

# STANDARD FOR CHILD WELL-BEING

## PURPOSE

The purpose of this standard is to provide direction and guidance to the Child and Family Services (CFS) program regarding child well-being. This standard is intended to achieve statewide consistency in the development and application of CFS core services and shall be implemented in the context of all applicable laws, rules and policies. The standard will also provide a measurement for program accountability.

## INTRODUCTION

A child who comes to the attention of child protection often has unmet physical, mental health, or educational needs. It is the responsibility of the CFS social worker to consider and address these areas of need throughout the life of a case.

## TERMS

### **Child Well-being**

For purposes of this standard, child well-being includes all aspects of screening, assessing, identifying, and meeting the physical, mental health, and educational needs of a child. Child well-being also includes maintaining a child's connectedness to family, supportive relationships, and the community.

### **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

The EPSDT program is part of Medicaid that covers preventative health care for children ages birth to 21 (including the month of their 21<sup>st</sup> birthday). Well baby and child check-ups include a physical and developmental screening. EPSDT will cover medical services ordered by the child's physician for any physical or mental health condition found during a well-child check even if the services needed are beyond what Medicaid usually covers. For services not covered by Medicaid, a certification of medical necessity and preauthorization are required. (See IDAPA 16.03.09 for more information regarding EPSDT and rules governing the Medical Assistance Program.)

### **Infant Toddler Program**

The Infant Toddler Program is the "lead agency" for children birth to three years old who qualify for early intervention services under federal education law (Part C – IDEA). Through the Infant Toddler Program, multiple agencies and programs, both public and private, coordinate activities and resources to ensure appropriate referrals, screening, assessment, identification, and treatment of children with suspected or identified developmental delays.

### **Alternate Care**

Twenty-four hour a day care provided for children in a location other than the family home. Examples of alternate care settings include: resource families, residential facilities, and treatment homes.

### **CFS STAFF REQUIREMENTS**

The standard provides information regarding CFS requirements and guidance and direction on implementation. Below are the requirements for CFS staff for this standard:

- CFS staff must ensure that all children have had their well-being needs assessed, and that services are being provided to meet all of their identified needs;
- CFS staff must work to engage the family with their involvement in the identification and meeting of the well-being requirements of their child(ren) in care;
- CFS staff must ensure that within thirty (30) days of entering care, a child will receive a medical examination, and thereafter, as recommended by their physician or other health care professional. CFS staff must ensure that the child's vision and hearing are screened either at the time of the medical examination, or by the child's school;
- CFS staff must ensure that children in alternate care complete Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT);
- CFS staff must refer all children between the ages of 0-3 who are found to be a victim of a substantiated report of child abuse or neglect to the ITP;
- CFS staff must refer all children between the ages of 0-3 to ITP who they complete a safety assessment on whom they suspect may have developmental delays;
- CFS staff must ensure that the immunization records of children in care will be reviewed and all immunizations will be brought up-to-date as needed;
- CFS staff must ensure that all children in alternate care who have either a first tooth that is exposed or are 12 months of age or older shall receive a dental examination no later than 90 days after placement;
- CFS staff must enter medications that are being taken on a regular basis and/or being taken for a specific treatment or illness in the Alternate Care Plan in iCARE;
- CFS staff must assess whether the mental health needs for in-home cases are relevant to the reason the agency is involved. CFS staff must continually assess the mental health needs of children and provide referrals to formal assessments as indicated;
- CFS staff must ensure that all children placed in alternate care, age three and older, receive a mental health screening, and if recommended, a full mental health assessment;

- CFS staff must ensure that all children requiring foster care at a level III or higher receive a mental health assessment unless the mental health of the child has previously been assessed and the information is current, and mental health needs are known and are being met;
- CFS staff must ensure that the case plans of each child in state custody must include a plan for ensuring the educational stability of that child and will be documented on the child's Alternate Care Plan, and in iCARE;
- CFS staff must ensure that the education screen in iCARE is recorded for the school of origin when children enter care, and is updated each time a child's school changes or there is a placement change;
- CFS staff must ensure that the education screen in iCARE is recorded once the educational best interest determination has been made in order to notify the child's school of their placement status and educational best interest determination; and
- CFS staff must ensure that the Every Student Succeeds Act (ESSA) social worker Point of Contact (POC) duties are fulfilled.

