I. AUTHORITY	The Director of the Child and Family Services Agency adopts this policy to be consistent with the Agency's mission and applicable federal and District of Columbia laws, rules and regulations, including, but not limited to, provisions in Titles 4 and 16 of the DC Code; the Health Insurance Portability and Accountability Act (HIPAA) of 1996; the LaShawn A. v. Williams Modified Final Order; and, the LaShawn A. v. Fenty Amended Implementation Plan (February 2007).
II. APPLICABILITY	This policy applies to all agency employees, private agency staff and contracted personnel.
III. RATIONALE	According to the *District of Columbia HIV/AIDS Epidemiology Update 2008,* as of December 31, 2007 there were 15,120 residents of the District living with HIV/AIDS, 3% of the population over the age of 12 years (adults and adolescents). This is a 22% increase from 12,428 cases reported at the end of 2006. The *DC Appleseed Center's Fourth Report Card (September 2008)*, reports that the Nation's Capital has the highest African-American AIDS case rate in the country (277.5 per 100,000) and the highest Hispanic rate of new AIDS cases in the country (109.2 per 100,000). The Report further states that between 1997 and 2006, 68.7 percent of newly-identified AIDS cases in the District were "late testers" (the national rate was 40 % for 2007). That is, they first learned of their positive HIV status less than one year before being diagnosed with AIDS. The city's high late tester rate reveals that too many District residents living with the HIV virus are not aware that they are HIV positive and are potentially infecting others. Youth (persons aged 13 to 24) account for less than 15% of living HIV/AIDS cases. Rates of sexually-transmitted diseases (e.g., chlamydia and gonorrhea) indicate that sexual behavior among adolescents poses a significant risk of later HIV infection (*District of Columbia, HIV/AIDS Epidemiology Update 2008*). Perinatal transmission of HIV accounts for the majority of cases of pediatric HIV/AIDS. In 2007, the District had 9% of all reported pediatric cases in the country far disproportionate to the population (*District of Columbia, HIV/AIDS Epidemiology Update 2008*). Between 2001 and 2007, there were 63 cases of HIV (not AIDS) and AIDS cases reported among children diagnosed at less than 13 years of age, of which 42 were HIV only cases. Many states reported no new cases among children during this same time period (*District of Columbia HIV/AIDS Epidemiology Annual Report 2008*).

	With an acknowledgement of the crisis that exists in the District of Columbia, CFSA seeks to address these significant health issues and to reduce the challenges it has faced in identifying and serving children and youth that may be HIV-positive or diagnosed with an AIDS-related illness. These challenges have included: • Conducting HIV testing only on a case-by-case basis, when indicated by a physician that there is a clinical presentation • Minimal knowledge regarding HIV-positive adolescents; of those adolescents known to be HIV-positive, very little information exists on where they are going for care or if the adolescent is in compliance with a health regimen • The continuance of involvement of adolescents known to be HIV positive in high risk behaviors, such as multiple pregnancies, sexual promiscuity, lack of medical compliance, etc. • The preparation of CFSA's youth who are HIV positive or have AIDS for the transition to adulthood • The limited knowledge by CFSA's Office of Clinical Practice of the universe of HIV testing or HIV positive tests among the children and youth served by CFSA CFSA is a partner with the District's Department of Health-HIV/AIDS Administration in developing a strategic youth and HIV prevention initiative. The Agency is committed to the provision of the appropriate related medical care services and supports, as well as HIV/AIDS awareness and education to the children and youth in care, parents/families, foster parents, and staff.
IV. POLICY	It is the policy of the Child and Family Services Agency (CFSA) to ensure that children and youth served by CFSA, and who have AIDS or HIV, or have signs or symptoms of HIV-infection, or who are at high risk for HIV infection, receive appropriate and timely counseling, testing, and/or medical services. Although current laws and statutes define HIV and AIDS as both a "sexually transmitted disease" and a "communicable disease" *(see Attachment A),* CFSA takes both definitions into consideration with the goal of optimizing treatment to children and youth in its care without any attached stigma. All children and youth coming into foster care will be screened for HIV. Children with a positive screening will have an expedited 14-day comprehensive health screen and appropriate referrals for further HIV testing. For children and youth already in care, screening and testing (if applicable) will be recommended, at minimum, on an annual basis during the healthcare process, as recommended by the District of Columbia HealthCheck Periodicity Schedule.

