DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Legislative and Regulatory Initiatives

Date: April 4, 2014

I am providing my analysis of ten (10) legislative and regulatory initiatives in anticipation of the April 10, 2014 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DPH Prop. Cancer Treatment Program Regulation [17 DE Reg. 955 (4/1/14)]

The Division of Public Health (DPH) proposes to revise its"technical, financial, and residency eligibility requirements for the Delaware Cancer Treatment program." At 955. The SCPD commented on prior versions of the regulations in May and December of 2004 and in September of 2007. I have the following observations.

First, DPH adds a new definition of "uninsured" as follows:

1.2. Definition of "uninsured" for purposes of this regulation - a person who meets all technical, financial, and residency requirements of this regulation.

This definition is counterintuitive and makes no sense. Literally, someone who is insured but not a Delaware resident would be considered "uninsured". Similarly, someone who is insured but "overincome" would be considered "uninsured". If the Division wishes to retain the reference, consider substituting "a person who meets §§4.1.4 - 4.1.6 of this regulation".

DPH should consider creation of a "definitions" section rather than inserting a definition in the "purposes" section. See Delaware Administrative Code Style Manual, §3.1. Indeed, the Manual recites as follows: "Define a term only if it is important and it is used more than once in the regulation." The term "uninsured is only used once (§1.1) in the regulation so there is technically no need for a definition of "uninsured". The better approach would be to establish a "definitions" section, substitute "Be uninsured" for "Have no health insurance" in §4.1.4, and then include all definitions in the definitions section, including "uninsured" and "inmate" and "public institution" (currently defined in §4.3.1).

Second, the regulation limits authorization for treatment to a "physician". See §§4.1.1, 4.2.1, and 11.2. DPH may wish to consider adding references to "advanced practice nurse". See 24 Del.C. §1902(b)(1). Alternatively, DPH could adopt a generic term (e.g. "licensed health care professional" and add a definition of the term to cover physicians and advanced practice nurses.

Third, in §3.1, the Division may wish to consider deletion of the extraneous "acting" in the second sentence.

Fourth, in §3.1, the third sentence lists protected classes. It omits some classes. See Title 6 Del.C. §§4501, 4502(14), and 4503.

Fifth, in §4.1.5.1, DPH should consider correcting the grammar. There should be parallel form in lists. In this section, some items begin with nouns and some items begin with verbs. See Delaware Administrative Code Drafting & Style Manual, §6.2.3.

Sixth, the regulation is inconsistent in the context of retroactivity. On the one hand, §4.2.4 authorizes 3 months of retroactive coverage for children with no analogous authorization for adults in §4.1. It's unclear why 3-months retroactive coverage would be authorized for children but not adults. Moreover, 12 month retroactivity for children and adults is authorized by §12.7. The Division may wish to clarify its intention and adopt a uniform standard.

Seventh, the references to "inmate of a public institution ... as used in the Delaware Medicaid program" do not provide much guidance. It would be preferable to provide a citation to 16 DE Admin Code 14120 for clarity and ease of reference.

Eighth, the Division is switching from a net income to a gross income standard for most forms of earned income. See §§5.3.5 and 5.3.6. This creates an anomaly since rental income (§5.3.11 and 5.3.12) is reduced by expenses to amount to net income. Obviously, it would be more consumer-oriented to continue to count net earned income.

Ninth, the Division proposes to change the residency standard as follows:

> 6.1. A Delaware resident is an individual who lives in Delaware with the intention to remain permanently ~~or for an indefinite period~~ or where the individual is living and has entered into a job commitment, or seeking employment whether or not currently employed.

The deletion of "or for an indefinite period" is highly objectionable. Residency does not require an intention to remain in the State permanently. See 16 DE Admin Code 14110.5 - 14110.8. See also 17 DE Reg. 386 (10/1/13). The term "or for an indefinite period" should be retained. DPH may wish to consult its assigned Attorney General for guidance.

Tenth, the Division proposes the following deletion:

Eligibility: ...

~~6.3.2. Will not be denied because of a durational residence requirement.~~

The implication of the change is to reinforce the proposed requirement in §6.1 that residency must be "permanent" to be eligible for the program. This is objectionable. Residency can be established without meeting a "permanency" standard. Section 6.3.2 should be retained.

Eleventh, the Division proposes the following revision:

7.4 Failure to provide requested documentation ~~may~~ will result in denial or termination of eligibility.

It would be preferable for the Division to retain discretion in how it addresses lack of documentation rather than adopting a "brittle" standard. For example, an individual may lack competency or attempt unsuccessfully to obtain documentation from other sources.

Twelfth, the grammar in §9.3 could be improved. The reference to "regardless as to if the individual" is somewhat awkward. Consider substituting "regardless of whether the individual".

Thirteenth, §11.2 recites as follows:

11.2 If eligibility is terminated, it may only be renewed for an individual who is diagnosed with a new primary cancer.

Literally, if someone became ineligible for one month due to excess earnings, or if someone's eligibility were terminated due to lack of documentation which is then located, this section would categorically preclude reinstatement or continued therapy in following months. This would be a harsh result. The section should be reconsidered. For example, for someone with variable income, could benefits be subject to "suspension" in a high-income month rather than outright termination of eligibility. Alternatively, if someone's eligibility is terminated (per §7.4) for lack of documentation, and the requested documentation is then acquired and submitted, reconsideration of eligibility should be allowed.

Fourteenth, the Division could consider deletion of §112.8 since no one would ostensibly be affected by this section in 2014 or later.

Fifteenth, in §10.1, the Division is modifying a reference to read "his/her". The Delaware Administrative Code Drafting & Style Manual (§3.3.2.1) discourages use of "him/her" and similar references. It would also be preferable to revise the multiple references to "his/her" in §5.6.2 and the reference to "his or her" in §3.2.

Sixteenth, appeal rights under §16.0 are meager and do not include even rudimentary due process. Compare Goss v. Lopez, 397 U.S. 254 (1970). Cf. Title 29 Del.C. §10121-10129. DHSS could consider applying 16 DE Admin Code 5000 to the program.

I recommend sharing the above observations with the Division and sharing a courtesy copy with the AARP.

2. DMMA Prop. Medicaid Coverage of Prescribed Drugs Reg. [17 DE Reg. 951 (4/1/14)]

The Division of Medicaid & Medical Assistance proposes to amend the Delaware Medicaid State Plan. Effective January 1, 2014 the Affordable Care Act disallows restricting access to barbiturates, benzodiazepines, and agents used to promote smoking cessation. DMMA is therefore proposing a technical amendment to conform to the ACA. The anomaly is that the current restrictions were just added last year. See 16 DE Reg. 1028 (4/1/13) (proposed); 16 DE Reg. 1270 (6/1/13) (final)]. Consistent with the attached March 30, 2014 article, Medicaid beneficiaries are more likely to smoke than the general population and the CDC recommends Medicaid coverage of all proven cessation treatments.

I recommend endorsement.

3. DPH Prop. Hospice Disposal of Medications Regulation [17 DE Reg. 961 (4/1/14)]

As background, the attached S.B. No. 119 was enacted in the summer of 2013. It requires the Department of Health & Social Services to establish standards for disposal of unused prescription medications following the death of an in-home hospice patient. The Division of Public Health is now issuing this proposed regulation to implement the new law.

I have the following observations.

First, the proposed standards are comprehensive but only establish guidelines for hospice providers. Hospice agencies must adopt policies which conform to an outline rather than adhering to specific standards. For example, each hospice agency could adopt a different timetable f\or medication disposal (§A.2) and a different approach if there is evidence of missing unused prescription medication (§A.7). Reasonable persons could differ on whether this approach conforms to the statutory requirement of a "standardized protocol".

Second, there are some anomalies in punctuation. For example, there is no period at the end of §A.3.

Third, in §C.2.a, the word "was" should be substituted for "were" since the subject (documentation) is singular.