### **IMPLEMENTING THE STANDARD**

#### **Child Well-being in Family Preservation In-Home Cases**

CFS social workers must address well-being for children receiving in-home services if the physical, mental health, or education needs are relevant to the reason why the agency is involved with the family or the need to address any need in these areas is a reasonable expectation given the circumstances of the family and the agency's involvement. For example, if a child was determined to be in need of in-home services as a result of a referral alleging child physical or sexual abuse, it is reasonable to expect the agency to assist the family in locating community resources so the child will receive the needed physical or mental health services.

#### **Child Well-being in Out-of-Home Cases**

CFS social workers must address well-being for children receiving out-of-home services if the physical, mental health, or education needs are relevant to the reason why the agency is involved with the family or the need to address any need in these areas is a reasonable expectation given the circumstances of the family and the agency's involvement. Federal and state requirements mandate that the agency screen and, when indicated, further assess and provide services to meet the physical, mental health and educational needs of a child when he/she is placed out of their home.

In all cases, the CFS social worker must address well-being by assessing and assisting the child so he/she can successfully transition through their respective stages of development.

### **Family Involvement and Consent for Medical Care in Out-of-Home Cases**

Whenever possible, the parent should accompany or meet the child at any medical or dental appointments and be present to sign permission for treatment. This also applies to other aspects of child well-being such as mental health assessments or appointments where medication could be prescribed, developmental screenings, parent teacher education conferences, and IEP meetings.

Parent(s) or legal guardian(s) shall sign a departmental form of consent for medical care and keep the child's social worker advised of where they can be reached in case of an emergency. Any refusal to give medical consent shall be documented in the case record along with the reason for the refusal.

### **Signing for Medical Treatment**

Whenever possible, the parent should be available and should sign for any non-routine care such as surgery. If a parent is not available to authorize surgery, and the child is in the legal custody of the Department, according to the Child Protective Act, the Department can authorize surgery "if the surgery is deemed by two (2) physicians licensed to practice in this state to be necessary for the child." In cases where the parent is not available, the surgery shall require a supervisor's signature and notification of the program manager prior to the signature.

The parent(s), or Department, if it is the guardian of the child, has the authority to consent to major medical care or hospitalization. In emergency cases where parents cannot be located and the child is in the legal custody of the Department, but not the guardianship of the Department, a CFS supervisor will be the one who signs for the necessary emergency medical treatment.

In the parent's absence, if a child is in CFS's custody, a social worker can sign for routine or regular care.

If a parent cannot be located or refuses to sign the Department's medical consent form for medical care, the social worker/supervisor will sign the form on the line provided for guardians. A child must not go without needed services, defined under the category of child well-being, because a parent cannot be located or is refusing to sign the consent form. All controversial situations must be brought to the attention of the regional program manager. When medical care is contrary to the spiritual beliefs of the family, medical treatment can only be administered through a judge's order and must not be authorized by the signature of a Departmental employee.

### **Medical Emergencies**

If there is a medical emergency or serious illness, the well-being of the child is the first priority. In emergencies, the alternate care provider will immediately seek medical help and simultaneously contact the child's social worker or supervisor if the child's social

worker is not available. In turn, the social worker will contact the child parent's so they can be involved, as well as the supervisor and program manager. A critical incident report will be completed by the social worker or other agency staff regarding the medical emergency.

### **Alternate Care Provider's role in Child Well-being**

Alternate care providers and resource families are valuable and important resources in supporting the child's well-being and educational progress and goals as they assist with the following:

- Encourage and monitor completion of homework assignments;
- Attend parent teacher's conference (also include the biological parent whenever possible);
- Attend IEP meetings with the parent and social worker. Note: Chapter 5 of the Idaho Special Education Manual states, "A foster parent may act as a parent if the natural parent's authority to make educational decisions on behalf of his or her child has been terminated by law. A foster parent shall be an individual who is willing to make educational decisions required of a parent, and has no interest that would conflict with the interests of the student.";
- Keep the social worker apprised of the educational progress and needs of the child;
- Work with the school regarding day-to-day school attendance and academic performance;
- Encourage the child with life skill development opportunities;
- Support the child with birth family connections whenever possible; and
- Support the child with positive community connections.