	It is also the policy of CFSA to ensure that all Agency staff, contracted agency staff, foster parents, and caregivers are informed and educated on all policies, procedures, laws and best practices pertaining to the care of HIV/AIDS infected children and youth. All social workers shall have basic knowledge about HIV/AIDS, including its transmission and risk factors for infection. In all cases involving children and youth with HIV/AIDS-related special needs, the social worker shall make sure the birth parent, foster parent, adoptive parent, and other caregivers receive the necessary information and training regarding care of the child, including medication and other treatment interventions, HIV/AIDS risk factors and universal infection control precautions. Special programs and initiatives will be targeted for the adolescent population. Programs include adolescents who are sexually active, who are substance abusers, who have returned from abscondence, and who have had a change in placements. This policy prescribes protocols and procedures for children and youth in CFSA out-of-home care. For children and youth and their families receiving services in their home, the assigned social worker shall consult with the Office of Clinical Practice-Clinical and Health Services Administration for assistance and guidance in ensuring that these families receive all necessary HIV and AIDS-related education, supports, and services.
V. CONTENTS	**A.** Screening **B.** Risk Assessment **C.** Referrals for Testing and Counseling **D.** Placement and Care of Children Known to Have HIV or AIDS **E.** Disclosure of an HIV Diagnosis to a Child **F.** Decline Consent for Testing **G.** Confidentiality and Disclosure **H.** Universal Infection Control Precautions for Staff
VI. ATTACHMENTS	**A.** DCMR 22, Chapter 2: Communicable and Reportable Diseases **B.** Risk Factors **C.** Authorization to Disclose Form **D.** Confidentiality and Nondisclosure Agreement Forms
VII. PROCEDURES	**Procedure A: Screening** 1. All children and youth entering foster care will be screened for HIV/AIDS as a part of the routine examination during the pre-placement screening. 2. The results of the screening, whether negative or positive, will be forwarded to the medical director, Office of Clinical Practice-Clinical and Health Services Administration. All results will be kept confidential. 3. If the screen is positive, the medical director and the assigned social worker shall discuss the next steps with the child or youth (if they have the capacity to consent). If the child or youth does not have the capacity to consent, next steps may be discussed with the birth parents or legal guardians.

	4. Children with a positive screening will have an expedited 14-day comprehensive health screen and appropriate referrals for further HIV testing. 5. For children and youth already in care, screening and testing (if applicable) will be recommended, at minimum, on an annual basis during the HealthCheck process or immediately if children or youth present with risk factors, have returned from abscondence, or have had a change in placements. Testing shall also be recommended with special attention to adolescents in the following categories: a. Children and youth showing symptoms of HIV-infection b. Children and youth who have a sibling or parent that is infected c. Youth with a history of sexual abuse or diagnosis of a sexually-transmitted disease d. Youth with a history of illicit substance use or abuse e. Youth who are known to be sexually active 6. Children and youth may request to be screened and/or tested on their own. 7. Post-screen counseling will be available at the time and location of the screening.
	Procedure B: Risk Assessment It is important to gather information related to the risk level for HIV infection and HIV/AIDS risk factors for all children in care (*see Attachment B "Risk Factors", developed by the Office of Clinical Practice, Health Services Administration*). Children and youth assessed by a social worker or healthcare provider to have risk factors for HIV/AIDS will be referred to the Office of Clinical Practice - Clinical and Health Services Administration to access counseling, testing, or medical services, if applicable. Information gathered in the risk assessment is confidential. Social workers investigating child abuse and neglect, and those serving abused and neglected children and their families at home should refer to the list of risk factors and must be knowledgeable about HIV/AIDS risk assessment
	Procedure C: Referrals for Testing and Counseling HIV/AIDS testing and counseling services shall be conducted by a certified medical professional, and readily available to all children and youth. Once the test results have been received, counseling for the child or youth shall be provided at the site where the testing is conducted. The social worker will consult with the Office of Clinical Practice-Clinical and Health Services Administration for the need of counseling and testing for the child or youth. The social worker shall refer the child or youth for any additional counseling, whenever appropriate, and after consultation with OCP. The social worker will consult with the child or youth and caregiver to determine who shall accompany the child or youth for testing and counseling (e.g., caregiver and/or social worker).

