DATE: September 24, 2010

TO: Regional Directors

THROUGH: Pete Digre, Assistant Secretary for Operations
          David L. Fairbanks, Assistant Secretary for Programs

FROM: Alan Abramowitz, State Director, Office of Family Safety

SUBJECT: New Provisions of Law: Health Care Oversight and Coordination Plan
          (The Patient Protection and Affordable Care Act, P.L. 111-148)

ACTIONS REQUIRED: Share with Partners and Child Protection Staff and
          Implement

DUE DATE: Effective October 1, 2010

PURPOSE: The purpose of this memorandum is to provide information about the new
policy under the Patient Protection and Affordable Care Act, P.L. 111-148 ("the Act"),
regarding the requirement to educate and inform youth in out-of-home care about the
importance of having a health care power of attorney, health care proxy or other similar
document. The effective date for the new requirements is October 1, 2010.

BACKGROUND: The Patient Protection and Affordable Care Act signed into law in March
2010, strengthens the health care services requirements under the Fostering Connections
Act. Section 2955(a) of the Act requires that the transition plan for each youth aging out of
foster care include information about the importance of designating someone to make
health care treatment decisions on behalf of the youth, should the youth be unable to do so
and should the youth not have a relative who would be so designated under state or tribal
law, or should the youth not want to have the relative make such decisions. The transition
plan must be developed during the 90-day period prior to the time the youth ages out of
care. As case plans and transition plans are developed or updated, case managers must
ensure that youth in out-of-home care receiving independent living services and youth who
age out of care are given information about the importance of designating another person
to make health care treatment decisions on their behalf should the youth or young adult
become unable to make these decisions and the young person does not want a relative to
make these decisions. It is also incumbent upon case managers to inform youth in care
and youth who age out of care about options for health insurance.

Attached is a sample medical power of attorney document for local use in developing your
area's medical power of attorney. It is our recommendation that each judicial review and
social summary report (JRSSR) for youth in out-of-home care include a status on the
delivery of this information. When providing this document to the youth, you should not
engage in the unlicensed practice of law. You should not prepare this form for the youth, nor should you answer questions specific to the preparation or operation of the medical power of attorney.

In addition to the health and education information that is required as part of each child's resource record (65C-30.011, F.A.C.), case managers must provide youth with information specific to their physical and mental health care needs as discussed above. The forthcoming administrative rule amendments will reflect these new requirements.

**ACTION REQUIRED:** Each Community-Based Care lead agency and case management organization must ensure local policy and practice abides by these federal requirements. Please share this information with all case management agencies and case management staff for implementation by October 1, 2010.

**CONTACT INFORMATION:** For additional information please contact Marci Kirkland at (850) 487-2464 or by email at Marci_Kirkland@dcf.state.fl.us.

cc: DCF Contract Managers for CBCs
    Jane Soltis, Consultant

Attachment
Health Care Surrogate Designation

I, ________________________________ [name of principal], hereby designate as my Health Care Surrogate(s):

______________________________ [name of surrogate]

In the event my said surrogate is not living or is unable to so serve, I then designate as my Health Care Surrogate(s):

______________________________ [name of alternate surrogate]

My Health Care Surrogate(s) designated herein shall serve subject to the following:

1. When effective. My Health Care Surrogate(s) named herein shall have the authority and power to act on my behalf during such time as I shall not have the capacity to make health care decisions for myself, as determined by my attending or treating physician and another consulting physician.

2. Revocation of Prior Designations. Any designation of a Health Care Surrogate made prior to the date of this designation is hereby revoked.

3. Powers. My Health Care Surrogate(s) shall have the final authority to make health care decisions on my behalf, and such powers shall include but not be limited to the following, in addition to the powers and authorities set forth in chapter 765, Florida Statutes:

(a) Consult with my health care providers to provide informed consent for me.

(b) Give any consent in writing with respect to my health care, or refuse consent or withdraw consent to my health care.

(c) Have access to any and all of my medical records and have authority to authorize release of such information to appropriate persons.

(d) Authorize the transfer and admissions of me to or from a health care facility.

(e) Apply for public benefits, such as Medicare and Medicaid but not limited to them, and in this regard and for this purpose, to have access to information regarding my income and assets.

4. Duration. This Health Care Surrogate Designation shall terminate upon the sooner to occur of the following:

(a) The execution by me of a written revocation of this Health Care Surrogate Designation; or

(b) The execution by me of another designation of health care surrogate after the date I execute this Health Care Surrogate Designation.
5. Reliance. My Health Care Surrogate and all health care facilities and health care providers shall be entitled to rely upon this Health Care Surrogate Designation until such person or facility receives actual knowledge or actual notice of the revocation of this Health Care Surrogate Designation by a subsequent writing.

6. Indemnity. My estate shall hold harmless and indemnify my Health Care Surrogate(s) from all liability for acts done in good faith on my behalf pursuant to this Health Care Surrogate Designation.

7. Withholding or Withdrawing Life Prolonging Procedures. I have executed a Living Will requesting life prolonging procedures to be withheld or withdrawn pursuant to chapter 765, Florida Statutes. My Health Care Surrogate(s) designated herein are hereby authorized to consent to the withholding or withdrawing of life prolonging procedures for me pursuant to chapter 765, Florida Statutes. [INCLUDE THIS PARAGRAPH ONLY AS APPROPRIATE]

I understand the full import of this Designation, and I am emotionally and mentally competent to make this Designation, and I further affirm that this Designation is not being made as a condition of treatment or admission to a health care facility.

This Designation is intended to comply in all respects with chapter 765, Florida Statutes.

This Designation is made this _____ day of _________________ [month, year].

__________________________
[name of principal], Declarant

The Declarant is known to me, I am neither the spouse nor a blood relative of the Declarant, and I believe the Declarant to be of sound mind and not under the influence of any duress, fraud, or undue influence. The Declarant signed the foregoing Health Care Surrogate(s) Designation in our presence. [NOTE: AT LEAST ONE OF THE WITNESSES MUST BE SOMEONE OTHER THAN THE DECLARANT'S SPOUSE OR A BLOOD RELATIVE]

Witness

Witness

Printed name of Witness

Printed name of Witness

STATE OF FLORIDA, COUNTY OF _________________ [name of County of execution]

I HEREBY CERTIFY that on this day, before me, an officer duly authorized in the State aforesaid and in the County aforesaid to take acknowledgments, the foregoing instrument was acknowledged before me by ________________________________ [name of principal], who is personally known to me or who has produced __________________________ as identification and who DID take an Oath.

WITNESS my hand and official seal in the County and State last aforesaid this _____ day of ______________________ [month, year].
Notary Public, State of Florida

(NOTARIAL SEAL)  My Commission Expires:
My Commission Number is: