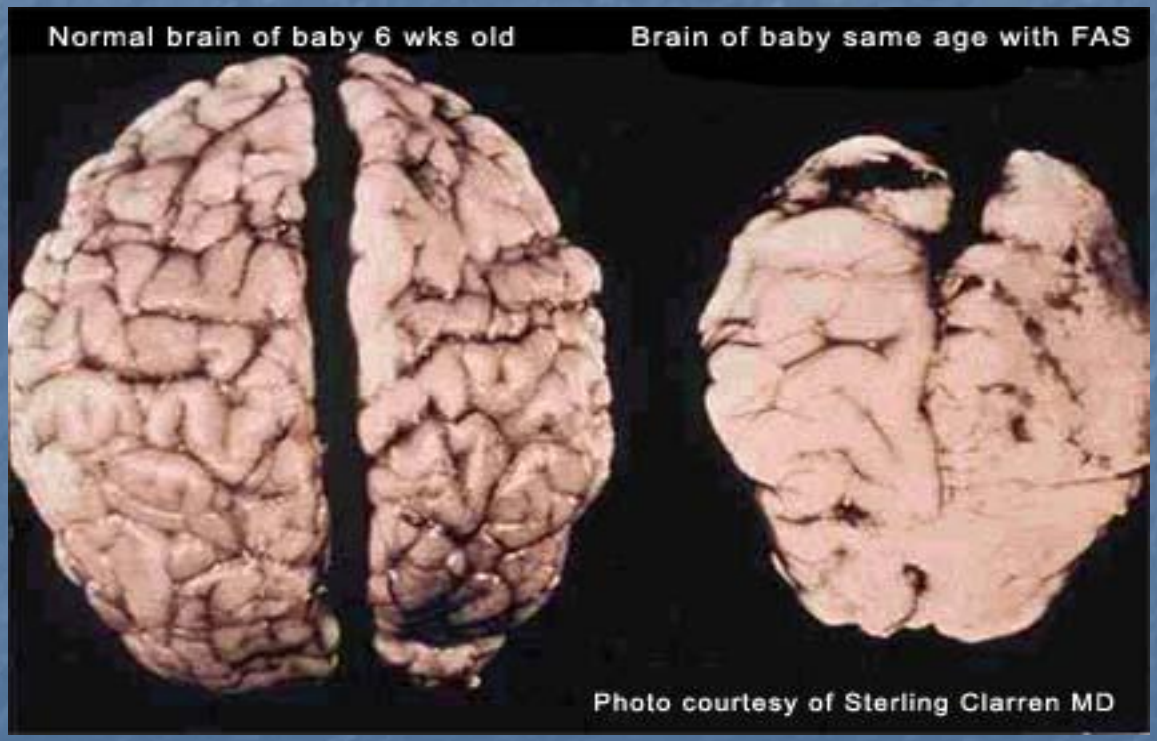
- Low birth weight
- Failure to thrive
- Small size for age in weight and length
- Small head for age (microcephaly)
- Large or malformed ears
- Underdeveloped fingernails or toenails
- Short neck
- Joint and bone abnormalities







FAS/FAE & the Brain



1. **Loss of Intellectual function (IQ).** The average IQ in children born with FAS is 65-80, depending on which source you read. A normal IQ is 100, with a standard deviation of 15. In general, IQ below 85 indicates mental retardation, with scores less than 70 indicating severe retardation.

2. **Behavior disorders**. About 70% of children with FAS are severely hyperactive, frequently engaging in disturbing self-stimulating behaviors such as body rocking, head banging, or head rolling. Behavior problems may include hyperactivity, stubbornness, impulsiveness, passiveness, fearlessness, irritability, sleep difficulties, and teasing or bullying of others.

3. **Learning disabilities.** With FAS the average academic functioning does not seem to develop beyond early grade school level, even with constant remedial help at school. Arithmetic and abstractions like time and space, cause and effect, as well as generalizing from one situation to another are particular deficits.

