



## **ACS EMERGENCY GUIDANCE FOR FOSTER CARE PROVIDERS: CASEWORK CONTACTS, FAMILY TIME AND FAMILY TEAM CONFERENCES**

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### **I. INTRODUCTION**

This memorandum provides guidance to ACS Contracted Foster Care Providers on conducting casework contacts, parent-child visits and family team conferencing during the COVID-19 emergency in New York City. This guidance will be updated as necessary during this pandemic. Unless otherwise noted, the guidance applies to both family-based and congregate care settings, including Close to Home programs.

The first priority for foster care providers should be the health and safety of children, families and staff. Communication is critical. Parents are particularly concerned about their children in foster care during this time; as such, it is important to maintain consistent communication by phone/text/email to keep parents informed. Similarly, foster parents will need support from providers and should receive regular updates from agency staff as well as having access to 24-hour phone support from the agency's on-call function. Agencies should continue to have additional staff people assigned to provide on-call and back-up on call support for the time being.

While it is imperative that caseworkers continue to prioritize the well-being of children in care and critical for parents and children to continue to have Family Time, these imperatives must be balanced against the health of children in care, parents, caseworkers, foster parents and all of the people with whom they come into contact. As such, these current extraordinary circumstances and serious risks to public health require alternative approaches.

The guidance below is intended to support thoughtful, case-by-case decision-making to meet the safety, permanency and well-being needs of children and families while mitigating health risks for all involved. When safely possible, casework contacts and Family Time (a.k.a. visits) should occur in person, and the guidance describes appropriate health precautions for staff and families. When health considerations indicate that in-person contacts or visits cannot be done safely, the guidance allows for



the use of video conferencing. Finally, the guideline notes that foster care Family Team Conferences should be held by video conference (preferred) or phone, except when safety concerns such as domestic violence require an in-person meeting.

Note that the federal Administration for Children and Families has updated its Child Welfare Policy Manual (Sec 7.3, Question 8) to include the following language about videoconferencing replacing a face-to-face casework contact with a child in foster care:

“...there are limited circumstances in which a title IV-B agency could waive the in-person aspect of the requirement and permit monthly caseworker visits to be accomplished through videoconferencing. Such circumstances are limited to those that are beyond the control of the caseworker, child, or foster family, such as a declaration of an emergency that prohibits or strongly discourages person-to-person contact for public health reasons; a child or caseworker whose severe health condition warrants limiting person-to-person contact; and other similar public or individual health challenges. Even in the face of such challenges, agencies must continue to comply with the monthly caseworker visit requirement.

“If an agency uses videoconferencing under these limited, specified circumstances, caseworkers must conduct the videoconference in accordance with the timeframe established in the Act, and must closely assess the child’s safety at each conference.”

Due to the need for social distancing, it is especially important that staff and families have access to technology so they can stay informed and maintain communication during the COVID-19 emergency. Foster care agencies should assess technology needs and purchase technology for staff, youth, parents and foster parents when needed to facilitate video and phone communication, including virtual casework contacts and visits.<sup>1</sup> For information regarding payment for COVID-19 related expenses, including cell phones and other technology, please see *Foster Care Provider COVID-19 Q&A*. For information regarding access to free WiFi and cell phone data, please see the ACS “Coping Through COVID-19” [webpage](#).<sup>2</sup>

## II. HEALTH AND SAFETY

It is important that all staff follow the CDC’s guidelines for infection control basics including hand hygiene:

- [Infection Control Basics](#)

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<sup>1</sup> It is important that agencies use platforms that support accessibility for people that have disabilities (i.e., mobility, vision, hearing and cognitive disabilities). The Mayor’s Office for People with Disabilities (MOPD) has published the following guide for accessible virtual meetings:

[https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide\\_05-01-2020.pdf](https://www1.nyc.gov/assets/mopd/downloads/pdf/virtual-meetings-accessibility-guide_05-01-2020.pdf)

<sup>2</sup> <https://www1.nyc.gov/site/acs/about/covidhelp.page#FreeWiFi>



- [Handwashing: Clean Hands Save Lives](#)

ACS requires that all provider staff routinely employ infection prevention strategies to reduce transmission of common respiratory viruses, including COVID-19. Providers must implement daily health screenings of employees reporting to work on site or in the community as per New York State and City guidance. For information on how to screen employees for COVID-19 before they can report to work in person, see “Coronavirus (COVID-19) Worker Symptoms Screening” here:

<https://portal.311.nyc.gov/article/?kanumber=KA-03314>.

In addition, staff should follow these general infection prevention strategies during the COVID-19 outbreak:

- Use a face covering during any interaction with the public. See the DOHMH [FAQ About Face Coverings](#)<sup>3</sup> for more information.
  - Providers must supply staff with extra face coverings to distribute to any family members who need one.
- Keep your hands clean. Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer if soap and water are not available. Use rubbing alcohol if hand sanitizer is not available.
- Avoid touching your eyes, nose, or mouth with unwashed hands.
- During home visits and other in-person contacts:
  - Try to maintain a 6-foot distance from all household members. In particular, avoid close contact with anyone who is sick. If close contact cannot be avoided, make sure to launder clothes at the earliest opportunity and avoid shaking the clothes.
  - Greetings should not include handshakes or physical contact; they should be done at a distance.
  - Cover your mouth and nose with a tissue when coughing or sneezing (in the absence of a tissue, cough or sneeze into your shirt sleeve or bent arm). The use of disposable gloves is not necessary, but staff may choose to wear them if available.
  - Use a hand sanitizer before entering the home, after physical contact with any household members and at the end of the visit. Do not use a hand sanitizer while wearing gloves.
  - Refrain from touching any surfaces unless necessary.

