

Chapter HFS 37

INFORMATION TO BE PROVIDED TO FOSTER PARENTS

HFS 37.01 Authority and purpose.
 HFS 37.02 Applicability.
 HFS 37.03 Definitions.

HFS 37.04 Information to be provided to foster parents.
 HFS 37.05 Timing of providing information.
 HFS 37.06 Confidentiality.

Note: Chapter HSS 37 was renumbered chapter HFS 37 under s. 13.93 (2m) (b) 1., Stats., Register, September, 1996, No. 489.

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

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

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

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

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

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

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

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

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

HFS 37.03 Definitions. In this chapter:

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

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

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

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

(2) “AODA” means alcohol or other drug abuse.

(3) “CAN” means child abuse or neglect.

(4) “Child’s family” means, unless otherwise indicated, the child’s biological or adoptive family.

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

(6) “Department” means the Wisconsin department of health and family services.

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

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

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

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

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

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

History: Cr. Register, February, 1995, No. 470, eff. 3–1–95; correction made under s. 13.93 (2m) (b) 6., Stats., Register, May, 2001, No. 545.

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

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

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

(3) An allegation regarding the foster child or the child’s family shall not be provided to the foster parents unless the placing agency determines that, if substantiated, the allegation would have a significant impact on the health, safety or welfare of the foster child or the foster parents or the foster child’s or foster par-

ents' family or on the success of the placement and related services.

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

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

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

or the foster parents, within 3 working days after receipt of the information.

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

HFS 37.06 Confidentiality. (1) At the time that any information regarding a foster child is first provided to the foster parents by the placing agency, the placing agency shall inform the foster parents of all confidentiality requirements mandated under state or federal law, including the requirements under ss. 48.396, 48.78, 48.981 (7), 51.30, 118.125, 146.82, and 252.15, Stats., and any placing agency policy, and penalties which may be imposed for violating the rights to confidentiality of the foster child and the foster child's family.

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

History: Cr. Register, February, 1995, No. 470, eff. 3-1-95; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, May, 2001, No. 545.

**CHAPTER HFS 37 APPENDIX A
INFORMATION FOR FOSTER PARENTS
FACE SHEET**

Date of Placement: ___ / ___ / ___

Child's Name: _____ Nickname(s): _____ DOB: ___ / ___ / ___ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: ___ - ___ - ___ Cultural Identification (as indicated by child if old enough): Height: _____ Weight: _____ lbs. Religious Preference (of child or family): Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations):
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Child's Social Worker With Whom Foster Parent Will Have Contact: Name: _____ Title: _____ Agency: Agency Secondary Contact (if social worker not available): Telephone: Regular Hours: (____) _____ After Hours: (____) _____
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Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s):
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS:
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors?
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a: <input type="checkbox"/> Voluntary Placement <input type="checkbox"/> Court-ordered Placement
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Medical Assistance #:
Insurance Company (if any): Name _____ Telephone: () _____
Policy #: _____ Group #: _____
Physician: _____ Type: _____
Address: _____
Telephone: () _____
Dentist: _____
Address: _____
Telephone: () _____
Other Health Specialists/Therapists
Name: _____ Telephone: () _____ Specialty: _____
Name: _____ Telephone: () _____ Specialty: _____
Preferred Hospital: _____ (Note: Use of hospital may be dictated by insurance company/plan)

Is foster parent expected to participate in therapy with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of	<input type="checkbox"/> Birth Mother:
Child's	<input type="checkbox"/> Stepmother:
(Check most appropriate one)	<input type="checkbox"/> Adoptive mother:
Address:	_____
Telephone: ()	_____
Name of	<input type="checkbox"/> Birth Father:
Child's	<input type="checkbox"/> Stepfather:
(Check most appropriate one)	<input type="checkbox"/> Adoptive father:
Address:	_____
Telephone: ()	_____
Child's Siblings:	
Name: _____	DOB: _/ _/ _ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Name: _____	DOB: _/ _/ _ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Name: _____	DOB: _/ _/ _ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Significant Extended Family Members (Name, Phone and Relationship):	
Legal Custodian: _____	
Relationship: _____	
Address: _____	Phone: () _____
GAL*/Legal Counsel: _____	
Address: _____	
Telephone: () _____	
*Guardian ad litem	

Significant individuals who may be having contact with the child:			
<u>Name</u>	<u>Phone</u>	<u>Relationship</u>	

Individuals whose contact with the child is forbidden or restricted (e.g., supervised visitation)			
<u>Name</u>	<u>Relationship</u>	<u>Type of Restriction</u>	<u>Rationale (e.g., court order, parents' wishes)</u>

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

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))		
<u>Type (FH, GH, RCC/CCI, hospital, etc.)</u>	<u>Name</u>	<u>Dates</u>

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

Day Care or Respite Provider(s)
_____ Phone: (____) _____
_____ Phone: (____) _____