	Procedure D: Placement and Care of Children Known to Have HIV or AIDS Children and youth who have HIV or AIDS require specialized services and additional resources to meet their special needs. All foster parents and congregate care providers, whether procured by the Agency or any of its private providers, must agree to participate in training on how to care for infants, children, and youth diagnosed with HIV or AIDS. They shall also be informed about supports that are available to them and to the child or youth. Whenever possible, HIV-positive children and youth should be placed with an agency that has staff with prior demonstrated experience in working with persons infected with HIV or persons who have AIDS, as well as foster parents and congregate care providers who are also experienced and trained. In order to assure proper care and treatment of an HIV-positive child or youth who should, for example, be protected against other contagious diseases such as measles and chicken pox, a care provider, including foster or kinship parents, or congregate care facility staff, should be given information (including medication regimen) regarding the child's HIV status prior to placement. **The *child's name, however*, *should not be disclosed until the placement is confirmed.*** All providers shall be informed that *HIV information is confidential (see Section G: Confidentiality and Disclosure).* Information about the HIV status of a child in a facility or foster home or about that child's parents or other family members may not be disclosed to other children residing in the facility or foster home or to family members of the foster parents.
	Procedure E: Disclosure of an HIV Diagnosis to a Child 1. Disclosure of HIV status to children and youth should take into consideration their age, cognitive ability, developmental stage, and clinical status. The child or youth's understanding of the nature of his or her illness is likely to develop over time, however, through questions and answers. It is important that the adults in the child or youth's life, including social workers be comfortable in providing accurate answers to the child or youth's questions. 2. The healthcare practitioner who administered the HIV test shall forward all test results, whether positive or negative, to CFSA's medical director within 24 hours of the receipt of the results. If the results are positive, the medical director shall immediately (within 24 hours) contact the child or youth's assigned social worker and together shall decide the course of action regarding notification and scheduling of the meeting with the healthcare practitioner and the foster parent/caregiver, birth parent(s) if appropriate, and the child or youth. 3. A youth who has the capacity to consent has the right to make certain decisions about the disclosure of information related to an HIV test. The consent must be an informed consent. The assigned social worker and the healthcare practitioner shall advise the youth during the post-test counseling and these rights shall be explained *(see policy on HIV, Sexual, and Reproductive Health Services).*

	4. The OCP-Clinical and Health Services Administration and the assigned social worker shall jointly ensure the child or youth receives the necessary treatments for both medical and mental health issues, and shall jointly monitor the child or youth's progress. Experience has shown that children who comply with or receive regular medical attention tend to do well. Therefore, the social worker must ensure that medical follow-up is taking place, the caregiver is adhering to the child's medication schedule and the child's counseling needs are being met. 5. Support groups or specialized counseling can be helpful for birth and foster/caregiver families dealing with these and other issues. Social workers shall contact the Office of Clinical Practice for further guidance.
	Procedure F: Decline Consent for Testing Occasionally, a child or youth and/or parent or legal guardian of a child or youth may decline or refuse HIV/AIDS testing of the child, despite such testing being medically advised. In each of these cases, the social worker shall consult with the Office of Clinical Practice. If the child or youth declines or refuses the HIV/AIDS testing, the social worker in conjunction with OCP, the healthcare provider, and the foster parent (if applicable) shall continue to engage the child or youth to consent to the testing. If the child or youth continues to decline or refuse the testing, a court order granting to CFSA medical guardianship for the specific purpose of consenting to HIV/AIDS testing must be obtained. The Office of Clinical Practice shall notify either the Agency assistant attorney general (AAG) or the guardian *ad litem* of the child to request the court order. When medical guardianship is granted to CFSA, the Agency may provide the necessary consent for HIV/AIDS testing. The Agency director or his/her designee may also provide consent when parental rights have been judicially terminated, or relinquished to CFSA, since this creates a legal guardianship relationship between the child and the Agency. ***For children already in care, under no circumstances may a CFSA social worker, foster parent, congregate care provider, or private agency staff independently provide consent for HIV/AIDS testing of a child or youth.***
	Procedure G: Confidentiality and Disclosure 1. Disclosure of the HIV status of an adult, child, or youth to anyone other than a foster parent, congregate care director, healthcare practitioner, or the assigned social worker, supervisor, and supervisory managers should be made only with the written, HIPAA-compliant (Health Insurance Portability and Accountability Act) authorization executed by the parent or guardian of the child or youth, the child or youth, or by court order *(see Authorization to Disclose Form, Attachment C).* 2. Protocols specific to Agency staff and private service providers for obtaining, maintaining and/or disclosing of confidential information pertinent to HIV/AIDS must comply with applicable federal and local law, as well as Agency policies and procedures as guided by professional standards *(see CFSA's Confidentiality Policy)*. Any unauthorized disclosure is prohibited by law and may result in criminal penalties.

