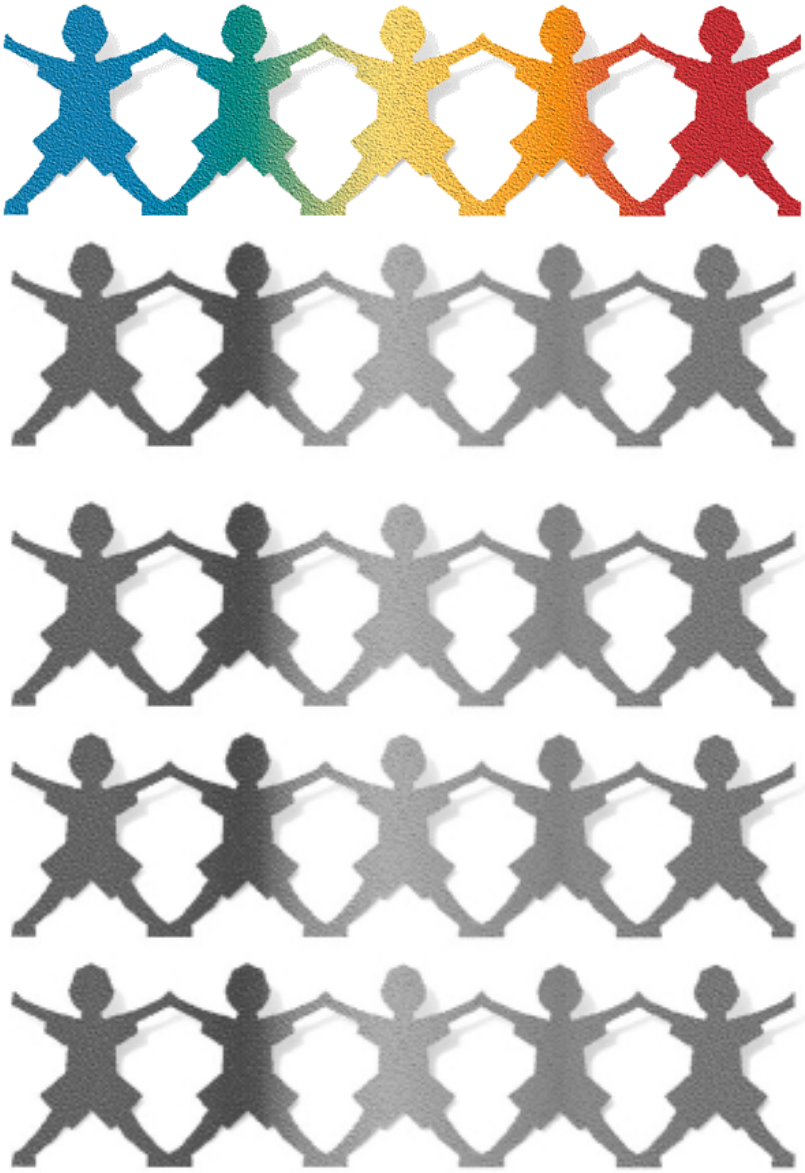

Safeguarding Foster Children's Rights to Health Services

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The Permanent Judicial Commission on Justice for Children

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Safeguarding Foster Children's Rights to Health Services

Sheryl Dicker and Elysa Gordon[1]

Federal and New York State law mandate the provision of health services to foster children. Study after study, however, reveals that the vast majority of foster children have far more fragile health and are far less likely to receive health care that can improve their lives and life chances than other children. Children living in foster care have high rates of acute and chronic medical problems, developmental delays, educational difficulties, and behavioral and mental health problems. Ensuring foster children's right to services to enhance their healthy development can improve their functioning and prognoses. It also can improve their prospects for a stable and permanent home.

Connecting Healthy Development and Permanency

The demands of caring for children with health problems can create tremendous stress for caregivers. As a result, inattention to foster children's health needs not only jeopardizes their healthy development, but can disrupt stable placements and impede reunification and adoption efforts. The Permanent Judicial Commission on Justice for Children is working to highlight the connection between foster children's healthy development and permanency and the role of the courts in safeguarding foster children's right to services that can address or ameliorate their health problems.