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

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

Placing agency has given the foster parent:

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

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

**CHAPTER HFS 37 APPENDIX B
INFORMATION FOR FOSTER PARENTS
CHECKLIST**

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

*NK=Not Known At This Time

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

*NK=Not Known At This Time

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

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Rheumatic Fever				
Has had electrocardiogram (EKG)				
Has had chest X-ray. If yes, when was last one?				
Heart murmur				
High or low blood pressure. Last check up?				
Irregular heart beat				
Shortage of breath				
Swollen ankles				
How many pillows does child sleep on?				
27. Urinary or prostate problems/Gall bladder				
Incontinence, urine or fecal				
Bleeding or burning when urinating				
Abnormally frequent urination				
Has had kidney or gall bladder stone				
28. Anemia				
29. Blood problems				
30. Cancer, leukemia, or other malignancy				
31. History of abusing or not taking prescribed medications				
32. Alcohol use or abuse				
33. Other drug use or abuse				
AODA treatment				
34. Is child menstruating?				
Child understands menstruation				
Child's periods are normal				
Excessive cramping or pain				
PMS symptoms				
Medication for cramps. If yes, what medication?				
Bleeding or discharge other than when menstruating				
Has had a "yeast" infection				
Has had a "Pap" test. If yes, when? Why?				
Abnormal results?				
35. Child has physical or developmental disabilities				
If yes, what type of disability?				
Autism				
Blindness				
Cerebral Palsy				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Deafness				
Dyslexia				
Emotional Disturbance				
Epilepsy				
Fetal Alcohol Effect				
Fetal Alcohol Syndrome				
Mental Retardation				
Muscular Dystrophy				
Neurological Impairment				
Physical Impairment				
Other (specify):				
Restrictions on Activities (e.g., lifting, driving, riding bikes)				
Special equipment (e.g., cane, walker, wheelchair)				
36. Considering the age of the child, his/her abilities are not appropriate for:				
Bathing				
Feeding				
Toileting				
Dressing				
Learning				
Receptive Language				
Mobility				
Danger Awareness				
Social/Emotional Functioning				
Capacity for Independent Living				
Other (specify):				
37. Limitations in verbal skills. (If yes, also check a or b below)				
a. Child is non-verbal				
b. Child has very limited verbal skills				
38. History of behavioral or emotional problems				
39. History of treatment for behavioral or emotional problems at a clinic or hospital				
40. Someone in child's immediate family has been treated or hospitalized for emotional or mental health problems. (If yes, also check below)				
Depression				
Anxiety				
Mood swings				

*NK=Not Known At This Time

		Yes	No	NK *	If "Yes", please comment
Suicide attempts					
AODA					
Mental Health					
41.	Has the child ever:				
	Felt hopeless or depressed				
	Had unexplained crying spells				
	Planned or attempted suicide				
	Had peculiar or bizarre thoughts				
	Had trouble eating or sleeping (either too much or too little)				
	Had an excess of energy or activity				
	Felt like hurting him/her self				
	Displayed reckless or dangerous behavior				
	Heard things no one else around him/her heard				
	Shown inappropriate emotions (reactions that didn't make sense in the situation).				
	Assaulted anyone physically (if yes, who, how recently, and how severely).				
	Assaulted anyone sexually (if yes, who, how recently, and how severely).				
	Assaulted or abused animals				
42.	Child has had any of the following problems at home or in the community.				
	Withdrawing socially (doesn't want to be around other people)				
	Lying or stealing				
	Arguing or fighting with peers or siblings				
	Clinging excessively to a parent, teacher or other person				
	Problems with police				
	Setting fires				
	Refusing to follow instructions from parents or obey house rules, etc.				
43.	Child ran away in past. (If yes, answer below)				
	For how long?				
	From where did child run?				
	Where did child go?				
	How was child returned? (Voluntarily, law enforcement, social worker?)				
	Why did child run?				
	Did/does child run alone or with others?				
44.	Child has had any of the following problems at school				
	Poor grades				

*NK=Not Known At This Time

	Yes	No	NK *	If "Yes", please comment
Difficulty making friends				
Suspensions from school				
Fighting or arguing with peers or teachers				
Frequent lying or stealing				
Frequent truancy (including cutting classes)				
45. Child has trouble sleeping. If yes, answer below:				
Child takes sleeping pills. If yes, how often?				
General sleeping pattern (sleep alone, cold or warm room, lights on or off, door open or closed, usual hours of sleep, naps, sleep with toy, pajamas, sleep walk, wake during night, etc.) (Circle appropriate description or describe:				
46. Child has fears/phobias. If yes, answer below:				
Darkness				
Animals				
Cars				
Loud noises				
Heights				
Water (e.g., swimming pools, baths, lakes)				
Weather (e.g., wind, thunder, storms)				
Other (specify)				
47. Child has a history of making abuse allegations against care providers				

*NK=Not Known At This Time