Alternate care providers and resource families should be encouraged to transport and accompany children to medical and dental appointments, however, must not sign consents for treatment. The parent or CFS social worker provides treatment consent. Alternate care providers and resource families will follow the prescribed directions of a qualified medical provider, who is designated by the parent and/or the child's social worker, when administering medication. An alternate care provider or resource family must not discontinue or in any way change the medication provided to a child unless directed to do so by a qualified medical professional. Likewise, an alternate care provider or resource family must not change the child's Healthy Connection medical provider, counselor, or other service provider without approval and notification from the legal parent and assigned social worker. At all times, alternate care providers and resource families must keep the assigned social worker apprised of the child's physical, mental, behavioral, emotional, and educational needs, and of any change in medication or treatment.

### **Medical Coverage for Children in Alternate Care**

Most children placed in alternate care are eligible for a medical card. Regardless of the funding source, every child in alternate care will receive medical care and have his/her medical needs met.

### **Medical Examination upon Entering Alternate Care**

Within thirty (30) days of entering alternate care, a child will receive a medical examination to assess their health status. Thereafter, a child will receive additional medical examinations or treatment according to a schedule prescribed by their physician or other health care professional. Whenever possible, the child's primary care physician and Healthy Connections provider selected by the child's parent or guardian prior to entering foster care will be maintained. If a change to the child's primary care physician or Healthy Connections provider becomes necessary, the social worker will attempt to obtain prior approval from the child's parent or guardian and notify them of the change.

### **EPSDT Screening**

Children in alternate care will participate in Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT). Children already receiving Medicaid at the time of placement shall be screened within thirty (30) days of placement. Children not receiving Medicaid at the time of placement shall receive a screening within thirty (30) days from the date Medicaid eligibility is established. The assigned social worker shall be responsible for completion of the EPSDT screening, and shall coordinate services if needs are determined.

If services are thought to be medically necessary for a foster youth and are denied, the social worker can resubmit the request for an appeal with additional information. Social workers are able to consult with Medicaid and/or Optum regarding the appeal process. Please see the resources section for the EPSDT Prior Authorization Request for Additional Services form.

### **Referrals to the Infant Toddler Program**

Any time there are suspected developmental delays, a child age birth to three years old, shall be referred to the Infant Toddler Program.

The federal Child Abuse Prevention and Treatment Act requires all children, birth to three years of age, who are the subject of a substantiated referral, be referred to the Infant Toddler Program for an evaluation and eligibility determination for services. Please see the standard for "Substantiated Reports of Children Birth to Three" for more information regarding the referral process to the Infant Toddler Program.

### **Immunizations**

A child's immunization record will be reviewed and all immunizations will be brought up-to-date with the proposed immunization schedule.

If parents refuse to authorize immunizations for their child a decision to immunize will be made on a case by case basis, following the doctor's recommendations and history of previous immunizations. The social worker must explore and document the reasons for the parents' refusal.

In cases where parents do not want to immunize their child the social worker will address their concerns during the case planning or review hearing in an effort to receive a judge's ruling on immunizing the child.

### **Dental Care**

All children who have either had their first tooth erupt or by 12 months of age or older and are placed in alternate care shall receive a dental examination as soon as possible after placement but no later than ninety (90) days after placement, and thereafter every six months or according to a schedule prescribed by the dentist. If the child is under age 3, they can be seen for this by their primary doctor. In these cases for children under the age of 3, this must be documented on their physical exam form.

Children's dental needs will be addressed, based on the recommendations of the dentist. If dental care that is not included in the state medical assistance program is recommended, a request for payment shall be submitted to the state Medicaid dental consultant. For children in shelter care, emergency dental services shall be provided and paid for by the Department, if there are no other financial resources available.

### **Vision**

Vision screening will be completed by the child's school or a medical provider unless otherwise indicated by a child's need.

### **Hearing**

Hearing screening will be completed by the child's school or medical provider unless otherwise indicated by a child's need.

### **Medication**

Whenever possible, the child's parents or guardians should be involved, consulted, and advised when medication is prescribed. Parents and resource families should know which medications a child is taking, the purpose of the medication, directions for administering the medication, and any side effects that could occur as a result of the medication. Youth and young adults in particular, shall be educated regarding their medications, including the need for the medication and its prescribed use.

Psychotropic medication should never be the first or only line of defense in the treatment of emotional and behavioral issues for children and youth in foster care. Any child who is prescribed a psychotropic medication must be receiving active concurrent counseling, psychosocial treatment, or specific treatment for trauma. Please see the Standard for Use

and Monitoring of Psychotropic Medications for Children and Youth in Foster Care for more information.

Medications that are being taken on a regular basis and/or being taken for a specific treatment or illness need to be documented in iCARE.