The Permanent Judicial Commission on Justice for Children was established in 1988 to address the problems of children in New York State whose lives are touched by the court system. The Commission is co-chaired by Chief Judge Judith S. Kaye and

Professor Ellen Schall of New York University's Wagner Graduate School of Public service and includes judges, legislators, state and local officials, and child advocates. As the nation's only children's commission based in the judiciary, the Commission was instrumental in the passage of New York's Early Intervention Laws of 1992 and 1993, established the nation's first statewide system of Children's Centers in the courts, and is spearheading efforts to reform the Family Court's handling of foster care cases. As part of the latter initiative, the Commission's research found that foster children had serious, unmet health needs that were seldom the focus of any entity in the child welfare or court system. In the Fall of 1997, the Commission formed a Health Care for Foster Children Working Group to ensure foster children's healthy development. A major product of the Commission's initiative is the upcoming publication of a booklet, "*Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*," to assist court actors in identifying foster children's health needs and gaps in services. The Working Group envisions the booklet to be one part of a strategy to insure that at least one person involved in the court process ask questions about a foster child's health and highlight the connection between a child's healthy development and his or her prospects for permanency.

The Health Profile of Foster Children

Children living in foster care have multi-layered health needs that present challenges for caregivers, health care providers and advocates. First, foster children require well-child health care, immunizations and the treatment of acute childhood illnesses. Second, foster children have health problems associated with poverty--low birthweight, increased risk of lead exposure, malnutrition. Finally, foster children have

further health risks specifically linked to parental neglect, maternal substance abuse, physical or sexual abuse and parental mental illness. Foster children are more likely than other children to have histories of maternal substance abuse, abuse and neglect, parental mental illness and multiple caregivers. While at high risk for health problems, foster children too often lack the most fundamental resource for ensuring healthy development--a stable, lasting relationship with a caring adult who can observe their daily development over time, advocate on their behalf and provide consent for evaluation and services.

The nationwide statistics paint a picture that cries out for a response: [2]

- Approximately 80 percent of foster children have at least one chronic medical condition, with nearly one-quarter of these children having three or more chronic problems.[3]

- Numerous studies document the prevalence of serious respiratory illness among foster children. One study of foster children from Oakland, CA, revealed that 16 percent had asthma -- about three times the national average for asthma.[4]

- Many studies document widespread growth retardation in infants and toddlers in foster care.[5] One study documented growth problems among foster children that were twice the expected rate found among the general pediatric population.[6] Another study found that three times the expected number of foster children younger than three in Baltimore were at or below the fifth percentile for weight and head circumference and more than five times the expected number were at or below the fifth percentile for weight.[7]

- Research reveals that nearly 80 percent of foster children are at–risk for a wide range physical and developmental health problems related to prenatal exposure to maternal substance abuse.[8]

- Foster children have high risk of exposure to HIV and tuberculosis.[9]

- Studies nationwide reveal that half of all foster children have substantial delays in cognition, speech and behavioral development, and some studies have found even higher numbers of foster children in need of early intervention services. A California study found that these developmental delays were magnified as the children aged and remained in care.[10]

- Foster children are often at a distinct developmental disadvantage at the point of birth. For example, nearly 40 percent of foster children seen at the Oakland, California

foster care clinic were born premature.[11] Studies nationwide document the prevalence of prenatal exposure to substance abuse and poor prenatal care among foster children.[12]

- Studies show that nearly half—perhaps even more—of all children in the child welfare system have mental health problems severe enough to warrant clinical intervention.[13]

The profile of New York State's foster children mirrors the national picture:

- A 1992 study by the New York State Department of Social Services (DSS) demonstrated that New York's foster children have serious physical and mental health problems. 73 percent of all New York foster children statewide and 84 percent of New York City foster children were placed due to serious risk to their health and safety. 51 percent of foster care case reports cite a problem with parental substance abuse and 19 percent reported alcohol abuse. 16 percent of the children placed were diagnosed with mental illness.[14]

- At Foster Care Pediatrics, a health clinic located in Rochester that serves approximately 80 percent of that county's foster children, 40 percent of the children have a chronic medical illness and 60 percent of those children under the age of five had a developmental delay requiring early intervention services.[15]