Fourth, §§B.1.b, B.2, C.2.b, and D1. have "odd" introductory symbols prior to subsections amounting to a bullet with a dash underneath. It's unclear what this symbol represents. If it is intended to be construed as "and/or", that term "should never be used". See Delaware Administrative Code Drafting & Style Manual, §6.6. Moreover, the Delaware Administrative Code Drafting & Style Manual (§2.3.1; §2.4.2) only permits numeric subparts and disallows bullets. If numeric subparts were used, appropriate punctuation (currently absent from the subparts) could also be added. See Manual, Figure 2.2.

I recommend sharing the above observations with the Division.

4. DMMA/DDDS Prop. HCBS Medicaid Waiver Renewal Reg. [17 DE Reg. 950 (4/1/14)]

On February 28, 2014, the Division of Developmental Disabilities Services (DDDS) forwarded a notice to the SCPD and other agencies that its draft waiver renewal was available for review on its website. The renewal document noted that DDDS intended to submit the renewal application to CMS during the week of March 10. Given the short timetable, I provided a March 10 analysis to the Councils which resulted in SCPD, DDC, and GACEC submission of conforming comments to DHSS on an expedited basis. The Department has now published the waiver renewal as a proposed regulation with a 30-day comment period. Since the content of the waiver renewal had not changed, I recommend reiterating the earlier comments supplemented by the following.

In Par. 4, the Councils objected to changing the minimum age of eligibility from 4 to 12 for a variety of reasons. As a supplement, I recommend reminding DHSS that it was prompted to terminate the license and contract of a major DDDS provider on an expedited basis when an investigation team issued a report documenting numerous violations of standards. See Growth Horizons v. Nazario, No. 1:94-cv-00132-RRM (D. Del. August 9 1994) (Stipulation). Expedited termination of a DHSS or ICT-funded pediatric provider could recur, resulting in the need to provide alternative residential services quickly. If children under 12 are ineligible for the waiver, DHSS would have no available waiver-funded placement options, including shared living, group homes, and emergency temporary living arrangements (ETLAs). Eliminating waiver eligibility of children between age 4 and 12 would also undermine implementation of the attached DDDS-DSCY&F MOU. For example, Section II.B.2 contemplates the availability of DDDS foster home/shared living placements for eligible children requiring residential services due to abuse, neglect or dependency. Licensed foster home/shared living arrangements are covered by the DDDS waiver.

In Par. 11, the Councils suggested that DHSS consider adding levels of care apart from ICF/IID. The Councils observed that the DDDS census listed 37 DDDS clients in nursing homes. As a supplement, the Councils could note that DHSS, while funding pediatric nursing home care, has historically confirmed its commitment to "make every effort to support a child's needs in a community setting if they can be met". See DHSS commentary at 11 DE Reg. 312 (9/1/07):

> The placing of children in any nursing facility needs to be an option for Medicaid eligible children in Delaware. Some children have needs that must be addressed in an inpatient nursing care facility. Medicaid will make every effort to support the client's needs in a community setting if hey can be met. Delaware is fortunate to be able to offer inpatient nursing care facility services to its citizens within Delaware. Previously, Delaware children who required these services had to be placed out-of-state.

It would facilitate diversion from pediatric nursing facility placement, and transition from nursing facility placements, if pediatric waiver-funded residential options were available. DHSS could therefore consider listing both ICF/IID and nursing level of care in the waiver.

I recommend resubmission of the earlier commentary plus the above supplemental remarks. Courtesy copies should be shared with MaryAnn Mieczkowski and Susan Cycyk.

5. H.B. No. 245 (Restroom Access)

This bill was introduced on March 13, 2014. As of April 4, it remained tabled in the House Health & Human Development Committee. H.A. No. 1 was placed with the bill by the prime sponsor on March 26.

As background, variations of this bill have been introduced on multiple occasions in the House: H.B. No. 329 in 2006 and H.B. No. 3 in 2007. The SCPD endorsed the concept of H.B. No. 3 in February 13, 2007 correspondence. In 2007 the legislation was stricken on the same day the House passed H.R. No. 18 which encouraged, but did not require, retail establishments to allow persons with covered conditions to use an employee restroom. Copies of the above legislation are attached for facilitated reference.

H.B. No. 245, with H.A. No. 1, would have the following effects. Customers of a retail establishments which have an employee restroom, not usually accessible to the public, would be permitted to use the restroom if the following conditions are met: 1) the customer has written documentation of a qualifying medical condition or uses an ostomy device; 2) two or more employees are working at the time of request; 3) the retail establishment does not normally make the restroom available to the public; and 4) access would not create an obvious health or safety risk. Retailers would not be liable for acts or omissions which do not constitute negligence. Retailers would not be required to make physical alterations to restrooms. Enforcement would be delegated to the Division of Public Health (DPH). A first violation would result in a warning. Any subsequent violation could result in a $100 civil penalty paid to DPH.

I recommend endorsement. The rationale for the legislation is compiled in the attached articles, "The Restroom Access Act: A Major Victory for Crohn's Patients" and "Paradee to Introduce Restroom Access Bill for Crohn's Sufferers". As the articles note, at least thirteen (13) states have passed similar legislation, including Connecticut, Illinois, Kentucky, Massachusetts, Texas, Washington, Minnesota, Colorado, Ohio, Michigan, Oregon, and Wisconsin. The Delaware legislation, which adopts a warning and civil penalty approach, is more benign to retailers than other states which impose criminal fines. Balancing the modest impact on retailers against the pain/embarrassment/suffering experienced by covered individuals, the legislation merits enactment.

6. H.B. No. 249 (CPR Training in Schools)

This legislation was introduced on March 13, 2014. As of April 4, it remained in the House Education Committee.

As background, similar legislation (H.B. No. 299) was introduced in 2012. It was tabled in the House Health & Human Development Committee. The Department of Education shared reservations about the legislation with the Committee.

As background, H.B. No. 249 would require participation of students in a CPR educational program as a condition of qualifying for a diploma. The requirement would apply to both public and private school students and be effective with the class of 2017. The CPR educational program would include both psychomotor learning and skills necessary to use an automated external defibrillator. An IEP team or Section 504 team could authorize modifications of instruction, or if such modification would be ineffective, an exemption from the law. The attached fiscal note suggests that 65 American Heart Association kits would be necessary to instruct a projected 9,755 public school students.

I recommend endorsement subject to consideration of some amendments.

First, the fiscal note is based on 9,755 9th graders in public schools. The DOE website lists 11,217 ninth graders in public schools for the 2012 -13 school year. See http://www.doe.k12.de.us/reports_data/enrollment/detailed_enroll.shtml . This may affect the size of the fiscal note somewhat.

Second, lines 27-29, which represent a variation on language suggested by the Councils, merits revision for two reasons: a) students with a §504 plan are not identified under Chapter 31; and b) apart from content, some accommodations in instructional "methodology" may be appropriate (e.g. an AHA or ARC instructional program may not be available in Braille or at lower reading levels). The following amendment would be appropriate: "The individualized education plan (IEP) or §504 plan of a student with a disability ~~identified under Chapter 31 of this title~~ may modify the method or content of instruction for CPR required by this section or, if such modification would be ineffective, exempt such student from application of this section."

Third, the predecessor legislation (H.B. No. 299) ostensibly authorized students to qualify for a diploma even if the instruction were "non-certified" (line 20). In contrast, H.B. No. 249 (lines 19-26) could be interpreted in multiple ways: 1) all students must take a certified course using certain instructional programs; or 2) only students who wish to obtain a certification are required to use certain instructional programs. The sponsors may wish to clarify this aspect of the legislation.

7. H.B. No. 263 (School District Nurse Funding)

This legislation was introduced on March 18, 2014. As of April 3 it remained in the House Appropriations Committee. The attached fiscal note reflects a State cost of $1,169, 647 in FY15.