### **Mental Health In-Home Cases**

The mental health needs of children traumatized by child abuse or neglect should be assessed as a component of the child comprehensive safety assessment process. When addressing mental health issues for an in-home case, a social worker should consider whether the mental health needs are relevant to the reason the agency is involved with the family and whether the need to address mental health issues is a reasonable expectation given the circumstances of the family and the agency's involvement. For example, if the referral indicates mental health concerns or during the comprehensive risk assessment process a child is exhibiting mental health symptoms, a referral should be made for a mental health screening and/or assessment. During ongoing contact with children and their parents, social workers will continue to informally assess the mental health needs of children and provide referrals to formal assessments and services as indicated.

### **Mental Health in Out-of-home Cases**

All children, age three and older, placed in alternate care shall receive a mental health screening, and if recommended, a full mental health assessment. Children shall be referred for mental health treatment as recommended by the assessment. Children age 3 and under who are the subject of a substantiated child abuse referral shall have their mental health needs assessed through the Infant and Toddler Program. During ongoing contact with children and their care providers, social workers will continue to informally assess the mental health needs of children and provide referrals to formal assessments and services as indicated.

The screening or mental health assessment must be done either by an outside agency, through one of the Mental Health Screening Tools (either the 0-5 or 5-adult version), or through the Child Adolescent Needs and Strengths (CANS) tool.

The Mental Health Screening Tools are behaviorally based and can serve as a source of information for anyone conducting a more comprehensive mental health assessment such as a psychologist, psychiatrist or other clinician. The CANS is a comprehensive information integration and communication tool for children, adolescents, and young adults. It is utilized to gather information, guide service planning, and to initiate appropriate referrals based on responses to the questions. Please refer to the resource section for the links for additional information.

### **Mental Health Assessments in Level III Placements**

All children requiring foster care, at a level III or higher, must receive a mental health assessment unless the mental health of the child has previously been assessed and the information is current, and mental health needs are known and are being met. There may be situations where a child requires foster care at a level III or higher due to known and documented needs other than mental health, such as a medical condition. In such cases, a variance can be made and approved by the program manager or designee to forgo a mental health assessment as part of the level III or higher placement process.

### **Educational Stability**

Stability in both placement and education are key features of recent federal child welfare legislation. In 2015, Congress passed the Every Student Succeeds Act (ESSA), which institutes new protections for children in foster care. These provisions complement those in the Fostering Connections Act, and require child welfare agencies to collaborate with both local and state educational agencies to ensure the educational stability of children in foster care.

Out-of-home placement can be coupled with the need for many changes which include moving to a new school. Additionally, many of these children are overwhelmed by trauma that affects learning; including attention, concentration, mood, interpersonal trust, and communication. Changing schools each time a child moves can seriously impair a child's ability to be successful in school.

The case plans of each child in state custody must include a plan for ensuring the educational stability of that child and will be documented on the child's Alternate Care Plan in iCARE. Department social workers must make diligent efforts to maintain the stability of the child's school setting, through efforts such as placement selection and transportation assistance. The case plan must assure that:

- The initial placement and all following changes in placement must take into account the appropriateness of the child's current educational setting and the proximity to the school in which the child was enrolled at the time of each placement change;
- Through coordination with local education agencies, children will remain in the school they are enrolled in at the time of each placement change (school of origin), unless that would not be in the child's best interest; and
- If remaining in their school of origin is not in the child's best interest, the agency must assure that the child has immediate and appropriate enrollment in a new school with all of the educational records of the child provided to that new school. Per ESSA regulations, enrollment must not be denied or delayed for any population of students because documents normally required for enrollment have not been provided. The enrolling school must immediately contact a child's school of origin to obtain relevant records and documentation.

ESSA regulations state that the State Education Agency (SEA), Local Education Agency (LEA), and Department should collaborate on the protocol for determining whether it is in the child's best interest to remain in his or her school of origin, and must consider all factors related to a child's best interest.

In making the best interest determination for a child, the following factors should be considered:

- Preferences of the child;
- Preferences of the child's parent(s) or education decision maker(s);
- The child's attachment to the school, including meaningful relationships with staff and peers;
- Placement of the child's sibling(s);
- Influence of the school climate on the child, including safety;
- The availability and quality of the services in the school to meet the child's educational and socioemotional needs;
- History of school transfers and how they have impacted the child;
- How the length of the commute would impact the child, based on the child's developmental stage;
- Whether the child is a student with a disability under the IDEA who is receiving special education and related services or a student with a disability under Section 504 who is receiving special education or related aids and services and, if so, the availability of those required services in a school other than the school of origin; and
- Whether the child is an English learner and is receiving language services, and if so, the availability of those required services in a school other than the school of origin, consistent with the Title VI and the Equal Educational Opportunity Act.