The consistent use of these infection prevention strategies cannot be overemphasized. **Even as more New Yorkers become vaccinated, these strategies must be used at all**

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<sup>3</sup> The DOHMH FAQ is online at <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-face-covering-faq.pdf>. **A double-layered, well-fitting face covering is recommended. Double masking may provide additional protection; see this DOHMH Fact Sheet for how to wear two face coverings: <https://www1.nyc.gov/assets/doh/downloads/pdf/covid/covid-19-two-face-coverings.pdf>.**



program locations because the vaccination status of individuals is unknown and children under the age of 12 cannot yet be vaccinated.<sup>4</sup>

To reduce anxiety, staff should explain to families that these are precautions and that the staff member does not have any symptoms. Staff with symptoms of COVID-19 or any other illness must not conduct in-person contacts of any kind.

Periodic testing can also help prevent the spread of COVID-19. DOHMH and ACS have the following recommendations with regard to testing. **With the exception of asymptomatic individuals who are fully vaccinated:**

1. All individuals who live and/or work in areas with high COVID-19 activity<sup>5</sup> who have not been tested in the last 90 days should get tested immediately.
2. All individuals who are at increased risk for exposure or for exposing others should be tested periodically (every 1 – 3 months). This includes staff in congregate care settings and those staff who regularly conduct home visits. Ideally, this should be done with a PCR or Nucleic Acid Amplification test.

Once an individual tests positive using a diagnostic test (PCR or NAAT) for COVID-19, a test should not be repeated until 90 days after completion of that test. This is because a person who has recovered from COVID-19 may have a positive test result even though they are no longer contagious.

All staff and families should continue to practice infection prevention strategies regardless of any negative test results.

Finally, vaccination is an essential strategy to protect against severe disease from COVID-19. The COVID-19 vaccine, after full vaccination, offers highly effective protection from severe disease and hospitalization after COVID-19 exposure. **Full vaccination** is defined as being two or more weeks after the final dose (e.g., first for Janssen/Johnson & Johnson, second for Pfizer and Moderna) of the vaccine approved by the FDA or authorized by the FDA for emergency use.

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<sup>4</sup> Note: Effective 5/19/21, New York State adopted the CDC guidance (<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/participate-in-activities.html>) on mask use and social distancing; see the NY State guidance here: [https://www.governor.ny.gov/sites/default/files/2021-05/NYS\\_CDCGuidance\\_Summary.pdf](https://www.governor.ny.gov/sites/default/files/2021-05/NYS_CDCGuidance_Summary.pdf). Importantly, the guidance explains, “The Department of Health strongly recommends masks and six feet of social distancing in indoor settings where vaccination status of individuals is unknown.” This includes foster care program facilities because individuals’ vaccination status is unknown and children under 12 are not yet eligible to be vaccinated.

<sup>5</sup> See <https://nycgov.maps.arcgis.com/apps/instant/lookup/index.html?appid=021940a41da04314827e2782d3d1986f> for NY State-designated COVID-19 zones.



All New Yorkers ages 12 and older are currently eligible for the vaccine.<sup>6</sup> Note that youth under age 18 need their parent or guardian's consent to receive the vaccine.<sup>7</sup> Eligible New Yorkers can book vaccine appointments by visiting the City's vaccine finder at <https://vaccinefinder.nyc.gov/>, calling 877-VAX4NYC (877-829-4692), or using the State's vaccine finder: <https://am-i-eligible.covid19vaccine.health.ny.gov>. New York City and State-run vaccination sites also accept walk-ins. Staff are strongly encouraged to be vaccinated if appropriate based on the advice of their doctor. Staff should also assist with vaccine access for all eligible youth and/or family members who wish to be vaccinated. Anyone who receives a vaccination should keep their vaccine card and any related documentation.

Staff should familiarize themselves with ACS' [\*Americans with Disabilities Act \(ADA\) Procedure\*](#) (2011),<sup>8</sup> and any successor policy or procedure, as individuals with disabilities may require reasonable accommodations to help them benefit from the programs, activities and services provided by the foster care agency. For example, individuals who have COVID-19, have a condition that increases risk of severe illness from COVID-19, or have a condition that renders them unable to medically tolerate a face covering, may require a reasonable accommodation to access programs, activities or services.

### **III. CASEWORK CONTACT REQUIREMENTS**

This section provides guidance on casework contacts by foster care agency staff with children, parents and foster parents/caregivers. When safely possible, casework contacts must be done in person using the infection prevention strategies described above. When health considerations indicate that in-person contacts cannot be done safely, they may be held via videoconference.

If neither in-person nor video contacts are possible, case planners should communicate with children and families by phone. However, phone contacts cannot be counted as a substitute for face-to-face casework contacts.

