TEXAS
Department of Family
and Protective Services

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Medical Consent Resource Guide

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Resource Guides

The purpose of Resource Guides is to provide information that helps you do your job better. This information includes reference material, procedures, and guidelines that help you complete the tasks you are required to do by policy.

It's important to remember that the information in Resource Guides does not substitute for policy. We may sometimes include policy statements, but only to show you the policy to which the information is related. We will highlight any policy that actually appears in the Resource Guide and will almost always include a link to the actual policy. For example:

> ***Per 4222.2 Re-Allowing Placement:***
>
> If the caseworker learns of a detailed justification for changing the status of and considering placements in a foster family that is on Disallowed Placement status, the caseworker must elevate this consideration through the regional chain of command to the regional director.

The policy in the handbook always takes precedence over what is in the Resource Guide. We try to keep policy and Resource Guides synchronized, but sometimes there is a delay. If you have questions, always follow the policy in the Policy Handbook.

Resource Guides provide important information on a range of topics, for the purpose of assisting and guiding staff to:

- make essential decisions
- develop strategies to address various issues
- perform essential procedures
- understand important processes
- identify and apply best practices

The information in the Resource Guide is not policy (except where noted), and the actions and approaches described here are not mandates. You should adapt the way you perform critical tasks to the individual needs and circumstances of the children and families with whom you work.

State office and field staff are working together to identify Resource Guide topics, define the content, and develop the appropriate guides. CPS will regularly post Resource Guides as they are developed and update them as needed.
Check the Resource Guides page, in the CPS Handbook, to see new or revised Guides.

We hope these Guides provide useful information to guide and assist CPS staff in effectively performing their job tasks. These Guides, combined with clear and concise policy in the Handbook, should help staff provide a high level of service to children in Texas.

INTRODUCTION

Texas law requires the court to specifically authorize an individual or DFPS to consent to medical care for each child in DFPS conservatorship. Consenting for medical care provides for informed decision-making regarding diagnosis and treatment for each child. A medical consenter is tasked with understanding the child's history, current circumstances, and needs so that they can work with medical providers to meet the child's medical and behavioral health needs.

In most cases, DFPS petitions the court to authorize DFPS to consent to medical care. Once the court does this, DFPS must then designate individuals as primary and backup medical consenters. An agency, treatment center, or other entity may not be listed as a medical consenter. Below are some references for how to determine who best to designate as a medical consenter based on the youth's placement.

See 11100 Medical Consent.

DESIGNATING MEDICAL CONSENTERS

DFPS may designate the following live-in caregivers as medical consenters:

- birth parents, when a child is placed in the birth parent's home who can manage the child's medical care;
- kinship caregivers in a kinship care placement;
- foster parents in foster family and foster group homes (excluding foster group homes with shift staff);
- pre-consummated adoptive parents;
- cottage parents at GROs offering child-care services only (children's homes); or
- family caregivers provided through home and community-based services (HCS), excluding HCS group homes with shift staff

If there are multiple home members, the caseworker designates both parties as primary medical consenters, with one partner designated as first primary consenter and the other as second primary consenter.

The caseworker may designate other kinship connections as backup medical consenter.

For example: a caseworker is placing a child with his or her grandparents. The grandparents are willing to serve as medical consenters, and the aunt and uncle are willing to serve as backup medical consenters. The caseworker designates:

- one grandparent as first primary medical consenter;
- the other grandparent as second primary medical consenter; and
- the aunt and the uncle as either first or second backup medical consenter.

DFPS CASEWORKERS/SUPERVISORS AS MEDICAL CONSENTERS

When DFPS is named the managing conservator at the time of removal, the removing caseworker will designate medical consenters. There can be up to four people who are designated as having medical consenter authority – Primary, Second Primary, Backup, and Second Backup. It is recommended that DFPS caseworkers list a DFPS representative as one of these medical consenters. This ensures that the court is notified that DFPS will retain the ability to consent for medical treatment if other consenters are unavailable.

LOCAL PERMANENCY SPECIALISTS

A Local Permanency Specialist (LPS) or their supervisor may be designated as a medical consenter or backup for youth in foster care who are placed in an area outside the legal Region responsible for their conservatorship. The LPS may attend medical appointments including those where psychotropic medications are prescribed and provide consent as detailed above.

RESOURCES

For questions about medical consent, caseworkers or other parties may email the Medical Consenter Mailbox at: medical.consenter@dfps.texas.gov. A person may also enter DFPS Medical Consenter in the "to" section of the email.

Well-Being Specialists may also be consulted for additional supports.