4. **Memory impairment**

5. **Speech and language disorders**

6. **Coordination impairment.** Many children with FAS have impaired fine motor coordination, impaired hand-eye coordination, and are "clumsy" and "accident-prone."

7. **Musculoskeletal abnormalities.** Variable musculoskeletal and limb defects are found in approximately 40% of cases, ranging in severity from minor problems such as contractures of the finger joints to more severe lesions, such as congenital hip dislocations and thoracic cage abnormalities.

8. **Social impairment.** In general, children with FAS do not consider consequences for their actions, lack responses to appropriate social cues, lack reciprocal friendships, withdraw socially, are sullen with mood liability, exhibit teasing and bullying behavior, and have periods of high anxiety and excessive unhappiness. These characteristics impair the child's ability to form satisfying and lasting relationships.

Research indicates the social maturation of individuals with FAS is arrested and not just delayed, at the level of a 4-6 year old child.

Secondary neurodevelopmental disorders can occur if there is a failure to properly deal with the primary disabilities. Secondary disabilities include:

1. Mental health problems
2. Disrupted schooling
3. Legal problems
4. Confinement (jail or juvenile detention, inpatient treatment for mental health)
5. Inappropriate sexual behavior
6. Dependent living
7. Employment problems

Developmental Skills Related to FAS/FAE

Skill	*Expected Developmental Age Equivalent*
Expressive Language	20 years
Physical Maturity	18 years
Reading Ability	16 years
Living Skills	11 years
Money, Time Concepts	8 years
Social Skills	7 years
Comprehension	6 years
Emotional Maturity	6 years

(D. Malbin, 1994)

- **Subject is an 18 year old with FAS/FAE**

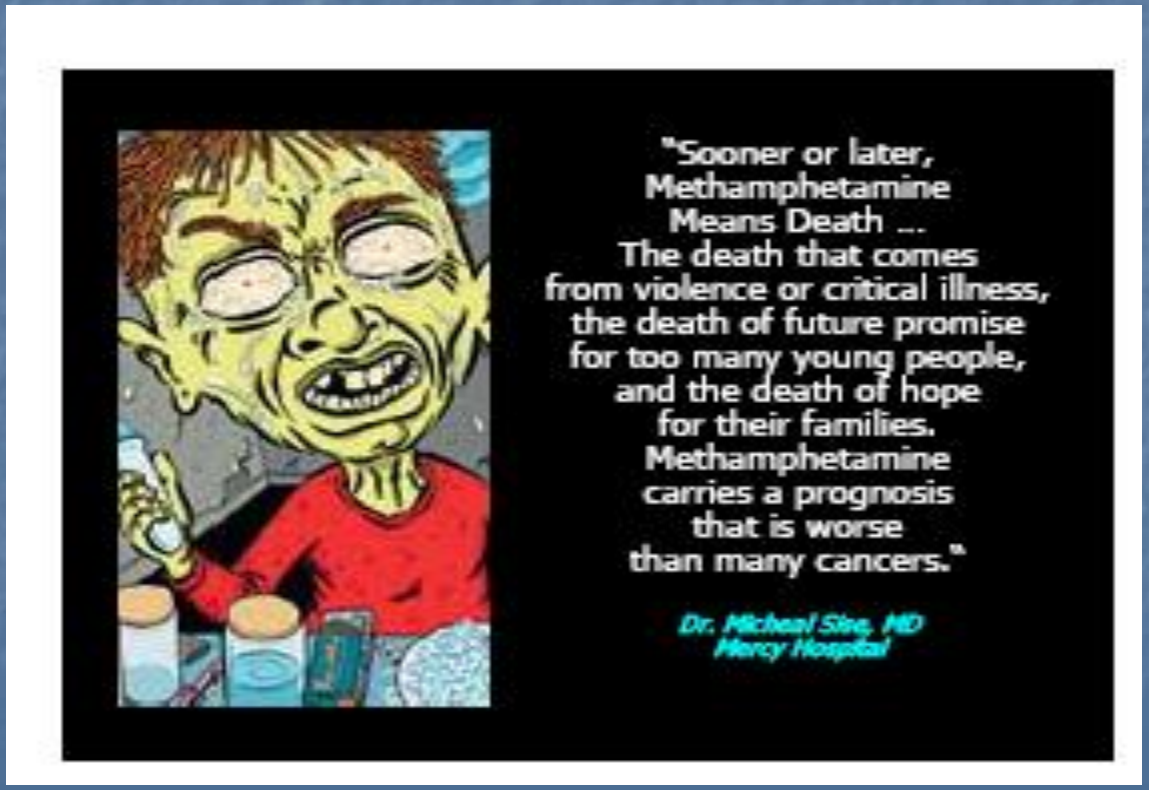
A shift in how to understand children with FAS/FAE may be helpful. This shift includes moving:

From seeing a child as:	To understanding a child as:
Won't	Can't
Bad	Frustrated, defended, challenged
Lazy	Tries hard
Lies	Fills in
Doesn't try	Exhausted or can't start
Mean	Defensive, hurt, abused
Doesn't care	Can't show feelings
Refuses to sit still	**Overstimulated**
Fussy, demanding	Oversensitive
Resisting	Doesn't "get it"
Trying to make me mad	Can't remember
Trying to get attention	Needing contact, support
Acting younger	Being younger
Thief	Doesn't understand ownership
Doesn't try	Tired of always failing
Doesn't get the obvious	Needs many reteachings

D. Malbin (1994)

How do we work with FAS/FAE kids?

Methamphetamines



Methamphetamine & Amphetamines

(Amphetamine, dextroamphetamine, methamphetamine, and their various salts are collectively referred to as amphetamines. In fact, their chemical properties and actions are so similar that even experienced users have difficulty knowing which drug they have taken. Methamphetamine is the most commonly abused.)

Street terms for methamphetamine:

Meth, poor man's cocaine, crystal meth, ice, glass, speed

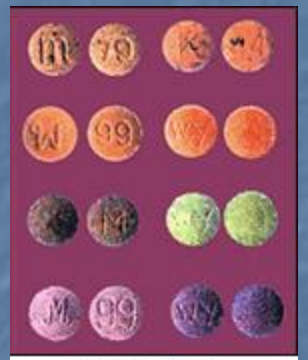
What Does Methamphetamine Look Like?

- white powder that easily dissolves in water.
- clear chunky crystals, called crystal meth, or ice.
- small, brightly colored tablets. The pills are often called by their Thai name, yaba.

What are the methods of usage?

Injecting
Snorting
Smoking
Oral ingestion

What Meth can look like



Yaba tablets

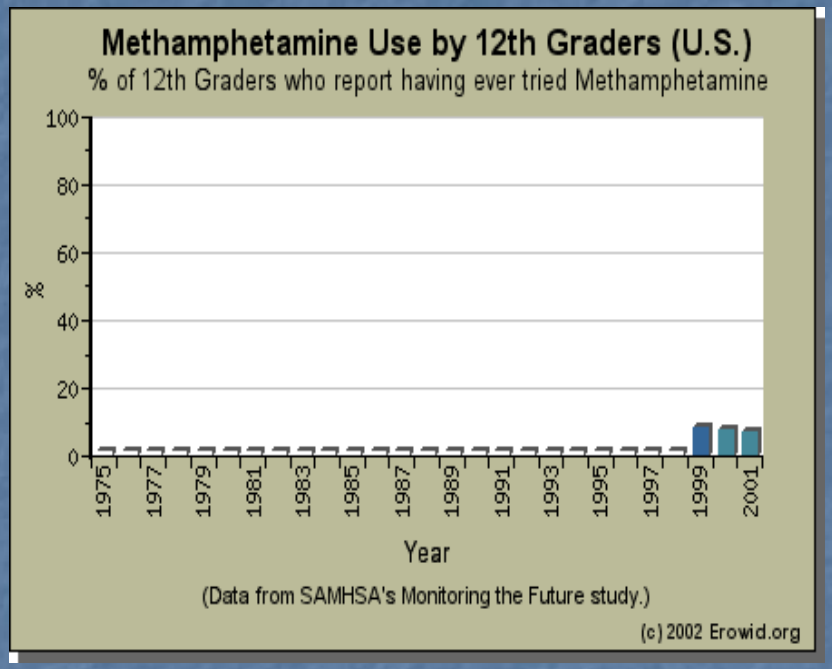
Who uses methamphetamine and amphetamines?