Case planners, in consultation with their supervisors and program directors, must assess each case to determine an appropriate plan for casework contacts. These plans should be reassessed at least monthly and adjusted for any changes in case circumstances, individual health considerations and/or public health considerations.

When determining whether casework contacts will occur in person or via video, case planners must consult with their supervisors and weigh both child welfare and health

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<sup>6</sup> Currently, the Pfizer vaccine is approved for individuals aged 12 years and older, and the Moderna and Johnson & Johnson vaccines are approved for those 18 years old and above.

<sup>7</sup> Consent must be documented on the NY State vaccine consent forms.

<sup>8</sup> The *Americans with Disabilities Act (ADA) Procedure* is available online here: <https://www1.nyc.gov/assets/acs/policies/init/2011/B.pdf>



considerations. Case planners must use infection prevention strategies during all in-person contacts. If staff determine that casework contacts should be done via video instead of in person, this decision and the reason(s) for it must be documented in CONNECTIONS.

### Child Welfare Considerations

Case planning teams must consider the purpose of casework contacts: to assess safety, advance the child's permanency plan, and promote well-being. For each case, staff should consider whether these objectives can be met effectively in person or via videoconference. Casework contacts conducted via either method should cover issues related to safety, permanency and well-being. This includes the status of participation in services for children and parents.

When discussing whether a contact should be conducted in person or by video, case planning teams should consider questions including but not limited to the following:

- 1) What are the **safety** concerns in this case? How will the method of contact (in-person or video) affect the worker's ability to assess child safety?
- 2) What is needed to advance **permanency** for this child? Can these steps be accomplished by video or other technology?
- 3) What are the child and family's **well-being** needs? Can these needs be met effectively via video contacts?

Regarding safety, staff must consider the following:

- Information from the most recent Family Assessment and Services Plan (FASP);
- The case planner's assessment of safety and risk given their most recent contacts with the family and any other information the case planning team deems relevant;
- Any indicators of abuse or domestic violence and associated safety concerns that cannot be accurately assessed via video (e.g., presence of a person causing harm may be difficult to detect via video);
- The existence of a safety plan, and the degree to which the safety plan can be enacted given the family's current circumstances;
- The child(ren)'s age and ability to communicate with the case planner by video chat;
- Transitions such as trial discharges to reunification or APPLA and extended home visits that may increase the need for in-person assessment of safety and risk;
- Any instances where the COVID-19 public health crisis may be causing challenges related to safety, health and/or child care;
- Any time gap of 60 or more days since the last in-person casework contact.

Children and families with high levels of child welfare need based on the factors above must be prioritized for in-person contacts. Staff must also consider any court orders



mandating a specific number of casework contacts and consult the child's Family Court Legal Services attorney as needed. If a case planner is unable to make a necessary in-person contact, another staff member must be identified to make the contact.

### Health Considerations

Providers must also consider the health of children in foster care as well as their parents, foster parents and household members. It is important to exercise particular caution when determining if in-person contacts are appropriate during the COVID-19 emergency in cases that involve individuals with increased health risks, including:

- Children who have medical conditions that increase their risk for COVID-19,<sup>9</sup> especially those that have heart, lung or immune-related conditions.
- Families with household members who are age 65 or older or who have underlying health conditions that increase the risk of severe illness from COVID-19.<sup>10</sup> This includes parents and foster parents as well as their children and any other household members whose age or underlying health conditions put them at greater risk for COVID-19. Please note that the specific list of conditions in this higher-risk category changes as research advances, so it is important to revisit the [CDC](#) and [DOHMH](#) websites regularly for updated information.

The risk factors listed above reflect current guidance from the NYC Department of Health and Mental Hygiene (DOHMH) regarding people who are at increased risk for severe illness from COVID-19. Please visit the DOHMH [website](#) for more information.

Staff should consider who in the household has particular health risks and what strategies can be used to reduce their risk for COVID-19 exposure. Case planning teams should work with their agencies' health services staff and/or contact the ACS Office of Child and Family Health for assistance in creative and responsible planning to reduce exposure. This includes thinking creatively about locations for contacts (e.g., outdoors spaces, reducing travel), ways to maintain social distancing, and barriers to infection transmission (e.g., face coverings, handwashing, changing and laundering clothes). To reduce potential health risks associated with public transit, providers should consider alternative transportation options such as walking, biking or driving when possible.

**Vaccines and Recent Recovery for Children and Youth in Care:** For eligible youth with consent (discussed above), the COVID-19 vaccine provides highly effective

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<sup>9</sup> See the [CDC website](#) for more information: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.

<sup>10</sup> See the DOHMH Advisory (<https://www1.nyc.gov/assets/doh/downloads/pdf/covid/covid-19-advisory-severe-covid.pdf>) and web page on groups at higher risk (<https://www1.nyc.gov/site/doh/covid/covid-19-prevention-and-care.page>) as well as the CDC website (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>) for more information about underlying conditions that increase risk for severe illness from COVID-19.



protection from severe disease and hospitalization after COVID-19 exposure. Staff should consider full vaccination as a factor that mitigates the health risks described above.