3. When CFSA has medical guardianship of a child or youth, or when parental rights have been terminated, the Agency has the authority to consent to the release of medical information.

4. If the foster parent receives knowledge of their foster child's HIV status while the child or youth is in their care, the foster parent is required to immediately notify the assigned social worker.

5. As necessary, CFSA will periodically update, develop and distribute protocols relevant to this policy. Generally, however, the following guidelines should be observed:

   a. All foster parents, guardians, and caregivers shall sign a *Confidentiality Agreement* (*See Attachment D)*.

   b. All congregate care facilities shall require that the director sign a *Confidentiality Agreement* regarding the disclosure of a child or youth's HIV-related information. The director shall consult with the child or youth's social worker and the OCP-Clinical and Health Services Administration to determine which facility staff member should also have this knowledge. Any facility staff member who is required to have this knowledge shall sign a *Confidentiality Agreement*.

   c. All *Confidentiality Agreements* shall be submitted to the social worker, who will forward to the CFSA-Office of Clinical Practice.

   d. CFSA's statement regarding unlawful re-disclosures and any other information related to confidential HIV/AIDS information shall be provided to the foster parent or caregiver in the placement packet.

   e. All HIV or AIDS-related documents must be kept strictly confidential. HIV-related medical information (e.g., HIV risk assessment materials, test results, and treatment reports) should be maintained in a sealed manila envelope in the medical section of the case record. The envelope must be clearly labeled "Confidential" and instructions should appear on the outside of the envelope as to who may have access to the information (see listing below). The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care and treatment of the child and to whom knowledge of HIV test results is relevant and necessary to their decisions and actions relative to the care and treatment of, or permanency planning for, the child. Generally, access will be limited to the social worker, supervisor and program manager or administrator directly responsible for investigating abuse or neglect or for providing or securing care and services for a child or youth or a family. CFSA's medical director, the Healthy Horizons Assessment Center nurse practitioner and OCP nurse, as well as parents and legal guardians shall have access (unless the child or youth has indicated that they do not want the information to be shared with birth parents/legal guardians). Additionally, written consent may be obtained from the child or youth who is of an age and mental status to give informed consent, to share information with others such as medical or dental care providers, for specific purposes.

f. Effects of any illness relevant to case goals may be discussed within case narration without specifying the diagnosis. Social workers should use the term “chronic illness” when referring to the condition of the child or youth in all case plans, FACES notes, court reports, Family Team Meeting reports and all other written documents. Reference to the HIV/AIDS status of a child or adult family member may be made on case forms and narrative material or case plans only as necessary to address issues of the child’s protection and progress toward permanency. The social worker shall consult with the Office of Clinical Practice-Clinical and Health Services for consultation, as necessary.

g. When it is necessary for the court to be advised of the HIV status of a child or youth or a parent, the social worker, preferably through the assigned AAG, shall request that a parent sign a release of information authorizing disclosure. A child or youth may also be asked to give consent to share information about himself or herself. If consent to disclose information to the court is denied, the AAG may state in the court report and on the record in the court room that CFSA has highly confidential information which it is prohibited, by law, from disclosing in public but which is pertinent to the progress of the case and request a court order to disclose the information. Whether disclosure is the result of consent or of court order, it should occur at the bench and not in open court.

