TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 749	MINIMUM STANDARDS FOR CHILD PLACING AGENCIES
SUBCHAPTER C	ORGANIZATION AND ADMINISTRATION
DIVISION 1	REQUIRED PLANS AND POLICIES, INCLUDING DURING THE APPLICATION PROCESS

§749.103. What policies and procedures must I submit for Licensing's approval as part of the application process?

(a) You must develop the policies and procedures identified in subsection (b) of this section. Your policies and procedures must comply with or exceed the minimum standards specified in this chapter, Chapter 42 of the Human Resources Code, Chapter 745 of this title (relating to Licensing), and any other applicable law.

(b) As part of the application process, you must submit the following policies and procedures to us for our approval:

(1) Policies and procedures related to record keeping, including where the records will be located. The policies must be consistent with Subchapter D of this chapter (relating to Reports and Records Keeping);

(2) Personnel policies and procedures consistent with §749.105 of this title (relating to What are the requirements for my personnel policies and procedures?);

(3) Conflict of interest policies consistent with §749.107 of this title (relating to What must my conflict of interest policies include?);

(4) Admission policies consistent with §749.109 of this title (relating to What must my admission policies include?);

(5) Placement policies consistent with §749.111 of this title (relating to What must my placement policies include?);

(6) Child-care policies consistent with §749.113 of this title (relating to What child-care policies must I develop?);

(7) Emergency behavior intervention policies consistent with §749.115 of this title (relating to What emergency behavior intervention policies must I develop if my foster homes are permitted to use emergency behavior intervention?);

(8) Discipline policies consistent with §749.117 of this title (relating to What are the requirements for my discipline policies for children in care?);

(9) Foster care policies consistent with §749.119 of this title (relating to What foster care policies must I develop?);

(10) Rights and responsibilities of the child-placing agency and the foster parents consistent with §749.121 of this title (relating to What policies must I develop concerning the rights and responsibilities of the child-placing agency and foster parents?);

(11) Additional policies for foster parents that provide treatment services consistent with §749.123 of this title (relating to What policies must I develop regarding foster parents who provide treatment services to a child with primary medical needs?);

(12) Additional policies for foster parents who offer a transitional living program consistent with §749.125 of this title (relating to What policies must I develop for foster parents who offer a transitional living program?);

(13) Policies for babysitters, overnight care providers, and respite care providers consistent with §749.127 of this title (relating to What policies must I develop for babysitters, overnight care providers, and respite care providers?);

(14) Policies for a legal risk placement program consistent with §749.129 of this title (relating to What policies must I develop for a legal risk placement program for foster-adoptive families?);

(15) Adoption policies, if applicable, consistent with §749.131 of this title (relating to What policies must I develop if I offer adoption services?);

(16) Volunteer policies consistent with §749.133 of this title (relating to What policies must I develop if I use volunteers?);

(17) Abuse and neglect policies consistent with §749.135 of this title (relating to What abuse and neglect policies must I develop?);

(18) An appeal process for adult clients consistent with Division 8 of this subchapter (relating to Clients and Appeals);

(19) A weapons, firearms, explosive materials, and projectiles policy, for foster care services, consistent with Division 3 of Subchapter O (relating to Weapons, Firearms, Explosive Materials, and Projectiles);

(20) A tobacco and e-cigarette policy consistent with §749.2931 of this title (relating to What policies must I enforce regarding tobacco products and e-cigarettes?); and

(21) A suicide prevention, intervention, and postvention policy consistent with §749.136 of this division (relating to What suicide prevention, intervention, and postvention policy must I have?).

§749.136. What suicide prevention, intervention, and postvention policy must I have?

(a) A child-placing agency that is licensed or certified to provide only foster care services or to provide both foster care services and adoption services must adopt either:

(1) The model suicide prevention, intervention, and postvention policy in §749.137 of this division (relating to What is the model suicide prevention, intervention, and postvention policy?); or

(2) Another suicide prevention, intervention, and postvention policy that is approved by the Executive Commissioner of the Texas Health and Human Services Commission or designee and:

(A) Addresses suicide prevention, intervention, and prevention for children in the care of your agency;

(B) Is based on current and best evidence-based practices;

(C) Requires employees to receive annual suicide prevention training that includes understanding of safety planning and screening for risk;

(D) Requires foster parents in homes verified to care for children five years of age or older to complete at least one hour of suicide prevention training:

(i) Within a year of being verified; and

(ii) every two years thereafter;

(E) Promotes suicide prevention training for non-employees, as appropriate; and

(F) Includes plans and procedures to support children who return to your agency's care following hospitalization for a mental health condition.