During 2000, 4% of the U.S. population reported trying methamphetamine at least once in their lifetime.

Abuse is concentrated in the western, southwestern, and midwestern United States.

How do methamphetamine and amphetamines get to the United States?

- Clandestine laboratories in California and Mexico are the primary sources of supply for methamphetamine available in the United States.
- Domestic labs that produce methamphetamine are dependent on supplies of the precursor chemical pseudoephedrine, which is sometimes diverted from legitimate sources. It is smuggled from Canada, and to a lesser extent from Mexico.
- Domestic independent laboratory operators, mostly in the western, southwestern, and midwestern United States, also produce and distribute methamphetamine but on a smaller scale.
- Yaba (meth in tablet form) is most often produced in Southeast Asia and sent by mail or courier to the United States.



Effects of Meth

POSITIVE

- increased energy and alertness
- decreased need for sleep
- euphoria
- increased sexuality

NEGATIVE

- disturbed sleep patterns
- tightened jaw muscles, grinding teeth (trismus and bruxia)
- loss of appetite (anorexia), leading to poor nutrition and weight loss with heavy use
- reduced enjoyment of eating
- loss of interest in sex, over time
- itching, welts on skin
- nausea, vomiting, diarrhea
- excessive excitation, hyperactivity
- shortness of breath
- moodiness & irritability
- anxiousness & nervousness
- aggressiveness
- panic, suspiciousness & paranoia
- involuntary body movements (uncontrollable movement and/or twitches of fingers, facial & body muscles, lip-smaking, tongue protrusion, grimacing, etc.)
- false sense of confidence and power (delusions of grandeur)
- aggressive and violent behavior
- severe depression, suicidal tendencies

NEUTRAL

•excessive talking
•weight loss
•sweating
•visual & auditory hallucinations (hearing voices)

Effects of Habitual Use

•fatal kidney and lung disorders
•possible brain damage
•permanent psychological problems
•lowered resistance to illnesses
•liver damage

You can identify methamphetamine users by...

- Signs of agitation, excited speech, have decreased appetites, and increased physical activity levels. Other common symptoms include: dilated pupils, high blood pressure, irregular heartbeat, chest pain, shortness of breath, nausea and vomiting, diarrhea, and elevated body temperature.

- Occasional episodes of sudden and violent behavior, intense paranoia, visual and auditory hallucinations, and bouts of insomnia.

- A tendency to compulsively clean and groom and repetitively sort and disassemble objects, such as cars and other mechanical devices.

Meth Ingredients

- Alcohol - Gasoline additives or Rubbing Alcohol
- Ether (starting fluid)
- Benzene
- Paint thinner
- Freon
- Acetone
- Chloroform
- Camp stove fuel
- Anhydrous ammonia
- White gasoline
- Pheynl-2-Propane
- Phenylacetone
- Phenylpropanolamine
- Rock, table or Epsom salt Iodine crystals
- Red Phosphorous
- Toluene (found in brake cleaner)
- Red Devil Lye
- Drain cleaner
- Muraitic acid
- Battery acid
- Lithium from batteries
- Sodium metal
- Ephedrine
- Cold tablets
- Diet aids
- Iodine
- Bronchodialators
- Energy boosters


1998
2002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Meth and Pregnancy

If methamphetamines are used during pregnancy, babies tend to be:

- Asocial
- Incapable of bonding
- Have tremors
- Have birth defects
- Difficulty sucking/swallowing
- Hypersensitivity to touch and light
- Cry for 24 hours without stopping
- Cardiac defects
- Cleft palate
- Birth defects
- Addiction and withdrawal
- Deficits in IQ, language ability areas
- High incidence of ADD/ADHD
- Learning disabilities and behavior disorders
- Bouts of unprovoked anger

❖ Children living with users and cooks at increased risk of shaken baby syndrome

.