6. Whenever possible, children and youth infected with HIV/AIDS should be placed with foster parents who are experienced and/or trained in working with persons infected with HIV or AIDS. Foster parents shall be trained in and use universal precautions on a daily basis. The foster parents should be given information regarding the child's HIV status prior to placement. ***The child's name, however, should not be disclosed until the placement is confirmed.***

7. In the case of a relative (kinship) caregiver, information that a child is HIV positive should be given prior to placement, but only when the placement is assured and with the consent of the child's parent since this information may indirectly reveal the parent's HIV positive status. If the parent refuses to give consent, CFSA shall petition the court for authorization to release this information in order to ensure proper care and attention to the child's special needs. The social worker shall inform the relative caregiver that information concerning the child's HIV status and that of any other family members, known or assumed, is confidential.

8. Prospective adoptive parents should be made aware of a child or youth’s HIV status, prior to identifying a specific child/youth, as part of making the determination regarding placement. Once the adoption is finalized, the adoptive parents have the same authority to release medical information about the child as would birth parents whose parental rights remain intact.

	9. Birth parents are entitled to receive information about the health status of their child <u>except</u> under either of the following circumstances: a. Parental rights have been terminated or relinquished or a court of general jurisdiction has ordered otherwise. b. The child has given sole consent to the testing and agrees to recommended treatment. If the child refuses treatment, a parent must be informed. (22 DCMR 602.6 and 602.7) 10. Information about a child's HIV status may be given to one parent, except in the situations enumerated above, even when it indirectly reveals the HIV status of the other parent. 11. When a child is being transferred to another jurisdiction, disclosure of HIV status to staff in the new agency should be limited only to those who need to know it in order to provide or arrange for care. Any necessary medical records should be sealed, marked "Confidential" and sent directly to those individuals.
	Procedure H: Universal Infection Control Precautions for Staff CFSA requires Agency staff, contracted agency staff, foster parents, and congregate care providers engaged in providing direct services to children, youth and families to be trained in and to use universal infection control precautions on a daily basis. CFSA staff should consult applicable procedures outlined in the Healthcare Management policy, Chapter II. Contract agency staff shall also abide by policies and procedures in effect in the agency in which they are employed.

Attachment A

TITLE 22. PUBLIC HEALTH AND MEDICINE
CHAPTER 2. COMMUNICABLE AND REPORTABLE DISEASES

CDCR 22-201 (2005)

22-201. COMMUNICABLE DISEASES

201.1 The following diseases shall be considered communicable diseases and shall be reported by telephone to the Director within two (2) hours of provisional diagnosis, or the appearance of suspicious symptoms:

(a) Animal bites

(b) Anthrax

(c) Botulism

(d) Cholera

(e) Diarrhea of the newborn, infectious

(f) Diphtheria

(g) Food-borne disease

(h) Meningococcal infections

(i) Plague

(j) Rabies of man and animal

(k) Severe Acute Respiratory Syndrome (SARS)

(l) Smallpox

(m) Staphylococcal infections acquired in hospitals and in newborns

(n) Streptococcal infections of the newborn

(o) Typhus fever

(p) Yellow fever

(q) An unusual occurrence of any disease

201.2 The telephone report required by § 201.1 shall be confirmed in writing within 24 hours in the manner indicated in § 200 of chapter 2 of this title.

201.3 The following diseases shall be considered communicable diseases and shall be reported by telephone to the Director within 24 hours of provisional diagnosis, or the appearance of suspicious symptoms:

(a) Aseptic meningitis syndrome

(b) Cryptococcosis

(c) Dengue

(d) Leprosy

(e) Poliomyelitis

(f) Psittacosis

(g) Relapsing fever, louse-borne

(h) Salmonella infections, including typhoid fever and paratyphoids

201.4 The telephone report required by § 201.3 shall be confirmed in writing within 48 hours of diagnosis in the manner indicated in § 200 of chapter 2 of this title.