(b) The suicide prevention, intervention, and postvention policy adopted under subsection (a) of this section may be part of a broader mental health crisis plan if the components of the plan include suicide prevention, intervention, and postvention.

§749.137. What is the model suicide prevention, intervention, and postvention policy?

(a) Purpose. The purpose of the model suicide prevention, intervention, and postvention policy is to:

(1) Protect the health and well-being of children in an agency's care by implementing procedures to prevent suicide, including screening and assessment procedures for risk of suicide;

(2) Require intervention when a child attempts or dies by suicide; and

(3) Address the needs of children in an agency's care, employees, caregivers, and adoptive parents after a child attempts or dies by suicide.

(b) Definitions.

(1) Postvention--Activities that promote healing and reduce the risk of suicide by a person affected by the suicide of another.

(2) Protective factors of suicide--Characteristics that make it less likely that a child will consider, attempt, or die by suicide, including:

(A) Effective behavioral health care;

(B) Connectedness to individuals, family, community, and social institutions;

(C) Supportive relationships with caregivers;

(D) Problem-solving skills, coping skills, and ability to adapt to change;

(E) Self-esteem or sense of purpose; and

(F) Cultural or personal beliefs that discourage suicide.

(3) Risk factors of suicide--Characteristics or conditions that increase the chance that a child may consider, attempt, or die by suicide, including:

(A) A prior suicide attempt;

(B) Knowing someone who died by suicide, particularly a family member, friend, peer, or hero;

(C) Access to lethal means;

(D) History of childhood trauma, including neglect, physical abuse, or sexual abuse or assault;

(E) A history of being bullied;

(F) A mental health diagnosis, particularly depressive disorders and other mood disorders;

(G) Abuse of alcohol or drugs;

(H) Social isolation;

(I) Severe or prolonged stress;

(J) Chronic physical pain or illness;

(K) Loss of a family member; or

(L) The ending of a relationship.

(4) Suicide contagion--Exposure to suicide or suicidal behaviors within a family, or from friends or media reports, that can result in an increase in suicide or suicidal behaviors.

(5) Suicide risk assessment--A comprehensive evaluation of a child by a medical health professional to confirm suspected suicide risk, estimate the immediate danger to the child, and decide on a course of treatment and a plan for intervention to ensure the child's safety.

(6) Suicide risk screening--A procedure in which a standardized instrument is used to identify children who may be at risk of suicide. The screening may be done orally (with the screener asking questions), with pencil and paper, or using a computer.

(7) Warning signs of suicide--Indicators that a child may be in danger of suicide and need help, including:

(A) Talking about wanting to die or to hurt or kill oneself;

(B) Looking for a way to kill oneself;

(C) Being preoccupied with death in conversation, writing, or drawing;

(D) Talking about feeling hopeless or having no reason to live;

(E) A change in personality;

(F) Giving away belongings;

(G) Withdrawing from friends and family;

(H) Having aggressive or hostile behavior;

(I) Neglecting personal appearance;

(J) Running away from home or a residential placement; or

(K) Risk-taking behavior, such as reckless driving or being sexually promiscuous.

(c) Prevention--Training.

(1) Employees and foster parents must complete at least one hour of suicide prevention training as follows:

(A) Employees must complete the training annually;

(B) Foster parents verified to care for children five years of age or older must complete the training:

(i) Within a year of verification; and

(ii) every two years thereafter; and

(C) The suicide prevention training must meet the instructor and documentation requirements of Subchapter F, Division 7 of this chapter (relating to Annual Training).

(2) The curriculum for the suicide prevention training in paragraph (1) of this subsection must include:

(A) The risk factors, protective factors, and warning signs of suicide;

(B) Understanding safety planning, including:

(i) How safety plans are created;

(ii) How safety plans are shared with employees and caregivers;

(iii) How safety plans are expected to be implemented by employees and caregivers; and

(iv) Each employee's or caregiver's role in the prevention of suicide, including never leaving a child alone if the suicide risk screening finds that the child is a high risk for suicide, until a mental health professional conducts a suicide risk assessment; and

(C) Understanding suicide screening, including clarifying:

(i) Each person's role in the screening process;

(ii) When an employee or caregiver should initiate a suicide risk screening for a child; and

(iii) What actions an employee or caregiver must take to initiate a suicide risk screening for a child.

(3) The agency must promote suicide prevention training for non-employees, as appropriate.

(d) Prevention--Suicide Risk Screening.

(1) The policy must describe the suicide risk screening tool that you will use and the process for implementing the screenings.

(2) The suicide risk screening tool must be supported by evidence-based research demonstrating the tool performs reliably regardless of who administers the tool or performs the scoring or rating.

(3) Any person who meets the conditions and training requirements of the screening tool manual or instructions may administer the suicide risk screening to a child. You must document that any person conducting a screening meets the conditions and training requirements.

(4) For children receiving foster care services, the screening tool must be administered:

(A) At admission for each child 10 years of age or older;

(B) At admission for each child younger than 10 years of age if:

(i) The information provided to the operation at the time of admission indicates that the child has a history of suicide attempts or suicidal thoughts; or

(ii) The parent who admits the child, a foster parent, or child-placing agency requests a screening to be administered because of the child's risk factors or warning signs of suicide;

(C) Every 90 days after admission for all children 10 years of age or older; and

(D) Immediately for a child of any age whenever the child exhibits warning signs of suicide that necessitate a suicide screening be conducted, including when requested by a foster parent.

(5) For children receiving adoption services, the screening tool must be administered immediately for a child of any age whenever the child exhibits warning signs of suicide that necessitate a suicide screening be conducted, including when requested by an adoptive parent.

(6) Any screening must be performed in a manner that protects the child's privacy.

(7) Each screening must be documented in the child's record.

(e) Intervention--Based on the Results of a Suicide Risk Screening.

(1) If the suicide risk screening finds the child to be a high risk for suicide, the agency, caregiver, or adoptive parent must:

(A) Immediately refer the child to a mental health professional for a suicide risk assessment;

(B) Not leave the child alone until a mental health professional assesses the child;

(C) Remove any harmful objects, chemicals, or substances that a child could use to carry out a suicide attempt;

(D) Alert each person responsible for the child's care or supervision of the high risk for suicide and any new or updated safety plan; and

(E) Upon conclusion of the risk assessment, follow through on recommendations by the mental health professional and update the child's safety plan and service plan accordingly.

(2) If the suicide risk screening finds the child to have a potential for risk of suicide, the agency, caregiver, or adoptive parent must:

(A) Refer the child to a mental health professional for a suicide risk assessment within 24 hours;

(B) Closely monitor the child to ensure the child's safety until a mental health professional assesses the child;

(C) Remove any harmful objects, chemicals, or substances that a child could use to carry out a suicide attempt;

(D) Alert each person responsible for the child's care or supervision of the potential risk of suicide and any new or updated safety plan; and

(E) Upon conclusion of the risk assessment, follow through on recommendations by the mental health professional and update the child's safety plan and service plan accordingly.

(f) Intervention--Returning Post Hospitalization. To ensure a child's readiness to return to care under the same child-placing agency following a mental health crisis (for example, from a suicide attempt or psychiatric hospitalization):

(1) Child placement management staff must meet with the child within 24 hours of the child's arrival to a home to discuss protocols that would help to ease the child's transition into the home post hospitalization, ensure the child's safety, and reduce any risk of suicide.

(2) The protocols must include:

(A) Weekly suicide risk screenings for the first 30 days or until the child is no longer reporting suicidal thoughts, whichever is longer;

(B) Creating or reviewing and updating the child's safety plan; and

(C) Removal of any harmful objects, chemicals, or substances that a child could use to carry out a suicide attempt or self-harm for a period to be determined by the treatment team, but not less than 30 days.

(3) The agency must alert any persons responsible for the child's care or supervision of the new protocols and new or updated safety plan.

(g) Postvention.

(1) Addressing Suicide Deaths.

(A) Create a Postvention Team and Written Action Plan and Protocols. To prevent suicide contagion and support employees, children, caregivers, and adoptive parents, you must create a postvention team. This team is responsible for developing a written action plan with protocols in the event of a death by suicide. The postvention team should consider:

(i) How a death would affect employees, caregivers, adoptive parents, and other children receiving services in the home where the death occurred; and

(ii) How to provide psychological first-aid, crisis intervention, and other support to the employees, caregivers, adoptive parents, and other children receiving services in the home where the death occurred.