Transportation costs should not be considered when determining a child's best interest.

The SEA, LEA, and Department should consult other relevant parties, such as the child, depending on age, foster parents, biological parents when appropriate, education decision maker(s), and other relatives for their perspectives on which school the child should attend during their time in foster care, consistent with the child's case plan.

The best interest determination (BID) needs to be made as quickly as possible in order to prevent educational discontinuity for the child. To the extent feasible and appropriate, the LEA must ensure that a child remains in his or her school of origin while this determination is being made. Please see the resource section for the link to the BID consideration factors and guidelines.

If there is disagreement regarding school placement for a child in foster care, the Department should be considered the final decision maker in making the best interest determination.

The above assurances relate to the circumstances at the time of the child's initial placement into foster care, as well as each time a child moves to a different foster care placement.

In an effort to ensure educational stability, children must remain in their school of origin unless one of the following factors apply:

- The child is involved in gang or illegal activity.
- The child's developmental or educational needs are not being met.
- There is risk of harm to the child due to proximity and access of the offender.
- The child has been moved to a permanent home due to adoption or guardianship.
- The youth is opposed to remaining in the school due to a feasible and logical reason.
- The child is in a residential treatment facility with educational services on site.
- The travel time/distance to the child's school of origin would negatively impact their overall well-being. As a general rule, a commute exceeding 45 – 60 minutes each way either with or without stops would not be considered in the child's best interest (this does not include a bus route). The determination will be evaluated individually based upon the child's needs and case circumstances.

Once the BID has been made by the social worker, the education screen within the child's profile in iCARE needs to be updated to reflect accurate information. After the justification for the BID has been entered, an e-mail notification will automatically be sent to the designated school personnel to notify them of the child's placement status and educational BID. Note: this needs to be completed when the child enters care and each time there is a change in placement. Please see the resource section for the ESSA iCARE training link for additional information.

### **Points of Contact**

ESSA requires that both SEAs and LEAs designate a point of contact (POC) for child welfare agencies. Additionally, the Department has identified one primary state POC, as well as a POC in each region.

The social worker will serve as the primary day-to-day contact between children in foster care and school staff, district personnel, and other service providers, in collaborating to ensure that children and youth in care have educational stability. The Department's regional POCs will serve as a liaison and additional support for the process, as needed. The Department's state-level POC will serve as a liaison between the SEA POC and the Department, and will collaborate with and provide support to the regional Department POCs, Department social workers, as well as the LEA POCs.

Social Worker roles and responsibilities include:

- \*Serving as one of the primary contacts between children in foster care and school staff, district personnel, and other service providers;

- \*Coordinating with the corresponding LEA POC on implementation of the Title 1 provisions including immediate enrollment;

- \*Provide notice to the educational agency (school and LEA) when a child has been placed in foster care or when there has been a foster care placement change (will communicate through an automated letter process);

- \*Facilitating transfer of records including immunizations, medical records, and copies of IEPs and Section 504 Plans;

- \*Working with LEAs to ensure that children in foster care are immediately enrolled in school, and to coordinate transportation services;

- \*Coordinating services so that children in foster care can access early educational services for which they are eligible, including Head Start and Early Head Start, home visiting, and preschool programs administered by the SEA or LEA, and screening and referrals to health, mental health, dental, and other appropriate services;

- \*Following IDHW established process for coordinating on best interest determinations with the LEA;

- \*Managing best interest determination and transportation costs agreements between the LEA and the CW agency;

- \*Coordinating with the LEA regarding sharing of information on the children in foster care on their caseload, consistent with FERPA and the confidentiality of information provisions in the Individuals with Disabilities Education Act; and

- \*Informing parents of children in foster care of the child's education rights.

Having designated POCs at both the state and regional level will help to facilitate a successful, sustainable collaboration. Please see the resource section for the link under the Points of Contact and roles for ESSA and the link to the ESSA flow chart for more information.

### **Educational Stability for Children with In-Home Cases**

The McKinney Vento Homeless Assistance Act allows school districts to assist students who meet the identified criteria of homeless to remain in their school of origin. Federal money is allocated to school districts to ensure that youth are able to remain in school despite their living circumstances. Each school district has appointed a liaison to help navigate and provide services to the homeless youth.