- At ENHANCE, a health clinic located in Syracuse that treats more than six hundred foster children annually, 60 percent of the children had developmental delays and 75 percent had immunization delays. Of preschool and school-age children, more than half demonstrated emotional and/or behavioral disturbances.[16]

And yet, research reveals that many foster children do not receive even basic health care once they are placed in foster care:

- In a study of young foster children in three urban centers--Los Angeles County, New York City and Philadelphia County-- the U.S. General Accounting Office (GAO) found that 12 percent of the children received no routine health care, 34 percent received no immunizations and 32 percent continued to have at least one unmet health need after placement. The GAO found that 78 percent of the children were at high risk for HIV, but only nine percent had been tested for the virus.[17]

- In New York State, the Department of Social Services reviewed 3,000 foster care case records and found that fewer than one percent contained all the legally required components of past medical history, only half documented the child's immunization status, more than half lacked medical consents, and only 65 percent of the children received an initial comprehensive medical examination within thirty days of placement as required under New York State law.[18]

- Studies reveal that very few foster children are identified as having developmental delays by caseworkers or caregivers. At the Center for the Vulnerable Child in Oakland, California, only one-third of the children were previously identified by caseworkers or foster parents as having delays even though assessments found that 84 percent had developmental or emotional problems.[19]

- Despite their level of need, less than one-third of children in the child-protective system nationwide receive mental health services.[20]

Unfortunately, systemic barriers frequently impede the provision of basic health services to foster children.[21] Health, child welfare, education and legal systems too often do not coordinate information about a particular foster child. High turnover among child welfare professionals and multiple placement changes can result in knowledge gaps about a child's health needs and inhibit consistent care by providers who are familiar with the child. Child welfare professionals and court actors too often receive minimal training on children's health and development and its connection to permanency. Advocates who are knowledgeable about foster children's health issues are often frustrated by the sheer numbers and complexity of foster care caseloads and the scarcity of resources to meet their needs.

The Legal Requirement to Address Foster Children's Health Needs

Federal Laws

The mandate to provide medical services to foster children is clear under federal law. All children under the age of 21 enrolled in Medicaid are entitled under federal law to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.[22] In many states, including New York, all foster children are eligible for Medicaid.[23] EPSDT is a comprehensive benefits package that requires medical, vision, hearing and dental screens to be performed at distinct intervals that meet current standards of pediatric and adolescent medical and dental care. The medical screen must include at

least five components: a comprehensive health and developmental history assessing both physical and mental health; a comprehensive unclothed physical exam; immunizations; laboratory tests including testing for high-risk exposure to lead; and health education.[24] In addition, EPSDT requires state Medicaid agencies to assure the provision of necessary treatment for both physical and mental health conditions to the extent required by the needs of an individual child.[25] In 1989, Congress amended the EPSDT statute to include broad language enabling states to finance through Medicaid an array of services that might otherwise be ineligible for Medicaid reimbursement including early intervention and developmental screening.[26] Federal courts have upheld the right to EPSDT services for children in out-of-home placement.[27]

Under the child welfare provisions of the Social Security Act (Title IV-B), states must submit plans to the federal government assuring pre-placement preventative and reunification services.[28] The provisions of that law, commonly known as the Adoption Assistance and Child Welfare Act, requires that the case plan designed for each child in foster care be "designed to achieve placement in the least restrictive (most family-like) setting available and in close proximity to the parent's home, consistent with the best interests and special needs of the child" and must contain a description of the services offered and provided.[29] Federal regulations enumerate services that may be may included: day care; crisis, individual and family counseling; and other services identified as "necessary and appropriate."[30]

The federal regulations further require fair hearings to be provided to parents, foster parents and children regarding either denial of services or the failure to deliver services promptly.[31] The Department of Health and Human Services has determined that

the failure to offer or provide appropriate services or to act expeditiously on a request for a specific service may be appropriate fair hearing issues.[32] The recently passed Adoption and Safe Families Act (ASFA) emphasizes the federal mandate to provide medical services as part of permanency planning.[33] Under ASFA, a foster child's "*health* and safety"[emphasis added] are "paramount concern[s]" in every child protective proceeding.[34]

In addition to Medicaid and EPSDT, many other entitlement programs provide eligible foster children with health and social services to support their healthy development. Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay are eligible for early intervention services under Federal and State law.[35] Early Intervention provides an array of services including occupational, speech and physical therapy and special instruction for the child as well as family support services to enable parents to enhance their child's development. Children age three through five who have a disability in one or more domains – physical development, hearing and vision, learning, speech and language, social and emotional development, and self-help skills that affect their ability to learn – can receive special education and related services under the Federal Preschool Grants Program. Children older than age five may be evaluated for school-age special education services.