RECOMMENDED MEDICAL CONSENTER DESIGNATION WHEN A COURT AUTHORIZES DFPS AS A MEDICAL CONSENTER

Determining who to designate as a medical consenter is an important first step to ensuring a continuity of care for youth as they enter foster care. Who you select should be based on who has the most access to the child and who knows the child's medical history and current condition best. An easy way to think about who the medical consenter should be is identifying the placement type.

If the child is placed in a home like setting with relatives, foster parents, or house parents, they are the best choice to be listed as a primary or secondary medical consenter. Medical consenters in home like settings include:

- Kinship/relative caregiver
- Foster Parent

- Pre-consumated adoptive parent
- Cottage parent

If the child is placed in a facility with shift staff, employees of this facilty can never be listed as a medical consenter. Emergency shelters, Residential Treatment Centers (RTCs), General Residential Operations (GROs), State Supported Living Centers (SSLCs), HCS group homes, Nursing homes, and Intermediate Care Facilities for Individuals with Intellecutal Disabilities (ICF-IIDs) can not have staff listed as medical consenters. When children are placed in these settings, a DFPS caseworker and/or Supervisor or other DFPS employee should be listed as medical consenter.

See: 11111 Selecting the Medical Consenter and Backup Medical Consenter
11112 Designating a Live-In Caregiver as the Medical Consenter
11113 Designating Medical Consenters for Children in Conservatorship Living in Residential Facilities

COURT AUTHORIZES SOMONE OTHER THAN DFPS

The court can also authorize someone other than DFPS to make medical decisions for the child or youth, including a youth who is at least 16 years of age. In these situations, DFPS must not designate a medical consenter or backup consenter other than the person authorized by the court, but DFPS must work with the authorized person to ensure the individual still complies with medical consent requirements.

JOINT MANAGING CONSERVATORSHIP AND MEDICAL CONSENT

If a parent shared conservatorship with DFPS in the case of Joint Managing Conservatorship, the parent who shares rights with the Department also retains the right to consent to medical care. See 6810 Families Who Are Unable to Obtain Mental Health Services

See 11120 Court Authorizes an Individual Other Than DFPS to Be the Child's Medical Consenter.
11140 Medical Consent by Minor Youth

RESPONSIBILITIES OF MEDICAL CONSENTERS

KNOWING THE CHILD'S MEDICAL HISTORY

Medical consenters need to be knowledgeable about the child's medical condition. Medical consenters and backup medical consenters may obtain from the caseworker:

- the child's known medical history, including known family medical history;
- copies of medical records in the caseworker's possession;
- information about known healthcare providers who have previously treated the child; and
- information about how to access health information through the Health Passport.

Form 2085-B Designation of Medical Consenter contains a clause allowing the medical consenter and backup medical consenter who are not CPS employees to obtain copies of medical records.

PAPERWORK AND TRAINING

Medical consenters must sign the 2085-B Designation of Medical Consenter and provide copies to the healthcare providers. They are responsible for providing contact information to caregivers. This ensures that medical care can be provided when needed. Training must be completed by all medical consenters on Informed Consent and Requirements for Medical Consenters.

PARTICIPATING IN EACH MEDICAL APPOINTMENT

A person consenting to medical care for a child must participate in each appointment set for the child with the healthcare provider. The level of participation depends on the nature of the medical care and the doctor's specific requirements. Participation can include in person attendance or electronic participation including phone call or other telephonic interactions.

Texas Family Code §266.004(i) Medical consenters must participate in each appointment of the child with the provider of the medical care.

Medical care includes:

- physical;
- dental;
- mental; and
- allied health care

Examples of allied health care include but are not limited to physical therapy, occupational therapy, speech therapy, and dietetic services.

NOTIFYING DFPS/SSCC OF MEDICAL CARE

Medical consenters must stay informed about the child's ongoing medical condition and treatment. Medical consenters must update all other medical consenters and DFPS/SSCC caseworkers of medical care provided.

See 11130 Responsibilities of Medical Consenters and Backup Medical Consenters.

MEDICAL COVERAGE

Almost all children and youth in DFPS conservatorship receive medical and dental care through Texas Medicaid. STAR Health, the comprehensive statewide healthcare system for children and youth in foster care, provides Medicaid services for most children and youth in DFPS conservatorship. Medical consenters must use STAR Health and its network of providers for medical and dental services.

Medicaid/STAR Health generally covers medical and dental care for children in DFPS conservatorship, but in some cases a service may be recommended that is not covered by Medicaid.

A court or a health care practitioner may order a service for a child that the medical consenter or caseworker is unsure is appropriate or covered by Medicaid. If the medical consenter is not the caseworker, the medical consenter should consult with the caseworker before giving consent.

If further assistance is needed, the caseworker consults with the regional Well-Being Specialist.

ROLE OF THE BACKUP MEDICAL CONSENTER

Backup medical consenters may consent to medical care when a primary medical consenter is not available.

Examples of situations in which a backup can be used include when:

- the primary medical consenter is:
  - in court;

- performing other priority duties;
- hospitalized;
- on vacation;
- on sick leave;
- unable to be reached within a reasonable time frame; or
- unable to attend an appointment in which psychotropic medication is prescribed or monitored. (See 11131.4 Psychotropic Medication Appointments.);

PREVENTATIVE CARE

A medical consenter may provide written consent for a person at a residential provider or other person to take the child for a preventative care appointment.

Preventive care is defined in the Medicaid Procedure Manual as the American Academy of Pediatrics Periodicity Schedule or Texas Health Steps medical checkups. Children in foster care should be seen at least twice a year by their primary doctor or more if in early childhood.

The periodicity table includes:

- well-child medical checkups;
- sensory screening (such as vision and hearing);
- developmental and behavioral assessment;
- immunizations;
- laboratory testing for screening purposes (such as blood work, urinalysis, TB testing, STD screening, and pelvic exams);
- anticipatory guidance (health education); and
- dental checkups

See 11131.1 Preventive Care

CONSENTING TO PSYCHOTROPIC MEDICATIONS

The medical consenter must attend all appointments with the child when psychotropic medication is being prescribed or modified. Attendance can be done in person or through telemedicine. For children placed out of the legal region of the medical consenter, an LPS worker may be utilized to attend appointments if they are named as back up medical consenters. When consenting to psychotropic medication, a medical consenter should consider non-pharmacological interventions before or in concert with prescription medication.

Additional guidance regarding appointments for psychotropic medications can be found at Making Decisions About Psychotropic Medications.

See:

11320 Psychotropic Medications

NON-PHARMACOLOGICAL INTERVENTIONS

Prior to using psychotropic medications, medical consenters and other caregivers should consider non-pharmacological (that is, strategies that don't involve medications) interventions for children in DFPS conservatorship whenever possible. This could include psychosocial therapies, behavior strategies or other interventions. Non-pharmacological interventions should also be used in conjunction with psychotropic medications.

The medical consenter or caregiver should seek assistance from the child's healthcare provider, child placing agency, CPS caseworker, and therapist to develop strategies to help the child to manage behaviors. Interventions and strategies employed should follow trauma-informed care practices.

SERIOUS OR COMPLEX MENTAL HEALTH NEEDS

The caregiver or medical consenter should contact the child's primary care provider if the child:

- has serious symptoms or is not getting better with non-pharmacological interventions;
- is a danger to himself or herself or to others; or
- exhibits complex problems. Ask the child's primary care provider if the child may need to see a psychiatrist.

If the child is immediately a danger to self or others, emergency care should be sought.

Medical Consenters may also contact the Local Mental Health Authority in their area community mental health assessment and treatment.

For additional information, see the Mental Health Resource Guide:

EMERGENCY TREATMENT AND MEDICAL CONSENT

Consent is not required when a child needs emergency medical care. The child can receive any care that will prevent bodily injury or death. Anyone caring for the child can take a child to an emergency room or call 911 in the event of emergency. A physician or other medical professional can decide if the circumstances are an emergency and can provide care without consent. Notification to the medical consenter of medical treatment in the event of an emergency should be made as soon

as possible but no later than 2 business days.

See 11131.6 Emergency Medical Care

INVOLVING MINOR YOUTH IN THEIR HEALTHCARE

ASSENT

As children develop, they should assume more responsibility for their health care decisions Medical consenters are expected to allow children and youth to participate as much as possible in making decisions about their medical care.

Assent involves the following elements (adapted from “Informed Consent in Decision-Making in Pediatric Practice” Pediatrics, Volume 138, Number 2, August 2016.):

- Help the patient achieve a developmentally appropriate awareness of the nature of his or her condition
- Tell the patient what he or she can expect with tests and treatments
- Make a clinical assessment of the patient’s understanding of the situation and the factors influencing how he or she is responding
- Solicit an expression of the patient’s willingness to accept the proposed care

. The medical consenter considers the wishes of the child in making the decision, although the medical consenter for the child makes the final decision.

Talking with children and youth about their health care and encouraging children to participate in the decision-making process of informed consent helps prepare children for the time when they will begin to make health care decisions on their own. If a youth is authorized to make some but not all of their health care decisions, the medical consenter should continue to prepare the youth to take on the remaining health decisions when they either reaches age 18 or the court authorizes the youth to consent to all health care.