**“Recently recovered”** is defined as recovered from laboratory-confirmed COVID-19 by meeting the criteria for discontinuation of isolation within the 3-month period of either the initial onset of symptoms related to the laboratory confirmed COVID-19 infection or, if asymptomatic during the illness, the date of the laboratory confirmed test. Children and youth who have recently recovered according to this definition may be considered to have immunity, and such immunity should also be considered as a factor that mitigates the health risks described above. (Note: Eligible youth who recovered from COVID-19 more than 3 months ago are encouraged to get the vaccine.)

Providers, in their established capacity to provide health care to children/youth in their care, should use the child/youth’s medical record to verify full vaccination or recent recovery from COVID-19 and should factor this information into decisions about contacts and visits.

Individuals who are *not* youth in foster care are not required to disclose their vaccination status or recent recovery. Therefore, this information must not be solicited from parents, foster parents, their family members or other visitors. Infection prevention measures must be maintained at all times.

### Decision-Making Framework

Case planners and supervisors should use the following framework to guide decisions between in-person and video contacts. For purposes of this framework, **“high child welfare need”** means there is a significant need for an in-person contact for reasons related to safety, permanency and/or well-being. **“High health risk”** means that someone in the household has one or more of the risk factors noted under Health Considerations, or the result of the COVID-19 Advance Screening questions in this guidance was **“in-person contact or visit may not be appropriate.”** When a client has a physical or mental impairment,<sup>11</sup> the Case Planner must discuss reasonable accommodations with the client in accordance with ACS’s *Americans with Disabilities Act (ADA) Procedure*.<sup>12</sup>

As illustrated in Figure 1, staff should weigh child welfare needs and health risks.

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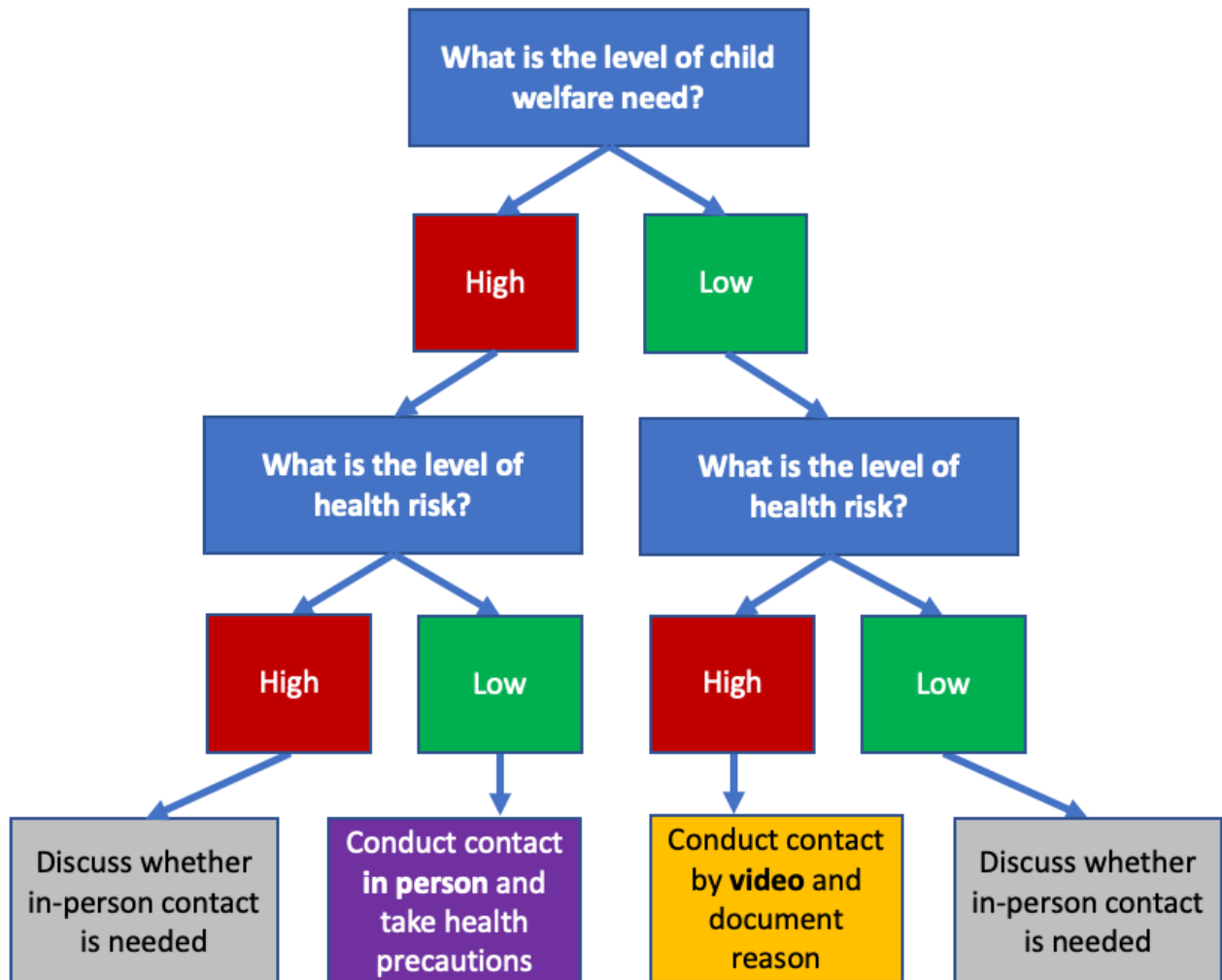
<sup>11</sup> For the purposes of reasonable accommodations during the COVID-19 pandemic, “impairment” includes a COVID-19 diagnosis or a condition that increases risk of severe illness from COVID-19. Supervisors are encouraged to consult with the ACS ADA Coordinator (email: [eeo\\_adacoordinator@acs.nyc.gov](mailto:eeo_adacoordinator@acs.nyc.gov)) when attempting to identify an appropriate reasonable accommodation or to gain clarity regarding clients’ rights.