❖ There is also an increased risk of child abuse and neglect of children born to parents who use methamphetamines

Meth=Child Abuse?

Kids in meth-oriented dwellings:

- 30% sexually abused

-28% physically abused

-35% positive for heavy metals

-30% positive for meth

Drug Enforcement Administration (DEA) data showed that 30% of labs nationwide, and 50% of Minnesota labs had children living in them at the time of seizure

Risks to Drug Endangered Children

Social hazards

- Abuse and neglect
- Poor nutrition, health care, hygiene
- Chaotic sleep, eat, life patterns
- Exposed to violent events and acts
- Exposed to poly substance abuse use
- Exposed to pornography, inappropriate sexuality
- Shame, isolation, poor socialization
- Caregivers unable to comply to interventions

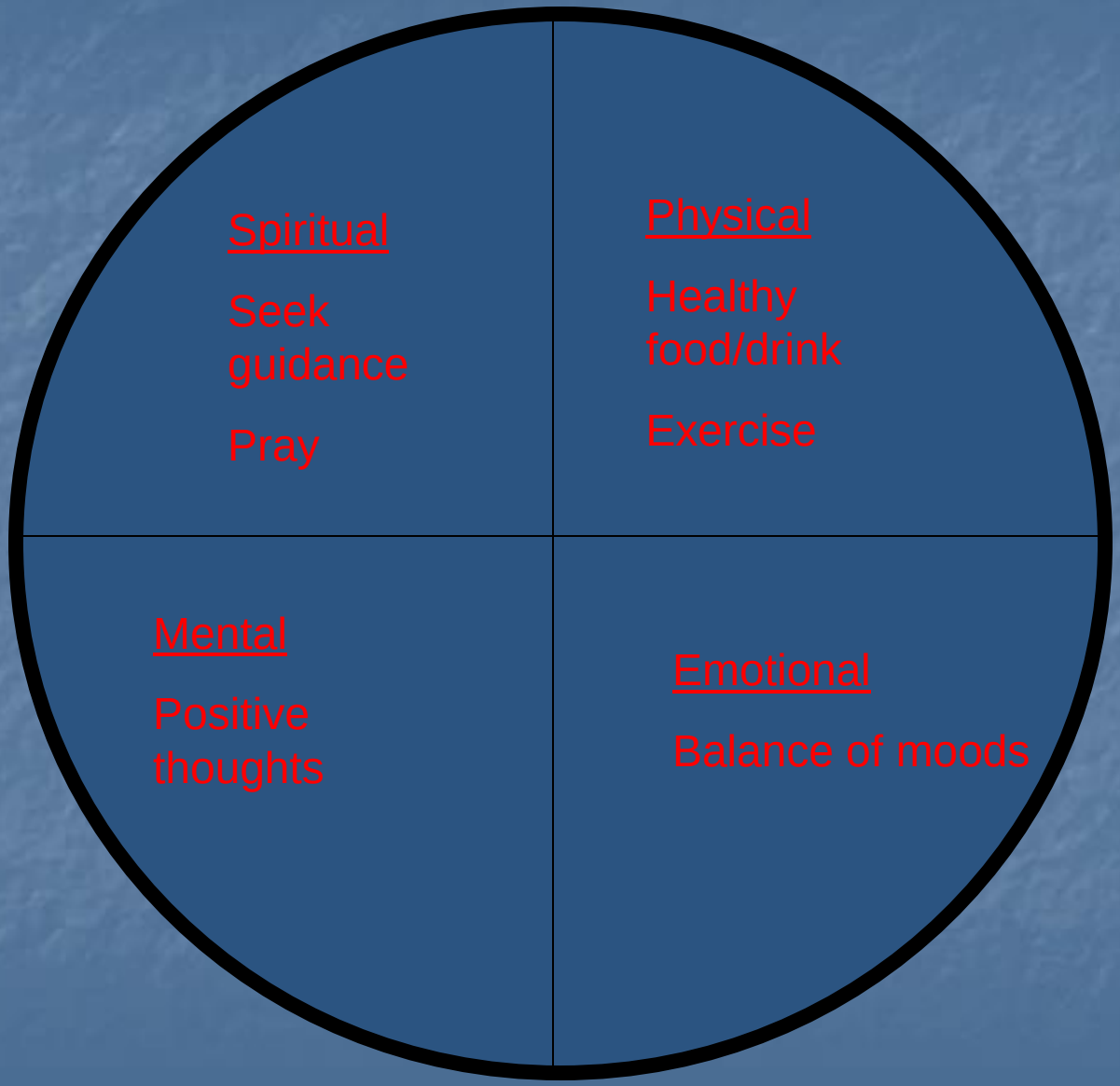
Chemical Hazards

- Second hand meth smoke
- Injury from exposure to metal, solvents, corrosives
- Risk of fire and explosion from mishandled volatiles, toxics; lack of safety equipment

Physical and Biological Hazards

- Weapons, explosives and booby traps
- Filth, feces, rodents, pests, contaminated needles
- Exposure to STDs and blood borne diseases (HIV/AIDS, E Coli, hepatitis A and C)
- Inadequate heating, electrical, plumbing
- Vicious animals

Medicine Wheel



Natural World	Un-Natural World
• A world of living at ease and at peace	• Survival to get by. It's a life full of extremes
• Having the ability to see the negative and the positive in life	• Many times, a person can only see the negative
• Creating a balance	• May see a negative or a positive, but are unable to create a balance

Child Abuse

Terms

Physical Abuse

Physical abuse occurs when a parent or caregiver purposely injures a child by hitting, biting, shaking, kicking, burning or throwing objects

Emotional Abuse

Verbal attacks, threat or humiliation are examples of emotional abuse. The effects are not visible on a child, but most of the time they destroy a child's self-esteem