DISCUSSIONS ABOUT THE USE OF MEDICATION

Medical Consenters should discuss issues with the child such as:

- how to talk to the healthcare provider and get the answers to any questions the child has about the medication, condition, or potential side effect

- why it is important to follow the directions on the label;
- why prescription medications should not be shared;
- how to prevent running out of medication; and
- why it is important not to stop medications abruptly but instead consult with the healthcare provider about how to discontinue a medication safely.

INFORMING YOUTH ABOUT CERTAIN RIGHTS

When a youth reaches age 16, a DFPS or Single Source Continuum Contractors (SSCC) primary worker must advise the youth of the right to request a hearing to determine whether they may be authorized by the judge to consent to their own medical care. The primary worker provides the youth with training on informed consent and the provision of medical care, as part of the Preparation for Adult Living (PAL) program.

To help ensure that youth are aware of their right to medical consent, CPS and SSCC staff review and address medical consent at multiple venues where youth plan for their futures, such as Circle of Support meetings, Discharge Planning, and Transition Planning meetings.

Caseworkers provide information on medical consent to youths before they turn 16 years old, and on an ongoing basis.

YOUTH BECOMING THEIR OWN MEDICAL CONSENTER

For youth to be identified as their own medical consenter, a Judge must order it. If a youth expresses the desire to consent to their own medical care, the caseworker:

- informs the youth that they should discuss this matter with their attorney ad litem;
- arranges for the youth to be present at their next court hearing to make the request to the court.

The court will decide whether the youth may consent to their own medical care at a permanency or placement review hearing or in a motion hearing requested by the child's attorney ad litem. The court may issue an order authorizing the youth to consent to some or all medical care. If the court determines the youth lacks the capacity to consent, the medical consenter previously authorized to consent continues to make medical decisions for the youth. In such cases, the court considers the child's capacity to consent at subsequent review hearings.

11141 Educating Children and Youth About Their Medical Care

CHANGING MEDICAL CONSENTER AND BACKUP CONSENTER

Situations may arise that cause DFPS to change a medical consenter or backup medical consenter.

JUSTIFYING A CHANGE IN CONSENTERS

DFPS may need to change a medical consenter when the child changes placements or the primary or backup medical consenter:

- is no longer associated with the child;
- fails to act in the best interests of the child;
- fails to appropriately involve DFPS in medical decisions as outlined in Form 2085-B Designation of Medical Consenter;
- fails to appropriately inform DFPS of the child's medical condition and medical care;
- is no longer employed with DFPS or the residential provider (including a foster parent);
- fails to provide consent in a timely manner without a reasonable explanation;
- fails to participate in the child's healthcare appointments without a reasonable explanation; or
- fails to attend psychotropic medication appointments with the child without a reasonable explanation.

To change a medical consenter, follow policy in 11117 Changing Medical Consenter and Backup Consenter.

DISAGREEMENTS BETWEEN THE MEDICAL CONSENTER AND BACKUP MEDICAL CONSENTER

The medical consenter and backup medical consenter are expected to keep each other informed about the child's ongoing medical condition and treatment.

Resolving Disagreements

If the medical consenter and backup medical consenter disagree about a medical decision made by either of them, they should discuss the issue with each other and obtain additional information from the healthcare provider as needed. If they are unable to resolve their disagreement, they refer the issue up to the caseworker and through supervisory channels.

If the medical consenter and backup medical consenter represent different agencies (such as DFPS/SSCC and a foster parent) supervisory personnel from both agencies work together to resolve the issue.

MEDICAL CONSENT EXCEPTIONS

IMMUNIZATIONS – 3-DAY EXAM

A medical consenter may not consent to immunizations at a child's 3-Day Exam.

The caseworker can help the health care provider contact the parent for consent for vaccines at the 3-Day exam. However, the caseworker cannot consent on behalf of the child or obtain consent from the parent for vaccines on behalf of the health care provider. In the 3 in 30 Resource Guide see *3- Day Medical Exam*.

A health care provider may not administer a vaccination as part of the exam without parental consent, however, the provider can administer a tetanus vaccination if the provider determines an emergency requires it.

Texas Family Code §264.1076

IMMUNIZATIONS

Unless there is a known objection by the parent or person with legal authority over the child at the time of removal, children in DFPS conservatorship should be immunized against disease.

Absent a court order mandating the immunization, the medical consenter cannot consent to immunization of the child at any time if the caseworker has informed them that the parent, or person who had legal authority to make medical decisions for a child before the child entered DFPS conservatorship, objects to the immunization.