The federal regulations promulgated pursuant to the Individuals with Disabilities Education Act specifically state that foster children may be referred for Early Intervention and special education services by parents as well as health care and social services workers.[36] Since these programs are premised on active parent involvement,

they require parental consent for services. The law, however, provides a broad definition of "parent" that includes the birth or adoptive parent, a legal guardian or relative acting as a parent, or in some circumstances the foster parent with an "ongoing long-term parental relationship with the child."[37] Where no parent as broadly defined under the regulations is willing or able to participate, the local school districts or local early intervention agency may appoint a surrogate parent for a foster child whose authority is limited to making educational or early intervention program services decisions for the child.[38] The law specifically excludes "an employee of the SEA (state education agency), the LEA (local education agency), or any other agency that is involved in the education or care of the child" from serving as a surrogate parent under Part B.[39] Under Part C, the surrogate parent may not be "an employee of any State agency or a person or employee of a person providing early intervention services to the child or to any family member of the child."[40] In addition to the Early Intervention and Preschool Special Education Programs, many foster children are eligible for other early childhood programs such as Head Start.[41] Other social services programs, such as the Child Nutrition Act (WIC), can support an eligible foster child's healthy development by providing nutritional supplements.

New York State Laws

All foster children in New York State are eligible for Medicaid. New York's Child/Teen Health Plan (C/THP) incorporates the federal EPSDT provisions that mandate comprehensive and preventive diagnostic and treatment services to all children who receive Medicaid.[42] Other provisions of New York law further reinforce the right of foster children to receive health services:

- Social Services Law § 398 requires the local social services commissioner to "provide for expert mental and physical examinations of any such child whom he has reason to

suspect of mental or physical disability or disease and pay for such examination from public funds" and to "provide necessary medical or surgical care in a suitable hospital."

- New York State Social Services Law § 366 specifically mandates medical services to foster children. The law requires that medical assistance, or Medicaid, defined as "payment of part or all of the cost of care, services, and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, or result in illness or infirmity" be provided to an otherwise eligible child under the age of 21 living away from his or her home.

Additionally, New York's Child Welfare Reform Act requires that social services officials provide preventive services to avoid a child's placement, to reunify a foster child with his or her family as quickly as possible, or to reduce the likelihood of reentry into foster care once a child has been discharged from such care.[43] State DSS regulations enumerate specific preventative and reunification services and differentiate between mandated and optional services.[44] Preventive services for children at risk for placement or for those in placement are mandated where there is a risk or impairment of the child's *health* or safety [emphasis added].[45] Each social services district must provide case management, case planning and casework contacts as well as "core services" that can address a child's health needs including day care, parent training, transportation, clinical services, crisis respite care for disabled or HIV-infected children.[46] Additionally, a district may offer family planning services, day services to children, intensive home-based family preservation services, and outreach activities.[47]

New York State regulations further outline specific standards for medical services to foster children. Administrative directive 90-ADM-21 includes standards from the EPSDT program, but also requires a comprehensive medical examination within thirty days of placement.[48] This examination must include:

- "a comprehensive health and developmental history;

- a comprehensive unclothed physical examination;
- an assessment of the child's immunization status and the provision of immunizations as necessary;
- an appropriate vision assessment;
- an appropriate hearing assessment;
- laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;
- dental screening and/or referral; and
- observation for child abuse and maltreatment."[49]

Under 90-ADM-21, local departments of social services and their contract agencies have specific obligations to ensure that foster children receive appropriate health care and that their caregivers receive assistance in accessing needed services: [50]