Neglect

Physical neglect is the most **common** form of child abuse and occurs when a parent or caregiver fails to provide for the physical needs, such as; food, clothing, shelter, and medical care. Emotional neglect occurs when the caregiver fails to provide love and attention for the child. Failure to provide guidance and supervision is also a form of neglect.

Sexual Abuse

Sexual abuse occurs when someone, usually an adult or older teenaged known to the child, uses the child for their own sexual gratification.

Symptoms/Indicators of Physical Abuse

BRUISES AND WELTS

- Unexplained, unusual, suspicious, non-accidental
- Located of face, lips, mouth, torso, buttocks, thigh in various stages of healing
- Clustered, forming regular patterns
- Reflecting shape of article uses (electric cord, buckle, etc)
- Choke marks
- Human hand marks
- Any bruises on infants

BURNS

- Shaped like a cigar or cigarette, especially on soles, palms, back or buttocks
- Immersion burns (socklike, glovelike; doughnut-shaped on buttocks or genitals)
- Patterned like an electric burner, iron
- Rope burns on arms, legs, neck or torso

FRACTURES

- Inconsistent with explanation
- Spiral fracture in infant
- Repeated fractures to same site

CUTS OR ABRASIONS- on mouth, lips, gums, eyes, genitals

ABDOMINAL INJURIES- Swelling of abdomen, constant vomiting

HUMAN BITE MARKS

HEAD INJURIES

INTERNAL INJURIES

Common Traits of Physically Abused Children

They may experience:

- Low self-esteem
- Refuses, draws away from contact
- Sleep disturbances
- Eating disorder
- Accept blame for anything that goes wrong or accepts blame for nothing
- Represses or blocks memory
- Extreme aggressiveness
- Extreme withdrawal
- Obnoxious, hurtful or destructive behavior
- Any behavior outside the range of the normal age and stage of development