As background, the attached Title 14 Del.C. §1310 currently authorizes school nurse funding for districts based on 1 nurse per 40 state units of pupils. Districts are also required to have "at least 1 school nurse per facility". If the "1-40" funding formula is insufficient to provide for 1 nurse per facility, the districts are directed to use either Division III equalization funds (§1707), academic excellence funds (§1716), or discretionary local operating expense funds to make up the shortfall.

The implication of the synopsis to H.B. No. 263 is that some public schools lack a nurse despite the statutory requirement. The bill authorizes districts to apply for supplemental State funds subject to annual appropriations. The bill also authorizes a district which receives the supplemental State funds to increase its local tax to pay for the local share of employment costs without referendum. See line 11 and Title 14 Del.C. §1902(b).

I recommend endorsement. The availability of school nurses has several salutary effects. First, it promotes inclusion of students with disabilities who may require some nursing services to be successful in integrated settings. Second, it facilitates screening of students for health problems. Third, it facilitates quick response in the event of a student injury or emergency (e.g. seizure).

8. H.B. No. 251 (Guardianship of Child)

This legislation was introduced on March 13, 2014. It was released from the House Judiciary Committee on April 2. Consistent with the Committee report, the legislation conforms to recommendations of the Office of the Child Advocate and Child Protection Accountability Commission.

H.B. No. 251 would effect many discrete revisions to the Family Court's processing of matters related to child guardianship. On September 27, 2013, the SCPD submitted comments to the authors of a draft version of the legislation. In general, the revisions are logical and are helpful in clarifying standards and procedures. However, there is ostensibly one (1) error in the bill, i.e., in line 85 the term "terminated" should be "rescinded". Moreover, the sponsors may wish to consider modifying the standard of proof in multiple sections based on the following rationale:

H.B. No. 251 adopts a "preponderance of the evidence" standard in some contexts (lines 41, 57, and 81) and a "clear and convincing evidence" standard in other contexts (lines 84 and 100). The "clear and convincing evidence" standard requires more proof to justify the involuntary transfer of guardianship authority from a parent to a petitioner.

At a minimum, it would be preferable to adopt a "clear and convincing evidence" standard in lines 41 and 81. As a result, "clear and convincing evidence" would be required to justify both an initial removal of guardianship authority from a parent and to justify rejection of a parental petition seeking return/rescission of guardianship.

This approach is supported by the following.

First, adoption of a clear and convincing evidence standard is manifestly more aligned with the philosophy espoused in the Delaware Supreme Court's Tourison decision cited in the synopsis. In Tourison, the Court unequivocally adopted a clear and convincing evidence benchmark which "respects a parent's fundamental right to care for his or her children by making it extremely difficult for a third party to overcome a fit parent's petition to rescind a guardianship." At 7. In drafting a conforming statutory framework, any benefit of the doubt should be accorded to making it "extremely difficult" to overcome the parent's application for rescission. The Court's manifest emphasis on deference to fundamental parental rights likewise supports adoption of a clear and convincing standard for initial petitions.

Second, it is an unfortunate reality that parents with disabilities are disproportionately divested of their children in various forms of child welfare proceedings. See University of Minnesota, Policy Research Brief: The Inclusion of Disability as Grounds for Termination of Parental Rights in State Codes (2006) , available at http://ici2.umn.edu/products/prb/172/default.html. See also National Council on Disability, Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children (2012), endnote 256, available at National Council on Disability: Publications & Policy Briefs: 2012 Publications: Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children. Both publications note that the rationale for the disproportionate removal of children is often based on stereotypes and misconceptions about diagnosed disabilities. Adoption of a clear and convincing evidence standard, while not a stand-alone solution to this problem, would focus attention on evidentiary proof as juxtaposed to stereotypes and inferences.

Third, in 1981, the Family Court was given "concurrent authority to appoint guardians of the person over minors under 18 years of age with the Court of Chancery." See synopsis to attached engrossed S.B. No. 247 (Attachment "A"). The relevant authorization [Title 10 Del.C. §925(16)] was placed in the "general jurisdiction" statute [§925] rather than the "exclusive jurisdiction" statute [§921]. Later enactment of Title 13 Del.C. §2303(a) is consistent with the conferral of general, but not exclusive, Family Court jurisdiction over actions related to guardianship of minors. Chancery Court continues to have jurisdiction over guardianship of minors. See Title 12 Del.C. §3901(a)(1) and §3902. In 2012, Vice Chancellor Noble issued a well reasoned decision holding that a "clear and convincing evidence standard" must be used in cases involving petitions for termination/rescission of guardianship. For facilitated reference, a copy of the redacted opinion is included as Attachment "B". The Court relied, in part, on precedents involving parental rights:

> Most states recognize the consequences that result from the appointment of a guardian and have responded by imposing, through statute, a clear and convincing evidentiary standard. ... The United States Supreme Court has taught that, for a wide range of government actions limiting personal choice, the proper standard is clear and convincing. These personal interests include parental rights, civil commitment, deportation, and denaturalization. ... Thus, the OPG must demonstrate by clear and convincing evidence that Ms. B continues to need a guardian of the person.

At 5-6. The bottom line is that it would be jurisprudentially anomalous to recommend legislation creating a different standard of proof in Family Court cases involving rescission of guardianship than already adopted by the Court of Chancery. Moreover, the Chancery Court's reasoning also extends to initial petitions for guardianship. Citing an ABA compilation, the Court observed that "(m)ost states recognize the consequences that result from the appointment of a guardian and have responded by imposing, through statute, a clear and convincing evidentiary standard." At 4. In fact, the most recent ABA compilation reveals that almost every state which has adopted a benchmark by statute has adopted a clear and convincing evidence standard applicable to petitions for guardianship. See Attachment "C" available at http://www.americanbar.org/content/dam/aba/administrative/law_aging/2013_04_CHARTConduct.pdf-15k-2013-05-01.

I recommend sharing the above observations with policymakers.

9. H.B. No.256 (Sexual Solicitation of Child)

This legislation was introduced on March 13, 2014. It was released from the House Judiciary Committee on March 26.

The legislation is designed to facilitate prosecution of individuals who solicit a child to engage in a prohibited sexual act. A "prohibited sexual act" is defined at Title 11 Del.C. §1100(7) as including a host of activities ranging from intercourse to nudity and sexual contact. "Sexual contact" is defined at Title 11 Del.C. §1161(f) and includes touching personal body parts either uncovered or covered by clothing. There is an attached, modest fiscal note which predicts that only three (3) persons would be imprisoned annually based on the legislation.

Some of the pros and cons of the legislation are presented in the attached March 17, 2014 News Journal article. The Attorney General's Office touts the advantages of mandatory sentencing and disallowance of a "fantasy" defense. Defense Counsel counters that mandatory sentencing demeans the role of Delaware's judiciary and that overzealous undercover officers can press individuals who otherwise have no intention of arranging an encounter.

I recommend taking no position on the legislation while sharing two (2) observations.

First, consistent with the attached March 31, 2014 News Journal article, mandatory minimum sentencing is becoming increasingly unpopular among the states.

Second, Delaware criminal law has historically acknowledged that older teens can consent to some sexual acts. See, e.g., Title 11 Del.C. §§767 and 761. For example, §761 provides as follows:

> §761. Definitions generally applicable to sexual offenses.
>
> ... (k) A child who has not reached that child's sixteenth birthday is deemed unable to consent to a sexual act with a person more than 4 years older than said child. Children who have not reached their twelfth birthday are deemed unable to consent to a sexual act under any circumstances.

[emphasis supplied]

H.B. No. 256 departs from the "4 years older" approach in favor of a "2 years older" approach for even 16-17 year olds (line 33). Thus, if a 20 year old college junior sends a phone message to a 17 year old college freshman girlfriend/boyfriend encouraging a tryst, a felony has been committed. The same result occurs if an 18 year old high school senior sends the same message to a 15 year old high school sophomore girlfriend/boyfriend. Reasonable persons may differ on the prudence of criminalizing such conduct which could often occur among consenting teens and young adults.

I recommend sharing the above observations with policymakers.

10. S.B. No. 181 (Child Protection Registry)

This legislation was introduced on March 27, 2014. As of April 4, it remained in the Senate Judiciary Committee.

The 9-page bill effects many discrete amendments to the standards and procedures for inclusion on the Child Protection Registry. In general, the changes are either relatively benign or enhance some due process rights. However, the sponsors could consider some features that would enhance due process further and foster the validity and reliability of findings.

First, the bill changes existing law by requiring DFS to file a petition for substantiation before any child is entered on the Registry (lines 128-129), requires the Family Court to appoint counsel for any unrepresented child (lines 155-156), and requires a hearing (lines 112-113). These are important protections designed to promote a fair process in which a child's qualifications for inclusion on the Registry are subject to more robust review. For similar reasons, it would be preferable to authorize appointment of counsel for adults who wish to contest inclusion on the Registry. The ramifications of inclusion in the Registry are comparable and adults may defer requesting a court hearing based on the daunting prospect of representing themselves against a state agency with counsel from the Attorney General's Office.

Second, the bill authorizes the Court to place a child or adult on the Registry based on the "preponderance of the evidence" (lines 158-159) rather than adopting a more exacting "clear and convincing evidence". Since the proceedings are quasi-criminal in nature, adoption of a "clear and convincing evidence" standard would be justified.

Third, there is an anomaly in the law in the context of the effect of a Court finding in criminal and juvenile delinquency proceedings. If the Court enters a finding of guilt in such a proceeding, the individual cannot contest inclusion on the Registry (lines 194-196). It is automatic. Conversely, if the individual is determined not guilty, DFS is not bound by the finding and can pursue inclusion in the Registry without any deference to the earlier Court finding (lines 197-201). Reasonable persons may differ on the merits of this approach. Proponents may justify this approach based on the higher standard of proof applied in criminal proceedings. Detractors may posit that it subjects the individual to extended, protracted proceedings and expense of representation despite acquittal.

I recommend sharing the above observations with policymakers.

Attachments

8g:legis/414bils
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examiner.com

Uneven progress in state Medicaid coverage for smoking cessation

Getty images

Barbara Mader
General Education Examiner
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March 30, 2014

More smokers would quit if state Medicaid programs covered more cessation treatments and removed barriers to coverage, according to a CDC study published in today's **Morbidity and Mortality Weekly Report.** All 50 states and the District of Columbia cover cessation treatments for at least some Medicaid enrollees. Efforts to expand state Medicaid coverage for all smoking cessation treatments and the removal of coverage barriers have shown mixed progress over the past five years.

Americans **enrolled in Medicaid** are more likely to smoke than the general population, and smoking-related disease is a major contributor to increasing Medicaid costs. Insurance coverage of proven cessation treatments leads to more smokers using the treatments and successfully quitting smoking. A recent study from the American Journal of Preventive Medicine found that more comprehensive state Medicaid coverage was associated with increased quit rates among smokers enrolled in Medicaid.

Seven states cover all approved medications and in-person counseling cessation treatments for all Medicaid recipients. All states have some barriers to getting these

treatments. The most common barriers are limits on how long treatment is covered and how much is covered per year; prior authorization requirements; and copayments.

"States can save lives and reduce costs by providing Medicaid coverage for all proven cessation treatments, removing barriers to accessing these treatments, and promoting the expanded coverage," said Tim McAfee, M.D., M.P.H., Director of the CDC's Office on Smoking and Health. "Reducing the number of smokers will save lives and reduce health care costs."

The study compares 2008 with 2014 data and found that 41 states made changes to the treatments they covered for at least some plans or populations. Nineteen states added treatments to coverage without removing any treatments from coverage and eight states removed treatments from coverage without adding any treatments to coverage. Fourteen states both added and removed coverage.

During this same period, 38 states made changes to barriers to accessing treatments for at least some plans or populations. Nine states removed barriers without adding new barriers, 12 states added new barriers without removing existing ones, and 17 states both removed and added barriers.

"There's evidence suggesting that smokers enrolled in Medicaid, like other smokers, want to quit and will take advantage of covered cessation treatments to help them quit for good," said Stephen Babb, M.P.H., co-author of the article.

Some of the strongest evidence comes from Massachusetts, which expanded its Medicaid cessation coverage in 2006.
"Massachusetts heavily promoted its new Medicaid cessation coverage to Medicaid enrollees and health care providers, and saw a drop in the smoking rate among Medicaid enrollees from 38 percent to 28 percent," said Babb. There was also an almost 50 percent drop in hospital admissions for heart attacks among those who used the benefit. It is important that all smokers who want help quitting, including smokers enrolled in Medicaid, have access to proven cessation treatments and services."

Fifty years after the first Surgeon General's Report linking cigarette smoking to lung cancer, smoking remains the leading cause of preventable death and disease in the

United States, killing nearly half a million Americans every year. More than 16 million Americans live with a smoking-related disease. Smoking-related diseases cost Americans $132 billion a year in direct health care expenses, much of which comes in taxpayer-supported payments. The most recent Surgeon General's Report, released in January 2014, recommends providing barrier-free access to proven cessation treatments, and expanding cessation services for all smokers in primary and specialty care settings.

Follow all the news about Green Living, American Made, Pets, Education, and Child Health by subscribing to my articles. Click on the "Subscribe" button, or here: **http://www.examiner.com/user-bmader**. Visit my blog for a chuckle at: **http://barb-says.blogspot.com**.

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DELAWARE STATE SENATE

147th GENERAL ASSEMBLY

SENATE BILL NO. 119
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE REGULATION OF HOSPICES AND TO THE UNIFORM CONTROLLED SUBSTANCES ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 1, Title 16 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§122. Powers and Duties of the Department of Health and Social Services.

(m) Establish standards for quality assurance in the operation of hospice programs, which shall include, but not be limited to establishing and implementing standardized protocol with respect to the safe disposal of unused prescription medication following the death of an in-home hospice patient, and control the practice of such programs. Upon receipt of an application for license and the application fee of $100, the Department shall issue a license if the hospice meets requirements established under this chapter. A license, unless sooner suspended or revoked, shall be renewed annually upon filing by the licensee and payment of an annual licensure fee of $50. A provisional license, as authorized by the Department, shall be issued when health requirements are not met and a licensure fee of $50 has been submitted. A hospice which has been issued a provisional license shall resubmit the application fee for reinspection prior to the issuance of an annual license;

Section 2. Amend Chapter 47, Title 16 of the Delaware Code by making insertions as shown by underlining and deletions as shown by strike through as follows:

§4739A. Practitioners.

SD : TGW : MMS:3081470091
LC : MJC : RAY:4801470031

Except for pharmacies and persons licensed, registered, or otherwise authorized to conduct research, no practitioner shall dispense controlled substances beyond the amount deemed medically necessary for a 72 hour supply.

§4798. The Delaware Prescription Monitoring Program. [Effective upon provision of funding; see 77 Del. Laws, c. 396, §3]

~~(b)(4) "Dispenser" means a person authorized by this State to dispense or distribute to the ultimate user any controlled substance or drug monitored by the program, but shall not include any of the following: a licensed health care facility pharmacy that dispenses or distributes any controlled substance or drug monitored by the program for the purposes of inpatient care, emergency department care for the immediate use of a controlled substance or when dispensing up to a 72 hour supply of a controlled substance or a drug of concern monitored by the program at the time of discharge from such a facility.~~

(b)(4) "Dispenser" means a person authorized by this State to dispense or distribute to the ultimate user any controlled substance or drug monitored by the program, but shall not include any of the following: a licensed health care facility pharmacy that dispenses, distributes or administers any controlled substance, or drug monitored by the program, for the purposes of in-patient care or emergency department care.