- Obtain Medical Consent - Within ten calendar days of admission to foster care, agencies must request written authorization from the child's parent or guardian for the child's "medical or psychological assessment, examination, and treatment and for emergency medical or surgical care in case the parent or guardian can not be located at the time the care is necessary"
- Obtain the Child's Medical History - Request written authorizations from the child's parent or caregiver for "authorization for release of medical records from providers who have previously treated the child."
- Notify Caregivers of the Child's Right to Services - The local social services department must notify the child's caretakers in writing of the availability of Child/Teen Health Plan services within 60 days of a Medicaid-eligible child's entry into foster care.
- Provide Care Coordination - Agency staff must consult with health professionals and the child's foster parents regarding health services necessary to meet the child's needs, ensure that follow-up health care is provided as needed or recommended by the child's physician, assist foster parents in arranging and scheduling care and transportation to the initial and follow-up examinations, and record in the case record that the required medical examinations have been performed.

The Role of the Court in Ensuring Healthy Development for Foster Children

Under the recently passed Adoption and Safe Families Act (ASFA), family courts have broad responsibility for permanency planning that can include making orders for health services necessary to return children to their families or to enhance a child's prospects for permanency. In addition to ASFA, New York's Family Court Act provides Family Court judges with authority to order medical services and to order social services officials to provide or arrange these services for foster children.[51] All those involved in the court process – lawyers, CASAs, and child welfare workers—can assist judges by making information about a child's health needs available to the court as an integral component of permanency. Every court proceeding can be an opportunity for judges, lawyers, advocates and child welfare professionals to ask questions about a child's health and to spotlight the connection between healthy development and permanency.

The New York Family Court Act (FCA) vests the Family Court with the responsibility of ensuring the "physical, mental and emotional well-being" of the children within its jurisdiction.[52] FCA Section 251 authorizes Family Court to order health services for foster children:

- Family court can order medical evaluations and services for children within its jurisdiction to "help protect children from injury or mistreatment and to help safeguard their physical, mental and emotion well-being."
- Family Court can order a child to be examined by a physician, psychiatrist or psychologist for medical, surgical, therapeutic, and hospital care or treatment.

Under the FCA Section 255, a judge also can order state and local officials to provide or arrange for services to ensure a foster child's healthy development. The court's legal authority ends when the action or proceeding terminates and the court loses jurisdiction over the parties.[53]

- Family Court can order any state, county, municipal, and in some cases, school district officer and employee, "to render such assistance and cooperation as shall be within his legal authority, as may be required, to further the objects of this act."

- The Family Court may order another agency or institution to perform a reasonable act in regard to a child "who is or shall be under its care, treatment, supervision or custody."

- The court can seek cooperation and use the "services of all societies or organizations, public or private, having for their object the protection or aid of children and families, including family counseling services, to the end that the court may be assisted in every reasonable way to give the children and families within its jurisdiction such care, protection and assistance as will best enhance their welfare."

Section 1015-a of the Family Court Act clarifies the roles of Family Court and the Department of Social Services and describes the parameters of the court's power and types of services that can be ordered.

- Family Court can order social services officials to provide or arrange for the provision of services and assistance to protect the child, rehabilitate the family and discharge the child from foster care.

- Courts can only order officials to provide those services outlined in the comprehensive annual services plan presently in effect.

- Under 1015-a, the court may require a social services official to make periodic progress reports to the court on the implementation of court-ordered services.

As stated in Section 1015-a of the Family Court Act, Family Court does not have unbridled discretion in ordering public officials to provide services to foster children and their families. The ordered services must be part of the current comprehensive services plan. Under Section § 255 a court only may order public officials to cooperate or provide assistance "within his (the public official's) legal authority." In addition, Section § 255 explicitly limits the Family's Court authority to order assistance and cooperation from school districts. Courts have invoked these sections to develop a two-pronged test to determine how far the Family Court may go in ordering the assistance and cooperation of

service agencies: (1) the ordered act must be with the legal authority of the court and the agency and (2) the order must further the objectives of the Family Court Act.[54] Although the courts have explicitly denied the Family Court's power to make orders that contravene or expand a public agency's legal authority, they have provided limited guidance regarding the court's authority to order services that extend beyond the needs of a particular foster child.[55]