201.5 The following diseases shall be considered communicable diseases and shall be reported in writing within 48 hours of diagnosis or the appearance of suspicious symptoms in the manner indicated in § 200 of chapter 2 of this title.

(a) Human Immunodeficiency Virus (HIV) infection

(b) Amebiasis

(c) Brucellosis

(d) Dysentery, bacillary

(e) Encephalitis

(f) German measles

(g) Glanders

(h) Hepatitis, infectious and serum

(i) Leptospirosis

(j) Malaria

(k) Rheumatic fever

(l) Ringworm of the scalp

(m) Rocky Mountain spotted fever

(n) Streptococcal infections, hemolytic

(o) Tetanus

(p) Trachoma

(q) Trichinosis

(r) Tuberculosis

(s) Tularemia

(t) Venereal diseases, including chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and syphilis

(u) Whooping cough

201.6 The following diseases and any other communicable diseases occurring as an outbreak of illness or toxic conditions, regardless of etiology, in an institution or other identifiable group of people shall be considered communicable diseases, but only when they occur in unusual numbers:

(a) Chickenpox

(b) Enterobiasis (pinworm)

(c) Glandular fever, infectious

(d) Histoplasmosis

(e) Impetigo contagiosa

(f) Influenza

(g) Kerato-conjunctivitis

(h) Mumps

(i) Pediculosis

(j) Pneumonia

(k) Scabies

201.7 The number of cases defined as a communicable disease in § 201.6 shall be reported by telephone to the Director within 24 hours of diagnosis or the appearance of suspicious symptoms.

201.8 The telephone report required in § 201.7 shall be confirmed in writing, if required by the Director, in the manner required by the Director.

History of Regulations since Last Compilation by Agency (August 1986)
August 1, 2003 *22 DCMR 201.1*, *299.1* amended at 50 DCR 6169 by the Department of Health; statutory authority *DC Code § 7-131*, Mayor's order 98-141
June 13, 2003 *22 DCMR 201.1*, *299.1* emergency at 50 DCR 4758 by the Department of Health; statutory authority DC Official Code § 7-131(a), Mayor's Order 98-141 [EXPIRED]
December 29, 2000 *22 DCMR 201*, *205*, *206*, *211* amended at 47 DCR 10209 by the Department of Health

Attachment B
Risk Factors

HIV-infected children younger than 13 years of age in the United States acquired the infection from their mothers in more than 90% of the cases.

Risk factors in these children include:

- Maternal history of human immunodeficiency virus (HIV) infection
- Paternal history of human immunodeficiency virus (HIV) infection
- Parental (mother and/or father) history of substance and/or alcohol abuse
- Maternal history of sexual abuse and/or domestic violence
- Maternal history of no prenatal care, inconsistent or late prenatal care
- History of sexual abuse (the child)
- History of premature birth
- *Poor growth
- *Frequent infections
- *Developmental delay
- *Anemia (low blood count)

**Requires social worker to (1) inquire about medical visits (routine and unscheduled to the hospital emergency department), outcomes of physical examinations and medications, and (2) observe child's growth and development at visits and report concerns to the OCP-Clinical and Health Services Administration.*

Transmission of HIV among adolescents is attributable primarily to sexual exposure.

Risk factors in these youngsters include:

- History of sexual abuse
- Sexual activity – homosexual and heterosexual
- History of a sexually transmitted disease
- History of homelessness
- Suspected or confirmed history of prostitution
- History of illicit substance use or abuse (inhaled or IV)
- Parental history of human immunodeficiency virus (HIV) infection
- Sibling history of human immunodeficiency virus (HIV) infection
- History of a current or past sexual partner who is HIV-infected or at increased risk of HIV infection
- Serious bacterial infections

Consider testing children and youth whose medical and family history is unavailable or inadequate for assessment of the aforementioned risk factors.