### **Transportation Protocol**

ESSA outlines how the SEA and LEAs must collaborate with the Department to ensure that transportation for children in foster care is provided, arranged, and funded. An LEA must ensure that a child in foster care needing transportation to the school of origin receives such transportation for the duration of the time the child is in foster care. (ESEA section 1112(c)(5)(B)). If there are additional costs incurred in providing transportation to the school of origin, the LEA will provide such transportation if (1) the local child welfare agency agrees to reimburse the LEA for the cost of such transportation; (2) the LEA agrees to pay for the cost; or (3) the LEA and local child welfare agency agree to share the cost. (ESEA 1112(c)(5)(B)).

IV-E funding may be used for transporting eligible children/youth to their school of origin.

The LEA POC, to the extent possible, will make every effort to coordinate school placement, transportation, and other educationally related services with child welfare staff and resource parents.

### **Educational Services**

Children, 3 years of age or older with suspected developmental delays, will be referred to their local school district for screening.

Social workers shall advocate for obtaining identified educational services for children. This might include arranging for priority testing for special education, participation in individual educational program development (IEP), special classes or meeting with school personnel to address the child's academic performance. The social worker shall include the birth/legal parents and resource parents whenever possible in this process. Regarding IEP development, Chapter 5 of the Idaho Special Education Manual defines "parent" as, "a biological or adoptive parent, foster parent, a judicially decreed guardian (**does not include State agency personnel if the student is a ward of the state**), a person acting in place of a parent, or a surrogate parent who has been appointed by the district. The term 'acting in place of a biological or adoptive parent' includes persons such as a grandparent, stepparent, or other relative with whom the student lives as well as

persons who are legally responsible for a student's welfare. A foster parent may act as a parent if the natural parent's authority to make educational decisions on behalf of his or her child has been terminated by law. A foster parent shall be an individual who is willing to make educational decisions required of a parent, and has no interest that would conflict with the interests of the student." If more than one biological or adoptive parents meet the definition of parent, the biological or adoptive parents serve as the parents in the IEP process, unless a judicial decree of order identifies a specific person or persons to make educational decisions for the student. Though social workers are not authorized to sign IEPs, their continued participation in the process and advocacy for the educational needs of the foster child is essential.

### **School Attendance**

Every child in the custody of the Department will:

- Be enrolled in and attend an accredited on-site public or private school;
- Be instructed in elementary or secondary education in accordance with the educational code of Idaho;
- Will have completed secondary school; or
- If a youth is at least 16 years of age and has previously dropped out of school with his/her parent's permission, the youth will participate in an independent living plan that will address his/her education (GED) and/or training.

If there are extenuating circumstances and it is determined that virtual academy (on-line) is the most appropriate educational setting for a child, a variance can be approved by a hub's manager. However, children attending virtual academy must also have a socialization plan to ensure social skill building opportunities and connections.

In the event a child is incapable of attending school on a full-time basis due to the medical condition of the child, the child's inability to attend school will be monitored on a regular basis and supported by regularly updated information in the case plan.

Every school-age child receiving an adoption assistance or subsidized guardianship payment will also comply with the above bullets. However, to meet their educational requirements, if they are no longer in the custody of the Department, they may also participate in private instruction that may include homeschooling or virtual academies without an approved variance from the hub's manager.

Whenever possible, parents or legal guardians should be encouraged to participate in the development of the child's educational plan. When parental rights are intact, the child's parent's or legal guardian's educational preferences for the child should be considered when developing the child's educational plan.

### **Documentation of Child Well-being**

Information regarding a child's physical health, mental health, and education must be entered on the relevant screens in iCARE.

**Resource Links for Child Well-Being:**

[Mental Health Screening Tools](#)

[Every Student Succeeds Act Flow Chart](#)

[Points of Contact and roles for the Every Student Succeeds Act](#)

[Education Best Interest Consideration Factors](#)

[Education Best Interest Guidelines](#)

[Child and Adolescent Needs and Strengths \(CANS\) Reference Guide](#)

[CANS in iCARE training](#)

[EPSDT Prior Authorization Request](#)

[ESSA iCARE training video](#)

[iCARE e-manual](#)

**Any action taken not consistent with this standard must be pre-approved by the FACS Division Administrator or designee. The action, rationale and approval must be documented in the file.**