Role of Law Guardians

A law guardian can make applications pursuant to Family Court Act sections 255 and 1015-a for the court to order health evaluations and treatment for a foster child.[56] Because law guardians are statutorily required to help protect their client's interests and to help their clients express their wishes, law guardians must interview the child and conduct an independent investigation of the circumstances related to the allegations of abuse and neglect.[57] Whether the child received adequate health care and whether the child presently requires screening for health problems should be one part of the attorney's investigation. Information about the child's health and functioning can help law guardians review or develop a permanency plan for the child. If a law guardian learns that a foster child has or may be at-risk for health problems, the law guardian can ask the court to order health evaluations and services for the child.[58] The law guardian can argue that services to address a child's health needs are essential to the child's protection, the family's rehabilitation and the child's discharge from foster care.[59]

Role of Other Court Actors

Court Appoint Special Advocates (CASA), social workers working in the court, Department of Social Services caseworkers and attorneys and attorneys representing parents also can ask basic questions about a child's health. They can assist the court in identifying a child's health needs and gaps in services and they also can provide information about resources to address the child's health problems and to enhance the capacity of biological and foster parents to care for the child. They also can incorporate services to promote a child's healthy development into the permanency plan, as a means to increase the child's prospects for reunification or adoption.

Conclusion

Federal and state law mandate that foster children receive services to enhance their healthy development and their prospects for permanency. Despite their rights to health care under the law, many foster children have compromised health and do not receive even basic health services to address their problems. The lack of services is alarming particularly in light of research revealing that children with disabilities are at a high risk of being abused or neglected and that stress created by the demands of caring for children with health problems can lead to family instability or dissolution.[60] Judges, advocates and child welfare professionals can reverse this grim forecast and strengthen families by safeguarding foster children's rights to health services.

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[3] Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, *supra*.

[4] *Id*.

[5] Blatt & Simms, *Foster Care: Special Children, Special N*eeds, *supra*; Chernoff, *supra*; Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, *supra*; Wyatt et al., *Widespread Growth Retardation and Variable Growth Recognition in Foster Children in First Year After Initial Placement*, 151 ARCH. PED. ADOLESC. MEd. 813 (1997).

[6] J. Silver et al., *Starting Young: Improving the Health and Developmental Outcomes of Infants and Toddlers in the Child Welfare System*, *supra* note 2.

[7] Chernoff et al., *Assessing the Health Status of Children Entering Foster Care*, *supra* note 2.

[8] Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, *supra* note 2; J. Silver et al., *Starting Young: Improving the Health and Developmental Outcomes of Infants and Toddlers in the Child Welfare System*, *supra* note 2; Szilagyi, *The Pediatrician and the Child in Foster Care*, *supra* note 2.

[9] A. Rosenfeld et al., *Foster Care: an update*, *supra* note 2; H. Ruff et al., *Early Intervention in the Context of Foster Care*, 11 DEV. & BEHAVIORAL PED. 265 (1990)

[10] Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, *supra* note 2

[11] *Id*.

[12] Child Welfare League of America, ALCOHOL AND OTHER DRUG SURVEY OF STATE CHILD WELFARE AGENCIES, Washington D.C. 1997. *See also* P. Curtis & C. McCullough, *The Impact of Alcohol and Other Drugs on the Child Welfare System*, 72 CHILD WELFARE 533, Volume 2 (1993); Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, *supra* note 2.

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[14] New York State Department of Social Services, Office of Quality Assurance and Audit, REPORT OF MEDICAL SERVICES PROVIDED TO CHILDREN IN FOSTER CARE, January 1995 (on file at the The Permanent Judicial Commission on Justice for Children).

[15] Interview with M. Szilagyi, M.D., Foster Care Pediatrics, Rochester, N.Y. (Apr. 1999).

[16] Interview with S. Blatt, M.D., ENHANCE, Syracuse, N.Y. (Apr. 1999).

[17] U.S. General Accounting Office, FOSTER CARE: HEALTH NEEDS OF MANY YOUNG CHILDREN ARE UNKNOWN AND UNMET, GAO/HEHS-95-114 (Washington D.C. 1995).

[18] Report on file at the Permanent Judicial Commission on Justice for Children.

[19] Halfon, *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable* Child, *supra* note 2.