(B) While the action plan needs to be flexible for varying situations, the written action plan must include:

(i) A communication strategy that:

(I) Does not inadvertently glamorize or romanticize the child or the death;

(II) Occurs in settings that allow the postvention team to monitor responses of individuals in the home;

(III) Strives to treat all deaths in the same way (for example, having one approach for honoring a child who dies from cancer, a car accident, or suicide);

(IV) Emphasizes the importance of seeking help for anyone with an underlying mental health diagnosis, such as a mood disorder;

(V) Emphasizes the importance of employees, caregivers, adoptive parents, and children recognizing the signs of suicide; and

(VI) Decreases the stigma associated with seeking help for mental health concerns;

(ii) Mental health resources for employees, caregivers, adoptive parents, and children who have a difficult time coping, including:

(I) Opportunities to debrief to process thoughts and feelings related to the suicide death; and

(II) Referrals to grief counseling and suicide survivor support groups to the extent possible; and

(iii) A review of lessons learned from the child's death by suicide. All communications regarding lessons learned should be approached in a way that ensures a blame-free environment.

(2) Addressing Suicide Attempts. In the event of a suicide attempt according to §749.505 of this chapter (relating to What constitutes a suicide attempt by a child?):

(A) The caregiver must, as needed, immediately call emergency services and render first aid until professional medical treatment can be provided;

(B) The caregiver must not leave the child alone until a mental health professional assesses the child;

(C) The caregiver must move all other children out of the immediate area as soon as possible;

(D) The agency must report and document the suicide attempt as a serious incident as required by:

(i) §749.503(a)(12) of this chapter (relating to When must I report and document a serious incident?);

(ii) §749.511 of this chapter (relating to How must I document a serious incident?); and

(iii) §749.513(1) of this chapter (relating to What additional documentation must I include with a written serious incident report?);

(E) The agency must offer mental health resources for employees, caregivers, and children who have a difficult time coping, including:

(i) Opportunities to debrief to process thoughts and feelings related to the suicide attempt; and

(ii) Referrals to community services and other resources when a child has attempted suicide; and

(F) The agency must conduct a review of lessons learned from the child's suicide attempt. All communications regarding lessons learned should be approached in a way that ensures a blame-free environment.

Helpful Information

• *Regarding subsection (c)(1)(C) for annual suicide prevention training:*
  o *More than likely training on suicide prevention will have to be tailored for each operation because some of the training is based on an operation's own safety planning and the specific screening tool an operation uses to screen for risk. However, related to training on risk factors, protective factors, and warning signs of suicide, one resource that might be helpful is the AS+K? Basic Gatekeeper Training.*
  o *An inspector should cite:*
  ▪ *§749.939(a)(1) – (4) if the training doesn't meet the instructor-led requirements; and*
  ▪ *§749.949 if the training documentation requirements are not met.*
• *Regarding subsection (c)(1) suicide prevention training for employees and foster parents and subsection (d)(3) training on the suicide risk screening tool, both types of training may be used to complete the annual training requirements at §749.930 and §749.931.*
• *Regarding subsection (c)(3):*
  o *Examples of non-employees that may be appropriate for suicide prevention training are non-employees that have routine contact with a child or perform a supervisory role for the child.*

Helpful Information
o *You do not have to promote suicide prevention training for foster parents* verified to care for children five years of age or older *because those foster parents are already required to receive routine suicide prevention training.* o *Examples of promoting suicide prevention training include sharing your suicide prevention policies and other relevant resources with the appropriate non-employees or encouraging appropriate non-employees to participate in other specific suicide prevention training.* • *Regarding subsection (d)(2), you may use any evidenced-based screening tool that is appropriate for your program. Two screening tools that are free, evidence-based, and have ample research supporting their validity and reliability, include the:* o *Columbia-Suicide Severity Rating Scale (CSSRS); and* o *Ask Suicide Screening Questions (ASQ).*

§749.138. What are the general requirements for an agency's policies and procedures?

(a) The requirements for policies only apply to your policies that are required or governed by this chapter.

(b) All employees and caregivers must be aware of and follow your policies and procedures.

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SUBCHAPTER H FOSTER CARE SERVICES: ADMISSION AND PLACEMENT
DIVISION 1 ADMISSIONS

§749.1107. What information must I document in the child's record at the time of admission?