~~(5) "Distribute" or "distribution" means the delivery of a drug other than by administering or dispensing.~~

(d) A dispenser including those dispensing an amount deemed medically necessary for a 72 hour supply, shall submit the required information regarding each prescription dispensed for a controlled substance, in accordance with the transmission methods and frequency established by regulation issued by the Office of Controlled Substances. When needed for bona fide research purposes and in accordance with applicable regulation, the Office of Controlled Substances may require a dispenser to submit the required information regarding each prescription dispensed for a drug of concern, but in no event should dispensers be required to submit such information any more frequently than that required for controlled substances. The following information shall be submitted for each prescription:

SD : TGW : MMS:3081470091
LC : MJC : RAY:4801470031

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
THE DIVISION OF CHILD MENTAL HEALTH SERVICES
THE DIVISION OF FAMILY SERVICES

AND

THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

I. PURPOSE

This cooperative agreement represents an understanding between the Department of Services for Children, Youth, and Their Families, The Division of Child Mental Health Services (DCMHS), The Division of Family Services (DFS), and the Department of Health and Social Services, the Division of Developmental Disabilities Services (DDDS), concerning children and their families served by DCMHS, DFS and DDDS where mental retardation/developmental disabilities (MR/DD), as defined by DDDS eligibility criteria, is suspected or is present. The purpose of this agreement is to delineate the responsibilities of the respective agencies in four areas:

1. Joint planning and services for eligible children and families
2. Residential placement of DFS children in DDDS homes and respite care
3. Developmental assessments of younger children ages 0-3
4. Transition of youth to adult services

This agreement is proposed and executed with the greatest spirit of cooperation and desire for ensuring the safety and welfare of children. All agencies recognize that certain action steps may be altered based on the specific needs of each child.

II. AUTHORITY AND RESPONSIBILITIES

A. Authority

1. The Division of Child Mental Health Services

   As required by Title 29 Del C. Ch. 90 § 9006, the Division of Child Mental Health Services shall be responsible for outpatient and residential mental health, preventive health services, and substance abuse treatment services for children and youth.

2. The Division of Family Services

   As required by Title 29 Del C. Ch. 90 § 9006, Title 16 Del. C. Ch. 9 § 901, and Title 31 Del C § 302, shall take necessary action and provide comprehensive protective services for abused and neglected children. The child protection system seeks and promotes the safety of children who are the subject of child abuse and neglect reports.

3. Division of Developmental Disabilities Services – as required by Title 29 Del. C. Ch. 9 § 7909A.

   The Division helps the people it serves achieve the quality of life they desire.

   The DDDS acknowledges that persons with MR/DD share the same basic rights as all citizens. The DDDS shall facilitate the exercise and protection of such.

B. Responsibilities

1. **Joint planning and services:** When DFS is involved with a child or family because of child abuse, neglect, and/or dependency and any of the adult individual/caretakers have MR/DD, the following activities will occur:

   a. The DFS caseworker from the appropriate region (Attachment 1) will call the corresponding DDDS Community Services Regional Program Director (RPD). By the end of the working day, the RPD or designee will determine the status of the adult individual/caretaker relative to DDDS services. The information will be reported to DFS within 24 hours.

   b. If the adult individual/caretaker is an open case with DDDS, the DFS case worker and DDDS Family Support Specialist will develop a strategy to provide the most appropriate service to the family, including defining parameters of responsibility. The plan of intervention will include immediate action as well as any follow-up deemed mutually necessary. The DDDS Family Support Specialist shall assist DFS in developing a plan to reduce risk to children in the home while accommodating the support needs

of the person with MR/DD. A joint service plan shall be developed and signed, outlining the responsibilities of each agency. DDDS and DFS shall convene on a quarterly basis (minimally) to discuss progress and ongoing problems within the family.

c. If the adult individual/caretaker does not have an open case with DDDS but MR/DD is suspected, the DFS case worker will complete the MR/DD Screening Tool (Attachment 2). If the results of the screening tool indicate that the adult individual/caretaker may have MR/DD, then the procedure outlined in 1.b. (above) of this agreement will be initiated. DDDS will assist the family and DFS prior to the individual's eligibility for DDDS services is formally determined. Within the first 90 days, the adult individual/caretaker must formally apply for DDDS services and be found eligible. If the adult individual/caretaker needs assistance in completing the intake forms and obtaining the needed information, the DDDS worker will help the adult individual/caretaker complete the necessary forms.

- Both DDDS and DFS will cooperate to minimize separation of the adult individual/caretaker with MR/DD from their children, as long as the safety of the child can be ensured.

- The Association for Rights of Citizens with Mental Retardation of Delaware (ARC) can be utilized by DFS/DDDS as a referral agent to help support the family.

- The DDDS will expedite eligibility determination for adults and/or children whose cases fall under this MOU. DDDS services are voluntary and will be offered to the family as long as the family is willing to accept them.

d. If the adult individual/caretaker is receiving services from DDDS and the DDDS Family Support Specialist becomes aware of the abuse or neglect of children, the DDDS Family Support Specialist will immediately report it to DFS by calling 1-800-292-9582 (Attachment 3). All social service personnel are mandated reporters and are required to report all known or suspected child abuse, neglect, or dependency.

- DFS uses the Risk Management Methodology to determine both the response time to begin the investigation and the determination of whether the children are at risk. DFS will complete the investigation within 45 calendar days and determine the need for ongoing services to the child and family.

- DFS and DDDS will work together to develop the most appropriate support plan for the family as noted in 1.a. (above).

e. Children open with DFS and/or DCMHS and who may be eligible with DDDS, will be referred by the DFS or DCMHS case manager to DDDS. DDDS will review application and provide a status advisory within 4 business days of receipt of application. If child is subsequently determined eligible for DDDS services, a joint planning meeting will be convened to review service plan within 10 business days of said determination.

f. Children whose cases are open with DDDS and who may also be eligible for DCMHS services* (as defined by DCMHS eligibility criteria) will be referred to DCMHS intake. DCMHS intake process will take place and a response will be issued to the DDDS Family Support Specialist within 4 business days of receipt of complete referral information. If the child is eligible for DCMHS services, a joint planning meeting will be convened to review the service plan within 10 business days. If the child is ineligible for DCMHS services, DDDS can consult with DCMHS regarding appropriate and available services for their purchase.

g. Appeals of eligibility will be made pursuant to the DDDS and DCMHS Appeals procedure. A response will be made available within 5 business days. DFS, DCMHS, and DDDS will ensure that applicants are aware of the appeal processes and contacts for appropriate advocacy organizations.

h. Regional Managers from DDDS, DCMHS and DFS will meet on a quarterly basis to review specific policy and procedural and problematic cases and issues of mutual concern. Either party can request a meeting at an earlier time if it is case related.

2. **Residential placement of DFS children in DDDS homes and Respite Care:** When DFS is involved with a family because of child abuse, neglect, and/or dependency and the child has MR/DD and is placed in a DDDS foster home, the following activities will occur:

In order to receive residential services, the individual must be deemed as an "emergency" on the DDDS Registry and meet the definition for placement. *Emergency is defined as homeless with health and safety issues in the Emergency category of the DDDS Registry.*

a. The DFS worker will do the following:

- Complete the DDDS profile application and submit to DDDS intake, including all pertinent requested records.
- Accompany the child to the placement and move their belongings.
- Provide the DDDS worker and provider with information about the child.
- Provide a copy of the custody order and Consent to Treatment Form.