[20]Halfon et al., *supra* note 8.

[21] G. Frank, *Treatment Needs of Children in Foster Care*, 50 AM. J. ORTHOPsych. 256 (1980); N. Halfon & L. Klee, *Health Services for California's Foster Children: Current Practices and Policy*

Recommendations, *supra* note 2; E.L. Schor, *The Foster Care System and Health Status of Foster Children*, 69 PEDIATRICS 521 (1982).

[22] The requirements for EPSDT are contained in the federal Medicaid Act. 42 U.S.C. §§ 1396a (a)(43), 1396d(a)(4)(B), 1396d(r) (West Supp. 1998). The Medicaid Act was amended in 1989 to strengthen the EPSDT provisions. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 stat. 2106, 2263 (1989). For the scope of services entitled under EPSDT see 42 U.S.C. § 1396d(r) (West Supp. 1998).

[23] Under Title IV-E of the Social Security Act, all children in federal foster care or adoption assistance programs are entitled to Medicaid and as a result, entitled to EPSDT services. In New York, foster children are entitled to Medicaid. 84 ADM-4. *See also* N. Ruptier, *Ensuring Health Care for Foster Children Through Medicaid's EPSDT Program*, 87 AM. J. PUB. HEALTH 290 (1997).

[24] 42 U.S.C.A. § 1396a-d (West Supp. 1998). For a detailed explanation of EPSDT and its relevant sections see Kristi Olsen et al., CHILDREN'S HEALTH UNDER MEDICAID: A NATIONAL REVIEW OF EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (National Health Law Program, Los Angeles, CA.: August 1998); Jane Perkins, TOWARD A HEALTHY FUTURE – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT FOR POOR CHILDREN (National Health Law Program/Texas Rural Legal Aid: 1995).

[25]42 U.S.C. § 1396d(r)(5) (West Supp. 1998). *See also* § 1396a (a) (43(B).

[26] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 stat. 2106, 2263 (1989). Additionally, several professional organizations and advocacy groups have suggested specific and more stringent standards for health care to foster children. *See* American Academy of Pediatrics, *Health Care of Children in Foster Care*, 93 PEDIATRICS 335 (1994); Child Welfare League of America, Standards for Health Care services for Children in Out-of-Home Care, (CWLA Press:Washington D.C. 1988).

[27] *Sanders v. Lewis*, No.2:92-0353, 1995 WL 228308, reprinted in, Medicare & Medicaid Guide ¶ 43, 120 (S.D.W.Va., March 1, 1995 and Aug. 16, 1993, March 1, 1995) (consent order and compliance plan requiring outreach and screening for children in out-of-home-placement); *L.J. by Darr v. Massinga*, 778 F.Supp. (D.Ma. 1991)(consent decree requiring initial and periodic examinations for children in out-of-home placement).

[28] Pub. L. 96-272 (1980), Social Security Act, Titles IV-B, IV-E, 42 U.S.C.A. § 620 et seq., 670 et seq.

[29] 42 U.S.C.A. § 675 (5)(A).

[30] 45 C.F.R. 1357.15

[31] Utilizing the regulations applicable to welfare fair hearings. 42 U.S.C.A. § 671(a)(12); 45 C.F.R. §1355.30 (incorporating 45 C.F.R. §205.10 by reference).

[32] U.S. Dept. of Health and Human Services, Administration for Children, Youth and Families, *Policy Interpretation Question*, ACYF-PIQ-83-4 (Oct. 26, 1983).

[33] Adoption and Safe Families Act of 1997, P.L. 105-89.

[34] Id. at Title I, § 101(a)(A).

[35] Individuals with Disabilities Act, 20 U.S.C.A. Chapter 33 § 1401 et seq. (1997).

[36] The newly passed federal regulations for the Individuals with Disabilities Act may be found in the *Fed. Reg*., Vol. 64, No. 48 (March 12, 1999). Part B regulations are found at 34 C.F.R. Parts 300 and 301. Part C regulations are found at 34 C.F.R. Part 303.

[37] Id. at § 300.20; 303.19.

[38] Id. at § 300.515; 303.406.

[39] Id. at § 300.515 (c)(2) (i).