(a) You must include the following in the child's record at the time of admission:

(1) The child's name, gender, race, religion, and date of birth;

(2) The name, address, and telephone number of the managing conservator, the primary caregivers for the child, any person with whom the child is allowed to leave the foster home, and any other individual who has the legal authority to consent to the child's medical care;

(3) The names, addresses, and telephone numbers of biological or adoptive parents, unless parental rights have been terminated;

(4) The names, addresses, and telephone numbers of siblings;

(5) The date of admission;

(6) Medication the child is taking;

(7) The child's immunization record;

(8) Allergies, such as food, medication, sting, and skin allergies;

(9) Chronic health conditions, such as asthma or diabetes;

(10) Known contraindications to the use of restraint;

(11) Identification of the child's treatment needs, if applicable, and any additional treatment services or programmatic services the child is receiving;

(12) Identification of the child's high-risk behaviors, if applicable, and the safety plan employees and caregivers will implement related to the behaviors;

(13) If a suicide risk screening is required at admission and the child is screened as having a high or potential risk of suicide:

(A) The identification of any risk factors or warning signs of suicide, if applicable and not already identified in paragraph (12) of this section; and

(B) The safety plan employees and caregivers will implement related to the risk factors and warning signs;

(14) The results of the suicide screening at admission, if required;

(15) A copy of the placement agreement, if applicable; and

(16) Documentation of the attempt to notify the parent of the child's location as required by §749.1113(c)(3) of this title (relating to What information must I share with the parent at the time of placement?), if applicable.

(b) For emergency admissions, you must meet the requirements in Division 4 of this subchapter (relating to Emergency Admission).

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SUBCHAPTER H FOSTER CARE SERVICES: ADMISSION AND PLACEMENT
DIVISION 2 ADMISSION ASSESSMENT

§749.1135. What are the additional admission assessment requirements when I admit a child for treatment services?

When you admit a child for treatment services, you must do the following, as applicable:

Figure: 26 TAC §749.1135

If:	Then:
(1) You intend to provide treatment services for a child with an emotional disorder or autism spectrum disorder	(A) The admission assessment must include a written, dated, and signed: (i) Psychiatric evaluation or psychological evaluation including the child's diagnosis; or (ii) Psychosocial assessment as defined in §749.43 of this title (relating to What do certain words and terms mean in this chapter?). (B) The psychiatric evaluation, psychological evaluation, or psychosocial assessment must have been completed within: (i) 14 months of the date of admission, if the child is coming from another regulated residential child care operation; or (ii) Six months of the date of admission, if the child is not coming from another regulated residential child care operation. (C) The admission assessment must include the reasons for choosing treatment services for the child.

If:	Then:
	(D) The admission assessment must include consideration given to any history of inpatient or outpatient treatment.
(2) You intend to provide treatment services for a child with an intellectual disability	(A) The admission assessment must include a written, dated, and signed: (i) Psychological evaluation with psychometric testing, including the child's diagnosis; or (ii) Psychosocial assessment as defined in §749.43 of this title. (B) The psychological evaluation or psychosocial assessment must be completed within 14 months of the date of admission. (C) The psychological evaluation must: (i) Be performed by a licensed psychologist who has experience with intellectual disabilities or published scales; (ii) Include the use of standardized tests to determine the intellectual functioning of a child. The test results must be documented in the evaluation; (iii) Determine and document the child's level of adaptive functioning; and (iv) Indicate manifestations of an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5). (D) The admission assessment must include the reasons for choosing treatment services for the child. (E) The admission assessment must include consideration given to any history of inpatient or outpatient treatment.
(3) You intend to provide treatment services for a child with primary medical needs	(A) The admission assessment must have a licensed physician's signed, written orders as the basis for the child's admission. An evaluation from a health-care professional must confirm that the child can be cared for

If:	Then:
	appropriately in a foster home setting and that the foster parents have been trained to meet the needs of the child and demonstrated competency. (B) The written orders or hospital discharge must include orders for: (i) Medications; (ii) Treatments; (iii) Diet; (iv) Range-of-motion program at stated intervals; (v) Habilitation, as appropriate; and (vi) Any special medical or developmental procedures. (C) The admission assessment must include the reasons for choosing treatment services for the child. (D) The admission assessment must include consideration given to any history of inpatient or outpatient treatment.
(4) You intend to provide services to a child that is determined to be an immediate danger to others based on the child's behavior and history within the last two months, or a child is screened as a high or potential risk of suicide based on the results of a suicide risk screening at admission	(A) The admission assessment must include a written, dated, and signed: (i) Psychiatric evaluation or psychological evaluation, including the child's diagnosis; or (ii) Psychosocial assessment as defined in §749.43 of this title. (B) The psychiatric evaluation or psychological evaluation must include: (i) The child's diagnosis, if applicable;

If:	Then:
	(ii) An assessment of the child's needs and potential danger to self or others; and (iii) Recommendations for care, treatment, and further evaluation. If the child is admitted, the recommendations must become part of the child's service plan and must be implemented. (C) The psychiatric evaluation, psychological evaluation, or psychosocial assessment must have been completed within: (i) 14 months of the date of admission, if the child is coming from another regulated residential child care operation; or (ii) Six months of the date of admission, if the child is not coming from another regulated residential child care operation.