<sup>12</sup> The *Americans with Disabilities Act (ADA) Procedure* is available online here: <https://www1.nyc.gov/assets/acs/policies/init/2011/B.pdf>



- If child welfare needs are high and health risks are low, casework contacts should occur in person.
- If child welfare needs are low and health risks are high, casework contacts should occur via video.
- If both child welfare needs and health risks are high, or if both are low, case planning teams should discuss with foster care management and agency medical directors which method of contact (in-person or video) can best meet the child and family’s needs while mitigating the risks to all involved. For cases where both are low, please note that some level of public health risk is a constant during the COVID-19 emergency; therefore, video visits may still be appropriate if health risks are relatively “low” in any individual case.

Figure 1. Decision-Making Framework





When appropriate based on the considerations above, in-person casework contacts must be conducted in accordance with ACS' Foster Care Quality Assurance Standards and 18 NYCRR 441.21.<sup>13</sup>

### Confidentiality

Casework contacts involve confidential conversations, which require especially thoughtful planning during COVID-19. For example, conversations occurring outdoors may be seen and/or overheard depending on the location. Phone and video conversations may be more private, although crowded living spaces also limit privacy. Sometimes a brief in-person contact followed by a more detailed phone conversation may be appropriate. Staff should work together with families to plan for meaningful case planning discussions that respect confidentiality.

### Additional Guidance by Contact Type

More detailed guidance for each type of casework contact is below.

#### **A. Casework Contacts with Children**

Casework contacts with children should be conducted in person or via video as appropriate according to the decision framework above. In-person contacts with children at high levels of child welfare risk should be providers' top priority.

If contacts are occurring by video, case planners should increase frequency as needed to assess safety. During the video contact, the case planner must ask to see and speak to every foster child in the household (as age and developmentally appropriate). If the case planner is unable to see/talk to every foster child, they should make a concrete plan with the caregiver to arrange video contact between the case planner and the child as soon as possible. Where case planners would normally use visuals to assess safety and well-being—for example, seeing that there is food in the home and home environment appears safe—they should attempt to do the same via video.

If child welfare risks cannot be addressed by video, case planners should conduct in-person casework contacts. If providers are concerned about a child's safety, are unable to gain access despite diligent efforts, and have reasonable cause to suspect that the child is being abused or maltreated, they should call the New York Statewide Central Register of Child Abuse and Maltreatment.

#### **B. Casework Contacts and Communication with Foster Parents/Caregivers**

Case planners and supervisors should apply the decision-making framework in Figure 1 to determine the most appropriate method for foster parent contacts. In cases where staff are making in-person contacts with children, ACS anticipates that

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<sup>13</sup> 18 NYCRR 441.21(b) outlines casework contact responsibilities with the parent or relatives. 441.21(c) outlines casework contact requirements with the child, and 441.21(d) outlines contact requirements with the child's caretakers.



in-person contacts with those children’s foster parents will likely happen at the same time. However, a decision to conduct in-person contacts with children does not automatically mean that contacts with foster parents must also occur in person.

In addition to the required casework contacts, provider staff should increase their frequency of phone, text and email communication with foster parents to provide as much support as possible during the COVID-19 emergency.

Casework contacts between case planners and childcare staff at congregate care programs may be conducted in person or via video.

### **C. Casework Contacts and Communication with Parents/Discharge Resources**

Case planners and supervisors must also apply the decision-making framework in Figure 1 to determine the most appropriate method for parent contacts. In-person contacts with parents/discharge resources whose children are currently living with them on trial discharge or on extended home visits should be prioritized. For parents whose children are not currently residing with them, a major purpose of casework contacts is to assess whether the child(ren)/youth would be safe if they were to return home.<sup>14</sup> Therefore, staff should consider their ability to assess this in-person versus by video.

While maintaining physical distance, case planners should also communicate frequently to let parents know how their children are doing and being cared for during this stressful time. Case planners should share information to address parents’ questions and concerns as much as possible, and should clearly explain the purpose of any new protocols, e.g., use of text, apps for video conferencing, etc.

Case planners should inquire about parents’ own safety and well-being and refer them to available services as appropriate. If parents are experiencing a disruption in needed services (mental health, substance abuse treatment, etc.), case planners should seek to help them connect with available services, including tele-health services, by contacting their current providers and/or by calling 311. If parents are required to receive in-person services (e.g. random drug screening) as part of a court-ordered service plan, case planners should work with parents to arrange transportation and participation in ways that mitigate the risks of COVID-19 exposure as much as possible. Providers should also contact FCLS as needed to discuss requesting a temporary modification of the court order.