[40] Id. at § 303.406(d)(1)(i)-(ii).

[41] Head Start regulations describe the purpose, scope and child health and developmental and family partnership components of the Head Start program. 45 C.F.R. Part 1304.

[42] 18 N.Y.C.R.R. Parts 507, 508.

[43] Soc. Serv. L. § 409 et seq.

[44] 18 N.Y.C.R.R. § 430.9-430.12. Preventive services may be either mandatory or optional – the categories reflect state reimbursement eligibility.

[45] 18 N.Y.C.R.R. 430.9(c)(1).

[46]18 N.Y.C.R.R. § 423.4 (c) (d).

[47] 18 N.Y.C.R.R. 423.2(b).

[48] 90-ADM-21 (July 5, 1990).
[49] Id. at IV (E).
[50] Id. at IV (B), (C), (F), (V).
[51] Family Court Act Art. 6-10.
[52] Family Court Act §1011.
[53] *See e.g.* Family Court Act § 1061.
[54] *See Currier v. Honig*, 50 A.D.2d. 632, 633 (3rd Dept., 1975)(holding that section 255 does not authorize ex parte order requiring county attorney to appoint an additional assistant*); New York Housing Authority v. Miller*, 89 Misc.2d141, 144, 390 N.Y.S.2d 806,809 (Sup.Ct., Spec. Term. N.Y.Co. 1977); aff'd, 60 A.D.2d 823,401N.Y.S.2d 992 (1st dept. 1978) (holding that Family Court could not order Housing Authority to ignore housing selection priorities imposed under laws and its own rules). Courts are also bound by section 255's limits on the Family Court's authority to order assistance and cooperation from school districts. See FCA 255.
[55] The New York Court of Appeals held that a family court's order may not establish "a general overview of the functions of the Department of Social Services" because doing so "violates the constitutional mandate of separation of powers." The Court and the concurring judges noted, however, that its decision did not "rule out the possibility that, in the proper circumstances, section 255 might empower the Family Court to fashion a remedy that extends beyond the immediate needs of a particular child*." See Lorie C. V. St. Lawrence County Dept. of Soc. Services*, 49 N.Y.2d 161, 400 N.E.2d 336, 424 N.Y.S.2d 395 (1980). Future litigation will determine under what circumstances section 255 may be available to promote system-wide change. Other new York cases have established circumstances under which a court order would be improper: where a court order is outside the court's legal authority (see *In the Matter of D. Children*, 60 N.Y.S.2d 838, 458 N.E.2d 383, 470 N.Y.S.2d 142 (1983); where the court order contravenes or expands the agency's constitutional or statutory authority (see *Lorie C., infra*); and where an order mandates a change or expansion of services without clear legislative authorization (*Matter of Dennis M.*, 82 Misc2d 802, 806, 370 N.Y.S.2d 458, 462 (Fam.Ct., Bronx Co., 1975. In 1987, the Legislature clarified the court's authority by adding FCA section 1015-a. *But see* In the Matter of Daniel M., 166 Misc.2d 135, 631 N.Y.S.2d 470 (Fam.Ct., N.Y. Co., 1995) (holding that 1015-a empowered court to commissioner of social services to pay for four hours of skilled nursing care that was not specifically mentioned in the current comprehensive services plan because plan stated that recruitment of foster homes for hard-to-place, including those with special medical and developmental needs, was a top priority).
[56] For a detailed analysis of the role and legal authority of the law guardian in representing children with medical needs see Ronald Richter, *How to Represent Children Who Suffer From Lead Paint-Related Disabilities in Family Court Proceedings*, (The Legal Aid Society, Juvenile Rights Division: New York: N.Y., Oct. 1998)(Submitted as addendum to training materials for seminar on lead poisoning held on Oct. 19-20, 1998)
[57] Family Court Act §241.
[58] Family Court Act §251.
[59] Family Court Act §1015-a. Where appropriate, the law guardian can ask DSS or the court to refer a child for evaluation for early intervention and special education services and to designate a surrogate parent for early intervention and educational planning for the child.
[60] *See* R.H. Hughes & J. Rycus, DISABILITIES AND CHILD WELFARE 9-12 (Child Welfare League of America Press: Washington D.C., 1998).