- Enroll the child in school, and attend IEP meetings.
- Develop the Plan for Child in Care within 30 days of placement. DDDS, the provider, and the child's family (if appropriate) shall participate in the planning.
- Provide services as needed to the child's family in an effort to reach permanency for the child
- Attend Child Placement Review Board (CPRB) meetings and Permanency Hearings
- Obtain an Educational Surrogate Parent if needed
- Enter the child in placement in FACTS (non-contractor provider, no pay)
- Handle all medical consents
- Facilitate applications for public benefits (e.g. Medicaid, SSI, Child Support, etc.)
- Help with special funding issues
- Make funeral arrangements with help from DDDS
- Work with DDDS case manager to address issues and concerns
- Two years in advance, work with DDDS case manager to determine the need for upcoming guardianship needs at age 18

b. The DDDS worker will do the following:

- Complete all DDDS residential paperwork and a Medicaid waiver packet in coordination with the DFS worker
- Meet the DFS worker and child at initial placement
- Visit the home every month
- Visit the school quarterly and attend IEP meetings
- Oversee, with a nurse consultant and provider, that child's medical appointments are kept:
    a. Specialists as needed
    b. Dental services
    c. Immunizations up to date
    d. Annual physicals
- Attend CPRB meetings and Permanency Hearings
- Complete an annual Essential Lifestyle Plan and forward copy to DFS
- Liaison with Medicaid for specialized equipment; contact DFS for funding as appropriate
- Keep DFS informed of concerns and changes in placement
- Complete all DDDS paperwork:
    a. Annual home compliance check and contract signatures
    b. Quarterly reports
    c. Quarterly RN reports
    d. Make respite arrangements

e. Work with the DFS worker to address issues and concerns

- Two years in advance, work with DFS worker to determine the need for upcoming guardianship needs at age of 18

c. Fiscal responsibility for Residential Placements

- DDDS funding/payments must have prior approval from the DDDS Director of Community Services
- DDDS will be representative payee for SSI and Social Security to the extent consistent with applicable law
- DFS/DCMHS will facilitate the payment process if the DSCYF is the payee
- DDDS will pay Difficulty of Care per new rate system. DFS will pay according to child Level of Care Rate. DCMHS pays according to medical necessity and clinical eligibility. Any costs that exceed the allowable agency rates must be jointly agreed upon. If additional funding is needed for the placement, it will be negotiated among DDDS, DFS, and DCMHS.
- DDDS will designate contact person(s) for all issues related to payments. (Attachment 1)
- At the beginning of the fiscal year, DDDS will submit an annual cost projection for each child residing in a DDDS foster home. This will be followed by an intergovernmental voucher that lists the name of the child and the annual projected cost of care attributed to DFS and DCMHS.
- DMSS client payments will notify the DDDS Director of Client Benefits of all child support payments which are received on children who are served jointly. This notification must occur at least once each quarter.

d. Respite

- When respite occurs with DDDS providers:

  - A DDDS respite agreement will be signed before the respite takes place unless an emergency placement is authorized by a DDDS administrator.
  - Funding shall be shared in accordance with the established formula, which is reviewed annually. If DCMHS services are involved, continued utilization is monitored regularly to determine ongoing medical necessity.
  - DDDS Respite Coordinator shall submit a DFS FACTS Registration Form for each DDDS Respite Provider to the DFS Foster Care Manager to facilitate payment.
  - DFS makes respite payments directly to the provider.

- When respite placement costs exceeds DDDS' rate system limit or requires placement other than foster families:
  - DFS, DCMHS, and DDDS representatives will jointly review the case, possible placements, and determine placement resources. They will also determine which agency will be the lead agency to follow up on the details of arranging the placement.
  - If DDDS does not have a provider, DFS has the option of approving an appropriate provider to provide respite, as they would with any other family active with DFS.

3. **Developmental assessments of young children ages 0-3:**
   When a child ages 0-3 in the custody of DFS is suspected of or has developmental delays and the parents are not available to initiate Part C services, the DFS worker will make a referral to Child Development Watch (CDW).

4. **Transition of youth to adult services:**
   When a youth in the custody of DFS and/or receiving services from CMH has been determined eligible to receive DDDS services and is listed in the DDDS *Registry*, the DFS caseworker or CMH caseworker (as appropriate) shall contact by email or letter the DDDS Community Services Regional Program Director (RPD) from the applicable region (Attachment 1) within 30 days following the youth's 16th birthday to initiate transition to adult services planning. When a youth in the custody of DFS and/or receiving services from CMH is suspected of having mental retardation/developmental disabilities (MR/DD), as defined by DDDS eligibility criteria, the DFS caseworker or CMH caseworker (as appropriate) will make a referral to the DDDS Office of Applicant Services within 30 days following the youth's 16th birthday to initiate the application process and transition to adult services planning. Both scenarios assume discharge from DFS or CMH at age 18.

III. DISPUTE RESOLUTION

If issues come up that cannot be resolved by the staff working directly with the child and their family, the respective supervisors should be alerted to attempt to resolve the issues. If resolution cannot be accomplished at the supervisory level, then Division liaisons should be contacted to assist in the resolution.

IV. CONFIDENTIALITY

The Divisions of Child Mental Health Services, Family Services, and Developmental Disabilities Services agree to exchange client/family information on families and children served by either Division in instances where information exchange is in the best interest of families or children needing or requesting services for either Division. (29 Del. C. §9016)

It is understood that information exchanged by any Division shall be restricted to client/family record reports and documents clearly pertinent to the family's or child's needs or problems. Further, any information exchanged shall only be used to facilitate efficient and timely evaluation, the provision of services and/or resolution of patient/client needs. Each Division assures that the confidential character of exchanged information will be preserved and, under no circumstances will exchanged information be shared with any agency, program or person not party to this agreement without the express written consent of the family or by the authority of Family Court.

No information in any form can be exchanged about drug or alcohol abuse treatment or sexually transmitted disease information without specific written consent for this information. Information about HIV testing or HIV status can only be shared with specific consent or if the Division of Family Services holds legal custody of that child.

V. Administration of Memorandum

Each agency agrees to assign appropriate program staff to serve as the points of contact for the purposes of effective and efficient management of the children and families served under this MOU.

It is expected that these staff will meet on a quarterly basis to ensure that the intent and spirit of this MOU is fully implemented.

MOU Attachments include:

- Attachment 1 – Names and telephone numbers of the staff described in this Memorandum of Understanding (included in this document)
- Attachment 2 – DDDS Quick Screen Tool for Identifying Individuals with a Possible Developmental Disability
- Attachment 3 – Child Abuse/Neglect Mandatory Reporting Form
- Attachment 4 – DCMHS Eligibility Criteria
- Attachment 5 – DDDS Eligibility Criteria

Memorandum of Understanding Among DCMHS~DFS~DDDS

This agreement is proposed and executed with the greatest spirit of cooperation and desire for client-centered activities. All agencies recognize that certain action steps may be altered based on specific individual's needs.

This Memorandum of Understanding will be reviewed annually.

Cari DeSantis, Secretary
Department of Services for Children,
Youth, & Their Families

Vincent P. Meconi, Secretary Department
of Health and Social Services

Susan Cycyk, Director
Division of Child Mental Health Services

Carlyse Giddins, Director
Division of Family Services

Marianne Smith, Director
Division of Developmental Disabilities

1. Administration of the Memorandum/Staff Contacts

Each agency has identified a liaison to address interagency issues:

DCMHS: Harvey Doppelt, Ph.D.
Clinical Psychologist
Community Mental Health Regional Director
1825 Faulkland Road, Main Administration Building # 2
Wilmington, DE 19805
(302) 633-2739

DFS: John Bates
Foster Care Program Manager
1825 Faulkland Road, Main Administration Building # 2
Wilmington, DE 19805
(302) 633-2643

DMSS: Theresa Stafford
Sr. Accountant, Client Payments
Barley Mill Plaza, Building 18
4417 Lancaster Pike
Wilmington, DE 19805
(302) 892-4532

DDDS: Flossie Ford
Client Benefits Accountant, Fiscal Unit
Jesse Cooper Building
Federal and Water Street
Dover, DE 19901
(302) 744-9600

1. New Castle County

DFS

Elwyn Office
321 East 11th Street
Suite 300
Wilmington, DE 19802
Phone: (302) 577-3824
Fax: (302) 577-7793
Contact: Debbie Colligan
Assistant Regional
Administrator