Case planners should continue the standard practice of informing parents about any change in their child’s medical status. In particular, case planners must inform parents if their child or anyone in their child’s foster household has symptoms of COVID-19. (If the household member with symptoms is an individual other than that particular foster child or the foster parent, just say “household member” without

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<sup>14</sup> See Foster Care Quality Assurance Standards, 2011, page 65.



identifying the individual.) If a child has symptoms of COVID-19, the case planner should facilitate communication between the parent and the child’s medical provider, so that the parent is aware of and can contribute to the child’s treatment plan.

#### **D. Advance Screening for In-Person Contacts**

Case planners must contact families for pre-screening prior to attempting any in-person contact. The case planner should ask each potential contact or visit participant the following questions.<sup>15</sup> Parents or caregivers may answer the screening questions on behalf of children in their care. If the contact or visit will occur inside someone’s home, all household members who may be present at the time of the contact or visit should be screened, even if they will not directly participate in the contact or visit.

**Note:** To the extent possible, screening should be done by sharing the introduction and questions with the individual in written format (e.g. email, text, or on paper).<sup>16</sup> Individuals should read the questions and answer for themselves, then provide the **overall results** of the screening—whether they are or are not cleared to proceed. If this is not feasible due to reading level, logistics or otherwise, staff should read the questions and answer choices to the individual. The questions should be made available in the individual’s primary language.

Regardless of screening method, agencies should not retain any health information for contact or visit participants (other than the child in foster care). The only information that should be documented is whether the screening was completed and whether the results indicated that an in-person contact or visit should occur.

#### **Screening Questions**

*You are being asked to answer this questionnaire to determine whether you have or may have COVID-19 or may have been recently exposed. This screening is for the sole purpose of helping to protect people from possible exposure to COVID-19. Your answers to these questions do not constitute a diagnosis of COVID-19 or advice about testing or care. You can consult CDC and health department websites for guidance in that regard.*

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<sup>15</sup> Note: A screening question related to travel is no longer required. However, anyone who is traveling should refer to the NY State Travel Advisory web page for detailed guidance: <https://coronavirus.health.ny.gov/covid-19-travel-advisory>.

<sup>16</sup> Staff should provide the screening questions to families in an accessible format. See the The Mayor’s Office for People with Disabilities (MOPD) *Accessible Documents Guide* for guidance on how to make print and electronic documents accessible to individuals with disabilities: <https://www1.nyc.gov/assets/mopd/downloads/pdf/MOPD-Accessible-Documents-Guide-2020.pdf>.



**Q1. Have you experienced any of the following symptoms of COVID-19 within the past 10 days: (1) a fever of 100.0 degrees F or greater, (2) a cough, (3) loss of taste or smell or (4) shortness of breath?**

**NO.** Go to the next question.

**YES,** and I have not tested positive for COVID-19 within the past 10 days, I have received a negative result from a COVID-19 molecular test, and I have been fever-free for the last 24 hours (without using fever-reducing medications). Go to the next question.

**YES,** and it's been 10 days since my symptoms began, I've been fever-free for the last 24 hours (without using fever-reducing medications), and other symptoms are improving. (The 10 days are measured from the day you were tested, not from the day when you got the test result.) Go to the next question.

**YES,** I have had a fever but I received a COVID-19 vaccine within 3 days prior to when my fever began, my fever lasted less than 24 hours, I have been fever-free for the last 24 hours (without using fever reducing medications), I have not had any of the other symptoms listed above, and I am not a health care worker. Go to the next question.

**YES,** I have had a fever but I received a COVID-19 vaccine within 3 days prior to when my fever began, my fever lasted less than 24 hours, I have been fever-free for the last 24 hours (without using fever reducing medications), and I have received a negative result from a COVID-19 diagnostic test. Go to the next question.

**YES,** and I am not in the categories above. In-person contact or visit may **not** be appropriate.

**Q2. In the past 10 days, have you tested positive for COVID-19, either using a test that used a nose or throat swab or tested saliva (i.e., not a blood test)? 10 days measured from the day you were tested, not from the day when you got the test result.**

**NO.** Go to the next question.



**YES**, and it's been 10 days since my symptoms began, I've been fever-free for the last 24 hours (without using fever-reducing medications), and other symptoms are improving. Go to the next question.

**YES**, and I am not in the above category. In-person contact or visit may **not** be appropriate.

**Q3. To the best of your knowledge, in the past 10 days, have you been in close contact (within 6 feet for at least 10 minutes over a 24-hour period) with anyone while they had COVID-19?**

**NO**. In-person contact or visit may proceed.

**YES**, but I am fully vaccinated (it has been 2 or more weeks following receipt of my second dose in a 2-dose series or 2 or more weeks following receipt of one dose of a single-dose vaccine), and I have remained asymptomatic since my last COVID-19 exposure. In-person contact or visit may proceed.

**YES**, but I have been previously diagnosed with laboratory-confirmed COVID-19, I have since recovered from COVID-19, it is within 3 months of my date of symptom onset from my initial infection (or, if I had no symptoms, from the date of my first positive diagnostic test) and I have remained asymptomatic since my last COVID-19 exposure. In-person contact or visit may proceed.