Symptoms/Indicators of Neglect

Child's Appearance:

- Inappropriate or poor hygiene
- Chronically unwashed
- Chronic diaper rash
- Inappropriate clothing for weather conditions, age, size
- Shaved head, matted hair, or untreated lice
- Extreme overweight due to overeating
- Untreated severe and chronic medical/dental condition
- Underweight
- Prone to illness
- Pale skin

Common Traits of Neglected Children

- Listlessness
- Delayed growth
- Delayed speech
- Chronic absenteeism
- Always tired
- May fall asleep in school

Symptoms/Indicators of Sexual Abuse

- Difficulty in walking or sitting
- Torn, stained or bloodied underclothes
- Bruises or bleeding in genital, vaginal, or anal area
- Blood or seamen on clothing
- Sperm in vagina
- Pregnancy
- STDs
- Genital or urinary irritation, injury and/or infection
- Frequent, unexplained sore throats or other pyshcial symptoms
- Bed-wetting, wetting/soiling pants

Common Traits of Sexually Abused Children

- Displays bizarre, unusual, sophisticated knowledge or behavior regarding sex
- Does unusual amount of sex play with self or toy
- Initiates sex play with other children
- Early pregnancy or unusual sexual behavior
- Complains of pain or itching in genital area
- Generally poor peer relationships
- Unwillingness to participate in physical activities
- Intense fear reaction to an individual or to people in general
- Unusual relationship between an adult and a child
- Appears withdrawn, engages in fantasy or unusually infantile behavior
- Excessive acting out of any kind
- Sudden drop in school performance or interest in activities
- Difficulty sleeping
- Regressive behavior
- Continuously depressed
- Acts overly grown-up
- Phobic behavior
- Extremely upset when bathing or changing diaper
- Poor self-esteem
- Self-destructive activity or suicidal
- Delinquent behavior and/or running away

What foster parents and parents can do to decrease the effects of sexual abuse on child victims

Some child victims:	As foster parents you should:
Believe that their bodies were permanently damaged, even if there has been no physical injury	Work with the agency to seek a doctor who knows about the sexual abuse and can reassure the victim if there has been no physical injury
Feel guilt for being a victim	Tell the child that what happened to them is not their fault and that they do not give consent for sexual abuse
Feel guilt over the consequences of reporting the abuse because it may have disrupted the	Reassure the child that they did the right thing in reporting the sexual abuse
Family member may blame the child for their pain	Let them know that they are not to blame and that they will be protected. Tell the child they are not alone and that there are other children who have experienced similar hurt. Reassure the child that children are to be loved and protected
Have a fear of being abused again. This could result in sleep disturbances or nightmares. Most victims also have feelings of depression	Encourage the child to talk about any fears, You have to create an environment in which the child can express all feelings, positive and negative, and fell believed and supported
Initiate sexual relationships. These relationships are sexual because that is the way they have learned to get attention and	Initiate healthy social activities that involve both sexes to enable the child to learn to relate to others in a non-sexual way

Helping a Child Set Boundaries (Things You can Say)

1. Your body belongs to you. You can tell people if you want to be touched or not
2. You can make decisions about your body
3. If someone wants to pat your bottom, you can tell them not to.
4. Your feelings will tell you when things don't seem quite right. Listen to your feelings
5. You deserve privacy when you need it
6. I'll tell you when I don't like certain touches, and you can too
7. You are safe with me
8. It is alright for me to give you a hug? You can say yes or no
9. No one can come in when you are talking a bath unless you say it is okay
10. You can ask for help washing your back, but nothing else
11. No one should come in to watch or peek

WAYS OF HEALING

Formal Ways of Healing

- Any referral or therapy should be a team decision and the caseworker should be involved
- Individual therapy
- Group therapy
- Family therapy- when appropriate and safe for the child
- Any combination of the above
- Participating in culture such as purification ceremonies

Informal ways of healing

- Consistent care by foster parents

- Helping the child deal with feelings

- Positive reminders by foster parents that encourage development in there areas