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SUBCHAPTER H FOSTER CARE SERVICES: ADMISSION AND PLACEMENT
DIVISION 4 EMERGENCY ADMISSION

§749.1189. At the time of an emergency admission, what information must I document in the child's record?

At the time of the emergency admission you must document in the child's record:

(1) A brief description of the circumstances necessitating the emergency admission;

(2) The date of admission;

(3) Allergies, such as food, medication, sting, and skin allergies;

(4) Chronic health conditions, such as asthma or diabetes;

(5) Known contraindications to the use of restraint;

(6) Identification of the child's high-risk behaviors, if applicable, and the safety plan employees and caregivers will implement related to the behaviors;

(7) If a suicide risk screening is required at admission and the child is screened as having a high or potential risk of suicide:

(A) The identification of any risk factors or warning signs of suicide, if applicable and not already identified in paragraph (6) of this section; and

(B) The safety plan employees and caregivers will implement related to the risk factors and warning signs;

(8) The results of the suicide screening at admission, if required; and

(9) For the purpose of providing treatment services:

(A) A brief description of the child's history;

(B) The child's current behavior; and

(C) Your evaluation of how the placement will meet the child's needs and best interests.

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SUBCHAPTER I FOSTER CARE SERVICES: SERVICE PLANNING, DISCHARGE SERVICE PLANS
DIVISION 1 SERVICE PLANS

§749.1309. What must a child's initial service plan include?

(a) You must base the child's initial service plan on the child's needs identified in the child's admission assessment and integrate trauma informed care in the care, treatment, and management of each child. The service planning team may prioritize the child's service planning goals and objectives based on the child's admission assessment. However, any required service plan components not initially addressed must have a justification for the delay in addressing the needs.

(b) The child's initial service plan must be documented in the child's record and include those items that a preliminary plan must include (see §749.1301 of this title (relating to What are the requirements for a preliminary service plan?)), and the items noted below for each specific type of service that you provide the child:

Figure: 26 TAC §749.1309(b)

Type of Service	Items that must be included:
(1) Child care services	(A)The child's needs identified in the admission assessment, in addition to basic needs related to day-to-day care and development, including: (i) Medical needs, including scheduled medical exams and plans for recommended follow-up treatment; (ii) Dental needs, including scheduled dental exams and plans for recommended follow-up treatment; (iii) Intellectual functioning, including any testing and plans for recommended follow-up; (iv) Developmental functioning, including any developmental delays and plans to improve or remediate developmental functioning; (v) Educational needs and how those needs will be met, including planning for high school completion and post-secondary education and training, if appropriate, and any school evaluations or recommendations;

Type of Service	Items that must be included:
	(vi) Plans for normalcy, including: (I) Social, extracurricular, recreation, and leisure activities; and (II) Integrating the child into the community and community activities, as appropriate; (vii) Therapeutic needs, including plans for psychiatric evaluation, psychological evaluation, psychosocial assessment or follow-up treatment, testing, and the use of psychotropic medications; and (viii) Cultural identity needs, including assisting children in connecting with their culture in the community; (B) Plans for maintaining and improving the child's relationship with family members, including recommendations for visitation and contacts between the child and the child's parents, the child and the child's siblings, and the child and the child's extended family; (C) Recent information from the current caregiver's evaluation of the child's behavior and level of functioning; (D) Specific goals and strategies to meet the child's needs, including instructions to caregivers responsible for the care of the child. Instructions must include specific information about: (i) The child's personal trauma history; (ii) Level of supervision required; (iii) The child's trauma triggers; (iv) Methods of responding that improve a child's ability to trust, to feel safe, and to adapt to changes in the child's environment; (v) Discipline techniques; (vi) Behavior intervention techniques; (vii) Plans for trips and visits away from the foster home; and (viii) Any actions the caregivers must take or conditions the caregivers must be aware of to meet the child's special needs, such as