If the caseworker has knowledge of the parent's objection, a notation must be made on Form 2085-B, *Designation of Medical Consenter,* that the Medical Consenter may not consent to immunizations.

If the medical consenter feels that a medical emergency requiring immunization exists, they should notify the caseworker. The caseworker should seek guidance from their supervisor and the attorney representing the agency in the case to determine whether to proceed with requesting a court hearing regarding the issue of immunization.

See 11215 Immunization

INPATIENT MENTAL HEALTH TREATMENT

A medical consenter who is not a CPS/SSCC employee may not request the admission of a child in conservatorship to a facility operated or licensed by the Texas Health and Human Services Commission for inpatient mental health (such as state hospitals) or to a private inpatient mental health facility. If someone other than a DFPS/SSCC employee brings a child or youth to this type of facility for voluntary admission, that person is required to find a DFPS/SSCC representative to approve the admission.

Only DFPS/SSCC may request the admission of a child in conservatorship to these kinds of facilities, and only if a physician states in their opinion that: (1) the child has a mental illness or demonstrates symptoms of a serious emotional disorder, AND, (2) the child presents a risk of serious harm to self or other if not immediately restrained or hospitalized.

SUBSTANCE USE DISORDER TREATMENT

A medical consenter who is not a DFPS/SSCC employee may not consent to the admission of a child in conservatorship to an inpatient facility for substance use disorder or chemical dependency treatment.

Only DFPS may request the admission of a child in conservatorship to these kinds of facilities, and only with the youth's consent. For more information, please email Substanceabusespecialist@dfps.texas.gov

See also:

1900 Substance Abuse Services Substance Use Resource Guide

Texas Health and Safety Code, §§462.022(c)

ECI AND SPECIAL EDUCATION SERVICES

Federal law governs the provision of informed consent for Early Childhood Intervention (ECI) or special education services provided by an independent school district. While services such as physical or occupational therapy would be considered medical in most situations, federal law classifies them as early intervention, educational, or related services if an ECI program provides them, or the school district for an eligible child provides them as part of a child's ECI or special education plan. The medical consent policy in 11100 Medical Consent does not apply to diagnostic testing or services provided by an ECI program or a school district, even if those services would be considered medical if provided elsewhere. The person acting as the child's caregiver or "surrogate parent" has the authority to make ECI and special education decisions.

See also 15200 Early Childhood Education Programs for Children

ABORTION

Neither CPS staff nor medical consenters designated by DFPS to consent to medical care for a child in DFPS conservatorship may consent to an abortion.

A youth who chooses to have an abortion must obtain parental consent and seek a judicial bypass (a court order allowing the youth to have an abortion without receiving consent from or telling her parents or legal guardian). The caseworker and medical consenter must not approve or authorize an abortion or sign abortion-related medical consent forms or assist the youth in applying for a judicial bypass.

For questions concerning a youth's request for an abortion, the caseworker may consult with the regional attorney.

See also:
6441 When a Youth in Substitute Care is Pregnant and 11741 If a Youth Is Pregnant 5750 Judicial Bypass to Notifying a Parent About Abortion.
11742 Informing Parents and Caregivers About Pregnancy and Abortion-Related Information.

ORGAN DONATION / ANATOMICAL GIFTS

Consent regarding organ donation depends on if the parents have retained rights.

When the child's parents have retained legal rights, the child's parents must consent. DFPS/SSCC or medical consenters cannot consent on their behalf.

When parental rights have been terminated, or the parents are deceased, medical consenters may ask about organ donation. CPS staff may make the decision to donate an organ of a child when DFPS is managing conservator.

Reasons DFPS May Not Approve Donation

Organ donation remains controversial for many people and it does not benefit the deceased child. For this reason, DFPS may decide not to approve organ donation.

Factors to Consider Before Approval of Donation

When a request for organ donation is received, the child's caseworker, supervisor, program director, and DFPS legal staff consider whether it is appropriate to give consent. Factors that must be considered in each individual circumstance include the:

- possible need for an autopsy of the child;
- concerns of any involved extended family; and
- donor statement on the child's driver's license, if any

See 11730 Organ Donation / Anatomical Gifts

END OF LIFE DECISIONS

Consent regarding withdrawing medical care for end of life decisions depends on if the parents have retained rights.

When the child's parents have retained legal rights, the child's parents must consent. DFPS/SSCC or medical consenters cannot consent on their behalf.

When parental rights have been terminated, or the parents are deceased DFPS may request a court order after providing medical opinions by the child's treating physician. If the court declines to rule on this request, the final decision must be made by DFPS Commissioner.