Attachment: C

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Authorization to Disclose Form

Client Name **Date of Birth**

Client Social Security Number

I give my permission to disclose any medical test results, diagnosis or treatment records for _____ (child or youth's name) to the following organizations and/or individuals to assure proper care and treatment and to whom knowledge of the information is relevant and necessary to their decisions and actions relative to the care and treatment of the child:

- ❑ Birth Parent(s) or legal guardian
- ❑ Staff of Congregate Care Facility
- ❑ School Professionals (as necessary)
- ❑ Other: _____

I understand that disclosure of any medical test results, diagnosis or treatment records is already granted to the 24-hour caregiver (i.e. foster parent(s), Director of Congregate Care Facility), healthcare practitioners, and the assigned social worker (and their supervisory managers).

I also understand that the record may contain information relating to a communicable or infectious disease.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits.

I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.

Print Name Date Signed

Signature Witness (Sign and Print Name)

If I am not the person who is the subject of the records, I am authorized to sign because I am the

Parent of Minor (print name and signature)

Legal Guardian (print name and signature)

200 I Street, SE ♦ Washington, DC 20003
www.cfsa.dc.gov

Attachment D

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Confidentiality and Nondisclosure Agreement

1. I, _____, am a licensed foster parent with the D.C. Child and Family Services Agency ("CFSA").

2. I have consented to the placement of a child/youth in my home that is HIV positive or has AIDS.

3. I have received training in the use of Universal Precautions and will ensure adherence to its practices for all children and youth in my care.

4. I understand that the child/youth or his or her family member's HIV/AIDS positive status is extremely sensitive and completely confidential and shall not be disclosed to others, including but not limited to babysitters, daycare providers, school faculty, their family members or friends or my family members or friends.

5. I understand that the child's and his or her family member's HIV/AIDS status is sensitive, confidential, and/or otherwise protected from disclosure to the public by applicable federal or District laws or by CFSA's policies and procedures.

6. I acknowledge that the unauthorized disclosure of the child's or his or her family member's HIV/AIDS status violates D.C. Official Code § 4-1303.06 as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), (Pub. L No 104-191, 110 Stat. 193 (1996)) and its implementing regulations (45 CFR part 160 and part 164, subparts A and E.

7. I understand and agree that whoever willfully discloses, receives, makes use of or knowingly permits the use of confidential information concerning the youth or individual in violation of D.C. Code Official Code § 4-1303.06, is guilty of a misdemeanor and upon conviction shall be fined not more than $1,000.00.

8. By signing this document, I acknowledge that I have and fully understand the above statements.

_____

PARTICIPANT'S SIGNATURE DATE

200 I Street, SE ♦ Washington, DC 20003
www.cfsa.dc.gov

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Confidentiality and Nondisclosure Agreement

1. I, _____, am an employee of _____ a contractor affiliated with the D.C. Child and Family Services Agency ("CFSA").

2. A child/youth that is either HIV positive or has AIDS has been placed in _____.

3. As an employee of _____, I acknowledge that I have received training in the use of universal precautions.

4. I understand that the child/youth or his or her family member's HIV/AIDS positive status is extremely sensitive and completely confidential and shall not be disclosed to others, including other employees of _____.

5. I understand that the child/youth and his or her family member's HIV/AIDS status is confidential, and/or otherwise protected from disclosure to the public by applicable federal or District laws or by CFSA's policies and procedures.

6. I acknowledge that the unauthorized disclosure of the child's or his or her family member's HIV/AIDS status violates D.C. Official Code § 4-130306 as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (Pub. L No 104-191, 110 Stat. 193 (1996)) and its implementing regulations (45 CFR part 160 and part 164, subparts A and E).

7. I understand and agree that whoever willfully discloses, receives, makes use of or knowingly permits the use of confidential information concerning the youth or individual in violation of D.C. Code Official Code § 4-1303.06, is guilty of a misdemeanor and upon conviction shall be fined not more than $1,000.00.

8. By signing this document, I acknowledge that I have read and fully understand the above statements.

_____

PARTICIPANT'S SIGNATURE DATE

200 I Street, SE ♦ Washington, DC 20003
www.cfsa.dc.gov