DDDS

Early Intervention Program
2055 Limestone Road
Suite 215
Wilmington, DE 19808
Phone: (302) 995-8576
Fax: (302) 995-8363
Contact: EIP Director
Sr. Social Service Administrator

DCMHS

Division Child Mental Health Services (DCMHS)
Main Administration
1825 Faulkland Road
Main Administration Building # 2
Wilmington, DE 19805
Phone: (302) 633-2739
Fax: (302) 633-2614
Contact: Harvey Doppelt, Ph.D.
Clinical Psychologist
Community Mental Health
Regional Director

1. Administration of the Memorandum/Staff Contacts

1. New Castle County

DFS

University Plaza
Cambridge Building
263 Chapman Road
Newark, DE 19702
Phone: (302) 451-2800
Fax: (302) 451-2821
Contact: Dave Desmond
Assistant Regional Administrator

DDDS

University Plaza
Stockton Building
263 Chapman Road
Newark, DE 19702
Phone: (302) 369-2180
Fax: (302) 368-6596
Contact: Michael Paoli
Regional Program Director

DCMHS

University Plaza
Cambridge Building
1825 Faulkland Road
Main Administration Building # 2
Wilmington, DE 19805
Phone: (302) 633-2739
Fax: (302) 633-2614
Contact: Harvey Doppelt, Ph.D.
Clinical Psychologist
Community Mental Health
Regional Director

2. Kent County

DFS

Barratt Building
821 Silver Lake Boulevard
Suite 200
Dover, DE 19904
Phone: (302) 739-4800
Fax: (302) 739-6236
Contact: Diana Fraker
Assistant Regional Administrator

DDDS

Thomas Collins Building
540 S. DuPont Highway
Suite 8
Dover, DE 19901
Phone: (302) 744-1110
Fax: (302) 739-5535
Contact: Albert Anderson
Regional Program Director

DCMHS

Georgetown State Service Center
546 S. Bedford St.
Room 2110
Georgetown, DE 19947
Phone: (302) 856-5826
Fax: (302) 856-5824
Contact: David Lindemer, Ph.D.
Child Psychologist Supervisor

3. Sussex County

DFS

Georgetown
546 South Bedford Street
Georgetown, DE 19947
Phone: (302) 856-5450
Fax: (302) 856-5062
Contact: Margaret Anderson
Assistant Regional Administrator

DDDS

Georgetown
Community Services
26351 Patriots Way
Georgetown, DE 19947
Phone: (302) 933-3135
Fax: (302) 934-6193
Contact: Carey Hocker
Regional Program Director

DCMHS

Georgetown State Service Center
546 S. Bedford St.
Room 2110
Georgetown, DE 19947
Phone: (302) 856-5826
Fax: (302) 856-5824
Contact: David Lindemer, Ph.D.
Child Psychologist Supervisor

1. Administration of the Memorandum/Staff Contacts

3. Sussex County

DFS **DDDS** **DCMHS**

Pyle
Rte. 2, P.O. Box 281-1
Frankford, DE 19945
Phone: (302) 732-9510
Fax: (302) 732-5486
Contact: Margaret Anderson
Assistant Regional
Administrator

Seaford
350 Virginia Avenue
Seaford, DE 19973
Phone: (302) 628-2024
Fax: (302) 628-2041
Contact: Margaret Anderson
Assistant Regional
Administrator

Milford
11-13 Church Avenue
Milford, DE 19963
Phone: (302) 422-1400
Fax: (302) 424-2950
Contact: Susan Taylor-Walls
Assistant Regional
Administrator

4. To Report Child Abuse or Neglect:

Statewide Report
Line Number: 1 (800) 292-9582 (24 hours a day/7days a week)

2. DDDS Quick Screen Tool

Identifying Individuals with a Possible Developmental Disability

Name:_____ **Date:**_____

Address:_____

Age:_____ **Informant/s:**_____

Screening completed by:_____

1. Is there documentation that the individual's deficits or limitations began prior to age 22 (for example: enrolled in special school or program, previous diagnosis of some type of mental retardation, autism, documentation of delays in development, or an IQ below 70)?

2. Does the individual have a high school diploma or a certificate of attendance? If neither, it is clear that the individual did not attend or regularly attend and complete school.

3. Is the individual performing substantially below the level expected for his/her age in two or more of the following adaptive skills areas (see definitions noted on the back of this form)? If so, circle those applicable.

    a. Communication
    b. Self-Care
    c. Home Living
    d. Social
    e. Community Use
    f. Self-Direction
    g. Health and Safety
    h. Functional Academics
    i. Leisure
    j. Work

4. Is it clear that the individual did not function at a higher or more independent level at a previous time in his/her life?

2. DDDS Quick Screen Tool

Adaptive Skills Areas

a. Communication: Ability to understand and express information through symbolic behavior (spoken word, written word, sign language, manually coded English) or non-symbolic behaviors (e.g.: facial expressions, body, body movement, touch, gesture).

b. Self-care: skills involved in toileting, eating, dressing, hygiene, and grooming.

c. Home living: home-related skills such as cooking, clothing care, housekeeping, food preparation, planning/budgeting for shopping, and home safety.

d. Social skills related to social interactions with others such as initiating, interacting, and terminating interactions, making choices, coping with demands, confirming conduct to social norms, and displaying appropriate socio-sexual-behavior.

e. Community use: skills related to the appropriate use of community resources, travel in the community, shopping in stores, purchasing/obtaining services from community businesses, visiting places/events.

f. Self-Direction: skills related to making choices, learning and following a schedule, engaging in/initiating activities of personal interest that are appropriate to the setting and conditions.

g. Health and Safety skills: related to the maintenance of owns own health in terms of eating, identification of illness, treatment and prevention, basic first aid, sexuality, physical fitness, and interacting with strangers.

h. Functional Academics: cognitive abilities and skills related to school that also have direct application in one's life (e.g.: writing, reading, basic science). Of importance is not the grade-level, but that the skills are functional in terms of independent living.

i. Leisure: the development of a variety of leisure and recreational interests that reflect personal choice and preferences. Skills would be choosing and self-initiating interests, using home and community activities with others and/or alone and determining amount and type of involvement.

j. Work: skills related to holding a part or full-time job in the community in terms of specific job skills and appropriate social behavior.

3. Child Abuse/Neglect Mandatory Reporting Form

State of Delaware
The Department of Services for Children, Youth, and Their Families

DIVISION OF FAMILY SERVICES
CHILD ABUSE/NEGLECT MANDATORY REPORTING FORM
(Title 16, Delaware Code, Chapter 9, Subsections 901-914)
Toll Free 24-Hour Report Line 1-800-292-9582

INSTRUCTIONS: Any physician, and any other medical person in the healing arts including any person licensed to render services in medicine, osteopathy, dentistry, any intern, resident, nurse, medical examiner, school employee, social worker, psychologist, or any other person who knows or reasonably suspects child abuse or neglect shall make an oral report to the Report Line using the number at the top of this page in accordance with 16 Del.C. §903).

Within 72 hours after the oral report, send a completed Child Abuse/Neglect Mandatory Reporting Form to the following address: Please type or print the information and sign the form on the back.