**YES**, and I am not in the categories above. In-person contact or visit may **not** be appropriate.

***Please share only the results of your screening with your case planner or other agency staff member. The results are either "in-person contact or visit may proceed," or "in-person contact or visit may not be appropriate."***

**If an individual is not cleared to proceed after screening,** the case planner should:

- Direct the individual to remain at home and contact their medical professional, if they have one.
- If the family needs help finding contact information for their medical provider/doctor, try to assist by conducting online searches.
- If the family does not have a primary care doctor or has been unable to reach their doctor, advise the family to call 311.



Note: New Yorkers who test positive for COVID-19 will receive a call from the Test & Trace Corps to make sure that they receive care and can safely separate to prevent the spread. Staff should encourage families to answer any calls from NYC Test+Trace or (212) numbers to get free resources and support.

If potential participants are cleared to proceed after completing the advance screening questions, the case planner should move forward with the in-person contact.

If the case planner and supervisor have determined that an in-person contact is appropriate, but the family cannot be reached by phone after at least three attempts, the case planner should go to the home and ask screening questions through the closed door.

#### Re-Screening If Needed

If, upon arriving at the home (or alternate location for the contact), the case planner finds or believes that one or more family members are exhibiting symptoms, the case planner should follow infection prevention strategies outlined in Section I and re-screen using the questions and guidance above. If the result of the screening is “in-person contact or visit may not be appropriate,” the case planner should calmly and kindly end the visit by setting up a follow-up plan for video conferencing. Similarly, if a household member refuses to wear a face covering<sup>17</sup> or maintain social distance, the case planner should calmly and kindly exit the home and finish the visit by video conference and also confer with their supervisor.

## **IV. FAMILY TIME (PARENT-CHILD AND SIBLING VISITS)**

It is critical to facilitate frequent communication between parents and their children to maintain their relationship, especially during the COVID-19 crisis. Providers are asked to work creatively and compassionately with parents, youth and foster families to support and facilitate Family Time while maintaining the safety and health of families and staff.

### **A. Level of Supervision**

In keeping with ACS Family Time policy, visits should occur with the least restrictive level of supervision that is safely possible and allowed by court order. Providers should re-evaluate cases where the court has given the agency discretion on the

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<sup>17</sup> Note: Children aged two or younger should not wear face coverings. Also, if someone has a health problem that makes them unable to tolerate a face covering, they do not need to wear one. This makes practicing physical distancing and hand hygiene even more essential. See the DOHMH COVID-19 Face Covering FAQs: <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-face-covering-faq.pdf>.



level of supervision to ensure that visits are moved to unsupervised as soon as safely possible.

### **B. Visiting Plans and Court Orders**

Providers should attempt to continue visits according to current visiting plans and in compliance with court orders, in person if consistent with the health and safety of the child, parent, case planner and foster parent. When necessary for health and safety reasons, case planners should arrange for video visits. If visiting orders cannot be upheld due to health and safety concerns, providers should contact the FCLS attorney for advice as to legal options. The FCLS attorney will contact the attorney for the child and parents' attorneys to discuss other visiting options. Similarly, if visiting plans change, providers should contact the FCLS attorney, who will promptly update all parties. Providers should continually revisit the Family Time plan as the public health situation evolves and as the weather changes providing opportunity for in-person visits outside.

### **C. In-Person Visits**

Provider staff must ask families the pre-screening questions above before any in-person visits regardless of the level of supervision. In-person visits should be held if:

- **Everyone attending the visit is cleared to proceed after pre-screening;**
- Attendees and their household members are not at high risk for COVID-19 (see page 5 for list of increased risk factors) or provider staff and attendees have agreed on a clear plan to reduce exposure for any individuals at high risk; and
- The court-ordered level of supervision can be maintained.
  - For supervised visits, providers are encouraged to use approved visit hosts. If a visit needs to be supervised by staff and the case planner is not available for any reason, another staff member must be identified to supervise the visit.

If a caregiver or their household member is at high risk for COVID-19, providers must make all possible efforts to maintain parent-child contact while mitigating health risks due to visits. This includes working with families on alternative visit locations, transportation and other logistics to minimize exposure and following the health precautions discussed above (washing hands and clothing after visits, etc.). Providers should support foster parents in making reasonable and prudent parenting decisions regarding the best interests of the child while mitigating health risks for the household.

Subject to government mandates regarding COVID-19, providers are encouraged to arrange visits in outdoor locations such as parks. Locations should also be chosen to limit travel to the extent possible and to avoid crowded spaces.





If visits are occurring at the provider agency office or in any indoor space, consideration must be given so that families and staff can **practice appropriate social distancing** per **NY State guidance**.<sup>18</sup> For example, agencies should stagger visits and consider room size to avoid any crowded situations in waiting or visiting spaces. Agencies should expand visiting hours if possible and should disinfect visiting spaces between visits. If necessary to maintain social distancing, providers should alternate between in-person and video visits in order to maintain in-person visiting for as many families as possible while also avoiding overcrowding.

Sibling visits should continue to occur in person if possible, following the same risk assessment and health guidelines explained above. If in-person sibling visits cannot occur, the visits should happen via video. Beyond regular sibling visits, providers also should encourage—and ask foster parents to encourage—frequent communication between siblings in care.

Congregate care staff should also refer to the [DOHMH COVID-19: Guidance for Congregate Settings](#)<sup>19</sup> for additional information about visits in congregate programs.

#### **D. Videoconferencing**

In all situations where in-person visits cannot occur, Family Time should occur via video. Case planners must consider the accessibility of the platform used for video conferencing. Reasonable accommodations, including but not limited to ASL interpreters and closed captioning, must be provided to clients who are deaf and hard of hearing. If staff determine that visits should be done by video, this decision and the case-specific reason(s) for it must be documented in CONNECTIONS.

If neither in-person nor video visits are possible, Family Time should occur by phone. However, this should be a temporary measure while staff assist youth and families with the technology needed for videoconferencing. Phone calls cannot be counted as a substitute for face-to-face visits.

Video visits should be at least as frequent as in-person visits would have been according to the current visitation plan, and preferably will be arranged even more frequently. For example, if the existing visitation plan involves visits three times per week, video visits should occur at least three times a week. It can be difficult for children to stay engaged in long videoconferences. Thus, shorter and more frequent video visits may lead to higher quality interactions.

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<sup>18</sup> see the NY State guidance here: [https://www.governor.ny.gov/sites/default/files/2021-05/NYS\\_CDCGuidance\\_Summary.pdf](https://www.governor.ny.gov/sites/default/files/2021-05/NYS_CDCGuidance_Summary.pdf). “The Department of Health strongly recommends masks and six feet of social distancing in indoor settings where vaccination status of individuals is unknown.” This includes foster care program facilities because individuals’ vaccination status is unknown and children under 12 are not yet eligible to be vaccinated.

<sup>19</sup> <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/guidance-for-congregate-settings-covid19.pdf>



For families with supervised visits that are transitioning to video, case planners should work with their supervisors to assess the safety reason for supervised visits and whether it applies to video visits. If so—for example, if there are concerns of emotional abuse or that parents will make plans to abscond with their children—staff should either join the video conference or make arrangements with foster parents or approved visit hosts to join. In some instances, foster parents may be able to maintain safety by observing the children during the video call (i.e. be in the same room and pay attention to how they are reacting) without having to join the call. Providers should consider how communication between parents and children has been happening already—if parents and foster parents already have an arrangement for safe phone communication, this can help inform the video visitation plan. If there is an active order of protection between a parent and the child’s caregiver, an agency staff member should facilitate the virtual visit. If case planning supervisors assess that there is no safety reason to supervise video visits, they should occur unsupervised. This assessment must be documented in CONNECTIONS.

Provider staff should also work closely with foster parents to help facilitate virtual visits. If foster parents have concerns about sharing their contact information, staff can assist with instructions for caller ID block, initiate visits using a video conferencing app, and/or provide a device for the foster family to use for virtual visits.

In some cases with unsupervised visits, parents may not feel comfortable engaging only with the foster parent during a virtual visit and may request the presence of a foster care agency staff member. Case planners should consult with parents to assess this. If requested, a staff member should join by video or phone to help facilitate the virtual visit.

Frequency of video Family Time and phone calls should be increased wherever possible so that children and parents can stay in close communication, especially as they are likely to be very worried about each other during the COVID-19 outbreak. This increased communication is encouraged regardless of whether families are having any Family Time in person.

### **E. Communicating with Kin**

During this time of social distancing, it is especially important for children to maintain connections with family. In addition to having parent-child and sibling visits, children should be encouraged and supported to communicate with extended family, friends, mentors and other significant people in their lives. Such communication could include phone, video conferencing and/or other apps like FaceTime or WhatsApp. This can help build and maintain children’s connections to their extended support networks, which are as vital now as ever.



## V. Documentation of Casework Contacts and Visits

Case planners must document all successful and attempted casework contacts and visits in CONNECTIONS. From the Method of Contact dropdown menu, select “face-to-face” for in-person interactions or “video conference” for interactions using video technology. If a contact or visit is completed via video due to health risks associated with COVID-19, case planners must note this in the narrative. (If a casework contact or visit is conducted by phone, select “phone” as the Method, but note that this cannot be counted as a substitute for an in-person contact or visit.)

When documenting the location of a video casework contact, select the location where the child, parent or foster parent was during the videoconference (e.g., case address, foster home, etc.). When documenting the location of a video visit, select the location where the child was during the videoconference. Case planners should select the same dropdown option for Purpose that they normally would, including selecting “First Visit” when documenting the first parent-child visit after a child enters foster care.

## VI. Family Team Conferences

All foster care Family Team Conferences should be held via videoconference except if safety concerns such as intimate partner violence necessitate a face-to-face meeting.<sup>20</sup> Parent to Parent meetings should also be held by videoconference unless all parties are already coming to the same location (e.g. for a visit) and they mutually agree to meet in person. If videoconferencing is not possible, conferences may be held by phone. For more information, please see [ACS Emergency Guidance for Family Team Conferencing during the COVID-19 Pandemic](#).

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<sup>20</sup> Note: The presence of intimate partner violence does not automatically mean that conferences should be held in person. Rather, case planners should work with their supervisors to determine the best method for a safe and effective Family Team Conference.