ADMISSION POLICY AND PROCEDURES

POLICY:

All referrals to the Foster Family Program shall be fully assessed to determine what, if any, placement would best serve the client's welfare. Admission procedures shall include a pre-admission appraisal, needs and service plan, medical assessment and admission agreement.

RATIONALE:

To enhance appropriate utilization of services.

PROCEDURE:

A. Pre-Admission Appraisal

The identification and evaluation of a client for possible admission to the Foster Family Program begins with a written referral or phone call to the program from a representative of a fully qualified placing agency, such as country, welfare services or county mental health. Referral information shall include:

1. Rationale for referral to the Foster Family Program
2. Family and placement history.
3. Medical History
4. Educational History
5. Clinical Evaluations/Records
6. Current Legal Status (Court Dependent, Voluntary, Mental Health Conservatorship).

This information will be utilized to complete a social study of the client's total situation to determine what will best serve his/her ultimate welfare.

B. A client is accepted into the Foster Family Program based on the following criteria:
   1. A child between the ages of 0-21.
   2. Alternatives for out-of-home placement have been explored/exhausted.
   3. A child whose emotional/behavioral problems require specialized care but are not so severe as to require residential treatment.
   4. A child who is transitioning from psychiatric hospitalization or other residential treatment programs.
   5. A child whose physical, social and emotional needs can be met by one of the agency's exclusive use foster homes.
   6. No child will be denied acceptance due to race, creed, color, religion or national ancestry.
   7. Children of the same family shall be kept together whenever possible unless it has been determined that this is not beneficial.
   8. The selection of a foster home for a particular child shall be based upon consideration of the client's total health, educational, religious, recreational, social and emotional needs and how well the foster home can meet the client's needs and potentialities.

C. Service Plan

Upon acceptance, a Service Plan for each client will be developed. This service plan will be developed by the Social Worker, in consultation with the placing agent, Consulting Psychologist and Clinician.

The case plan shall include a statement of needs, measurable objectives, specific plans and time frames. The case plan shall be reviewed on a monthly basis. A formal report will be prepared quarterly.

D. Medical Assessment/Care:

The foster Family Program shall provide adequate preventative and remedial medical care through a qualified physician or through a medical clinic organized to provide the necessary medical service. The medical care provided shall include:

1. Complete physical examination
2. Prompt treatment of remedial physical conditions.
3. Necessary laboratory tests and immunizations.
4. Immunization of children over 6 months of age against diphtheria, immunization of children under 6 years of age against whooping cough.
5. Provision for tuberculin test or chest x-ray for each client and provision for nose and throat culture and appropriate tests for venereal disease when indicated.
6. For infants, continuing medical supervision; for older children and adults, physical examination at least annually or more often as recommended by the client's physician or as the client's condition indicates.
7. Care in case of illness or accident, including provision for medical care and hospitalization as required.
8. Dental examinations semi-annually followed by necessary treatment and arrangements for orthodontic care for children as required
9. Continuing observation of the client's progress and discussion with the physician of any deviations for satisfactory conditions.

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Foster Parent Signature Date

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Foster Parent Signature Date