Type of Service	Items that must be included:
	medications, medical care, dietary needs, therapeutic care, how to communicate with the child, and reward systems; (E) If the child is 13 years old or older, a plan for educating the child in the following areas: (i) Healthy interpersonal relationships; (ii) Healthy boundaries; (iii) Pro-social communication skills; (iv) Sexually transmitted diseases; and (v) Human reproduction; (F) If the child is 14 years old or older, plans for the caregivers to assist the child in obtaining experiential life-skills training to improve the child's transition to independent living. Plans must: (i) Be tailored to a child's skills and abilities; and (ii) Include training in practical activities that include, but are not limited to, grocery shopping, meal preparation, cooking, using public transportation, performing basic household tasks, and money management, including balancing a checkbook; (G) For children 16 years old and older, preparation for independent living, including employment opportunities, if appropriate; (H) For children who exhibit high-risk behaviors or have a suicide risk screening that indicates a high or potential risk of suicide: (i) Plans to minimize the risk of harm to the child or others, such as special instructions for caregivers, sleeping arrangements, or bathroom arrangements; and (ii) A specific safety contract developed between the child, employees, and caregivers that addresses how the child's safety needs will be maintained; (I) Expected outcomes of placement for the child and estimated length of stay in care;

Type of Service	Items that must be included:
	(J) Plans for discharge; (K) The names and roles of persons who participated in the development of the child's service plan; (L) The date the service plan was developed and completed; (M) The effective date of the service plan; and (N) The signatures of the service planning team members that were involved in the development of the service plan.
(2) Treatment services	For children receiving treatment services, the plan must address all of the child's waking hours and include: (A) The child-care services planning requirements noted in paragraph (1) of this subsection; (B) A description of the emotional, behavioral, and physical conditions that require treatment services; (C) A description of the emotional, behavioral, and physical conditions the child must achieve and maintain to function in a less restrictive setting, including any special treatment program or other services and activities that are planned to help the child achieve and to function in a less restrictive setting; and (D) A list of emotional, physical, and social needs that require specific professional expertise, and plans to obtain the appropriate professional consultation and treatment for those needs. Any specialized testing, recommendations, or treatment must be documented in the child's record.
(3) Treatment services for children with an intellectual disability	(A) The child-care and treatment services planning requirements noted in paragraphs (1) and (2) of this subsection; (B) A minimum of one hour per day of visual, auditory, and tactile stimulation to enhance the child's physical, neurological, and emotional development; (C) An educational or training plan encouraging normalization appropriate to the child's functioning; and (D) Career planning for older adolescents who are not receiving treatment services for a severe or profound intellectual disability.

Type of Service	Items that must be included:
(4) Transitional living program	(A) Child-care service planning requirements noted in paragraph (1) of this subsection; (B) Plans for encouraging the child to participate in community life and to form interpersonal relationships or friendships outside the transitional living program, such as extra-curricular recreational activities; (C) Plans for education related to meal planning, meal preparation, grocery shopping, public transportation, searching for an apartment, and obtaining utility services; (D) Career planning, including assisting the child in enrolling in an educational or vocational job training program; (E) Money management and assisting the child in establishing a personal bank account; (F) Assisting the child with how to access resources, such as medical and dental care, counseling, mental health care, an attorney, the police, and other emergency assistance; (G) Assisting the child in obtaining the child's social security number, birth certificate, and a driver's license or a Department of Public Safety identification card, as needed; and (H) Problem-solving, such as assessing personal strengths and needs, stress management, reviewing options, assessing consequences for actions taken and possible short-term and long-term results, and establishing goals and planning for the future.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 749 MINIMUM STANDARDS FOR CHILD-PLACING AGENCIES
SUBCHAPTER Q ADOPTION SERVICES: CHILDREN SERVICE
DIVISION 5 REQUIRED INFORMATION

§749.3391. What information must I compile for a child I am considering for adoptive placement?

(a) As part of the Health, Social, Educational, and Genetic History report, you must compile the following information for a child you are considering for adoption placement:

Figure: 26 TAC §749.3391(a)

Type of Information:	Including:
(1) Abuse or neglect history:	Physical, sexual, or emotional abuse history.
(2) Health history:	(A) Current health status; (B) Birth history, neonatal history, and other medical, dental, psychological, or psychiatric history, including: (i) Available results and diagnoses of any medical or dental examinations; (ii) Available results and diagnoses of any psychological, psychiatric, or social evaluations or suicide risk assessments; and (iii) To the extent known by the Department of Family and Protective Services based on information collected under Human Resources Code §264.019: (I) Whether the child's birth mother consumed alcohol during pregnancy; and (II) Whether the child has been diagnosed with fetal alcohol spectrum disorder; and (C) Immunization record.
(3) Social history:	Information about past and existing relations among the child and the child's siblings, birth parents, extended family members, and other persons who have had physical possession of or legal access to the child.
	(A) Enrollment and performance in educational institutions;

Type of Information:	Including:
(4) Educational History:	(B) Results of educational testing and standardized tests; and (C) Special educational needs, if any.
(5) Family History	Information about the child's birth parents, maternal and paternal grandparents, other children born to either of the child's birth parents, and extended family members, including their: (A) Health and medical history, including any information obtained in the medical history report and information on genetic diseases or disorders; (B)Current health status; (C) If deceased, cause of and age of death; (D) Height, weight, eye, and hair color; (E) Nationality and ethnic backgrounds; (F) General levels of educational and professional achievements; (G) Religious backgrounds; (H) Results of any psychological, psychiatric, or social evaluations, including the date of any such evaluation, any diagnosis, and a summary of any findings; (I) Any criminal conviction record relating to the following: (i) A misdemeanor or felony classified as an offense against the person or family; (ii) A misdemeanor or felony classified as public indecency; or (iii) A felony violation of a statute intended to control the possession or distribution of a substance included in the Texas Controlled Substances Act; and (J) Any information necessary to determine whether the child is entitled to, or otherwise eligible for, state or federal financial, medical, or other assistance.

(b) In addition, you must document the following in the child's record:

Figure: 26 TAC §749.3391(b)

Type of Information:	Including:
(1) History of previous placements:	Information about the child's previous placements, including the dates and reasons for each placement.
(2) Child's legal status:	Information about the child's legal status.
(3) Child's understanding of adoptive placement:	Information about the child's understanding of adoptive placement.

(c) This section does not apply to an adoption by the child's:

(1) Grandparent;

(2) Aunt or uncle by birth, marriage, or prior adoption; or

(3) Stepparent.

§749.3395. What information must I provide the adoptive parents prior to or at the time of adoptive placement?

(a) The agency must discuss information about the child and his birth parents with the prospective adoptive parents.

(b) According to the Texas Family Code §162.0062, you must inform the prospective adoptive parents of their right to examine the records and other information relating to the history of the child, including the Health, Social, Educational, and Genetic History (HSEGH) report and the child's health history within the HSEGH, if you are required to do a HSEGH for the adoption.

(c) Any records or other information examined by the prospective adoptive parents or any written information provided to the prospective adoptive parents must be edited to protect any confidential information.

(d) You must also provide the prospective adoptive parents with:

(1) Research, which may be suggested reading materials and/or websites, on how any known health issue that the child has and/or any trauma the child has experienced (i.e. abuse or neglect) may impact child development and the family's ability to maintain permanency;

(2) Information about the Department of Family and Protective Services (DFPS) adoption assistance programs, if the family may be eligible for such assistance;

(3) Information about community services and other resources available to support a parent who adopts a child, including community services and other resources for a child who has suicidal thoughts or attempts suicide; and

(4) The options available to the adoptive parent if the parent is unable to care for the adopted child, including working with the parent's post adopt provider about the possibility of post adoption substitute care services or working with the child placing agency that placed the child for adoption regarding any additional services. You should also inform the adoptive parents that the Texas Family Code, §162.026 makes it illegal to informally transfer the custody of an adopted child to a person, unless the person is a relative or stepparent of the child or an adult who has a significant long-standing relationship with the child, or the transfer of custody is a formal transfer of custody of the child through a court.

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PART 1 HEALTH AND HUMAN SERVICES COMMISSION
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SUBCHAPTER Q ADOPTION SERVICES: CHILDREN SERVICE
DIVISION 6 POST-PLACEMENT SUPERVSION

§749.3423. What responsibility do I have to offer counseling services to the adoptive family?

(a) To reduce the risk of adoptive placement breakdown, you must offer counseling services to the adoptive family.

(b) Counseling services may be provided by your agency or by an outside counseling resource.

(c) The counseling services must provide mental health resources for the child, if applicable, the adoptive parents, and other children in the care of your agency that are placed in the adoptive home, including:

(1) Opportunities to debrief to process thoughts and feelings related to a suicide attempt or suicide death;

(2) Referrals to community services and other resources for a child who has suicidal thoughts or attempted suicide; and

(3) Referrals to grief counseling and suicide survivor support groups.

(d) You must ensure that the adoptive family is aware that counseling is available.