DIVISION OF FAMILY SERVICES – STATE OF DELAWARE
87 Reads Way
New Castle, DE 19720-1648

IDENTIFYING INFORMATION

Child's Name (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Victim (Yes/No)
1.				
Current Address:				
2.				
Current Address:				
3.				
Current Address:				
4.				
Current Address:				
5.				
Current Address:				

Parents'/Custodians'/Caretakers' Names (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Perpetrator (Yes/No)
Mother				
6.				
Current Address:				
Father				
7.				
Current Address:				
Custodian/Caretaker (Relationship)				
8.				
Current Address:				

Please specify for numbers 1 - 8 above:

Foreign language spoken: #'s_____ Specify type:_____

Disabilities: #'s_____ Specify type:_____

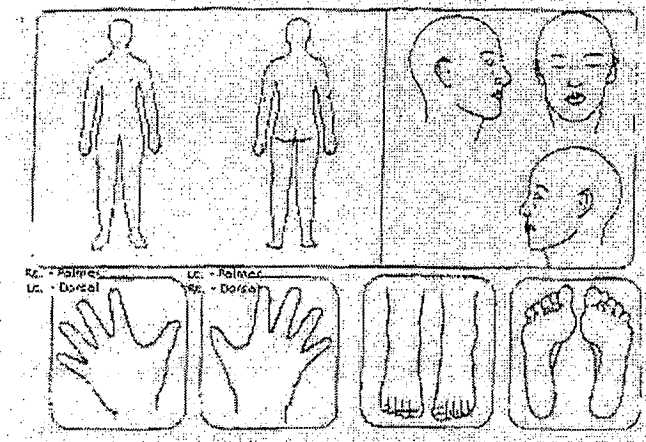
Document No.: 37-06-10-03-05-13 Page 1 of 2

3. Child Abuse/Neglect Mandatory Reporting Form

DESCRIPTION

1. Describe the child's current condition/injuries and the reason you suspect abuse/neglect. Include evidence, if known, of prior abuse and/or neglect to this child or sibling. Add pages or attach further written documentation as needed.

2. If applicable, note the exact location of any injury by placing a number on the model below. Use the lines to the right of the models to describe the corresponding injury that each number represents. Check the category of injuries below.
_____ Physical Abuse _____ Sexual Abuse _____ Physical Neglect



3. Actions taken "T" or pending "P"
_____ Medical Examination
_____ X-Rays
_____ Photographs
_____ Notification of Police
_____ Notification of Medical Examiner
_____ Other: _____

REPORTING SOURCE (CONFIDENTIAL)

Signature | *Title or Relationship to Child* | *Date of Report*

Facility/Organization | *Address* | *Telephone No.*

REPORT LINE USE ONLY

Date of Oral Report: _____ Report was: _____ Accepted _____ Rejected

Date Written Report Received: _____

Prior DFS Case Activity/Reports? _____ Yes _____ No If "yes", specify dates: _____

4. DCMHS Eligibility Criteria

Division of Child Mental Health Services
Department of Services for Children Youth and Their Families
State of Delaware

CS 001 **DCMHS SERVICE ELIGIBILITY**
Authored by: **Utilization Management Committee**
Approved by: Susan Cycyk, M.Ed., C.R.C., C.P.R.C. Title: Division Director
Date: November 29, 2006 Originated: 5/01/97 Revisions: 12/19/99; 11/19/03; 8/31/05; 11/29/06

PURPOSE: To define eligibility criteria for services provided by the Division of Child Mental Health Services ("DCMHS"), State of Delaware.

DEFINITIONS: Applicable definitions are given in the appendix to DCMHS policy "Development and Revision of Policies."

POLICY: Consistent with statutory authority (16 Del C. chapter 90), agreement with the State Medicaid Office under the Diamond State Health Plan (DSHP), the HCFA 1115 waiver, DCMHS hereby establishes eligibility criteria for mental health and substance abuse services for children and youth who are served by DCMHS. Eligibility for service is established when criteria 1, 2, 3, and 4 below are all met or when criteria 5 is met.

1. Age: Children and youth are eligible:

   A. Up to Age 18 -Children and youth are eligible for services until their 18th birthday.

   B. Over age 18 -For those youth active with DFS or DYRS and over the age of 18, DCMHS may:

      1) Manage the case and provide services available through DSCYF consolidated contracts, and/or

      2) Provide its Consultation and Assessment service for diagnostic services and treatment planning up to age 19.

2. Residence: Delaware residents are eligible for services.

3. Medical Necessity: Medical necessity is established by the application of DCMHS "Level of Care Criteria." These criteria are available on the DCMHS website.

4. Categorical Eligibility:

   A. Insurance and Medicaid Benefits: DCMHS services are intended as a primary resource for those who have no other reasonable means to pay for mental health services i.e. individuals who have:

      1) Medicaid benefits, and require extended services beyond the 30 unit Diamond State Health Plan outpatient benefit or require a higher level of service than is provided by DSHP outpatient benefits, or

      2) No Medicaid and no private mental health or substance abuse benefits, or

      3) Exhausted all applicable private insurance mental health or substance abuse benefits. Please note that the absence of a level of care or specific provider in a mental health insurance package is not grounds for categorical eligibility.

   B Insurance Co-pay: In general, DCMHS does not function as a secondary payor for the purpose of funding insurance co-payment for the privately insured. There are two exceptions:

      1) If a youth is hospitalized in a DCMHS designated psychiatric hospital on an involuntary basis, or is hospitalized on an emergency basis with DCMHS authorization, and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DCMHS may reimburse the Provider up to the allowable Contract rate for up to 72 hours.

      2) If a youth has both private insurance and Medicaid, where the private insurer is the primary payor and Medicaid is the secondary payor, then the parent, legal guardian or other legally liable individual

4. DCMHS Eligibility Criteria

is not responsible for any co-pay amount and by federal regulation private providers may not bill parents for that amount. In such a situation, Medicaid providers who have a contract with DCMHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DCMHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid allowable charges, the provider must obtain DCMHS authorization for the service prior to the initiation of the service, in addition to any other authorizations which may be required by other payers.

C. Duplicated DSCYF Services: DCMHS provides mental health and substance abuse treatment for children and youth active with another division when the mental health or substance abuse treatment is not available through the other division, or as otherwise specified in an MOU with another DSCYF division.

D. For clients meeting eligibility requirements for DCMHS services, and who also qualify for services from other state agencies, divisions within state agencies, school districts, physical/medical health care services, and/or other services, DCMHS will provide medically necessary mental health and substance abuse services arranged in concert with these other agencies. DCMHS does not provide services that substitute for services which are the responsibility of another agency.

5. Mental Health Crises – Crisis services may be provided to children and youth meeting criteria A. or B. below.

A. DCMHS crisis services and short-term emergency hospitalizations may be provided to non-resident youth under the age of 18 years of age who are in the State of Delaware and are at imminent danger to self or others arising from mental health or substance abuse disorders. DCMHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

B. The DCMHS crisis service also may be utilized by privately insured persons if they meet criteria 1, 2, and 3 above for initial crisis response (excluding crisis bed) intervention, but subsequent treatment is the responsibility of the insurance carrier unless the youth otherwise meets eligibility criteria and is admitted to DCMHS services.

APPLICATION:

A. The application of this policy in a particular circumstance may be appealed by the affected parent or guardian, custodian or other legal caregiver if the parent is unavailable. (See also DCMHS Appeals Policy).

1) Providers and advocates may assist children and families with an appeal under this policy.

2) Families will be advised of their appeal rights whenever a client is determined to be ineligible for DCMHS services under this policy.

3) When DFS or DYRS has legal custody, staff in disagreement with DCMHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

B. DCMHS staff may request a review by the Division Director if application of the policy would yield a result substantially contrary to the combined interests of the State and the client. The decision of the Director will be documented in writing and signed by the Director, and kept on file by the DCMHS Quality Improvement unit.

Mydocs/UR/CS001Rev11-29-06.doc

4. DCMHS Eligibility Criteria

DELAWARE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
ELIGIBILITY CRITERIA

The Division of Developmental Disabilities Services provides services to those individuals whose disability meets all of the following conditions:

(A) (i) is attributable to mental retardation (1992 AAMR definition) and/or (ii) Autism (DSM IV)and/or (iii) Prader Willi (documented medical diagnosis) and/or (iv) brain injury (individual meets all criteria of the 1992 AAMR definition including age manifestation) and/or (v) is attributable to a neurological condition closely related to mental retardation because such condition results in an impairment of general intellectual functioning and adaptive behavior similar to persons with mental retardation and requires treatment and services similar to those required for persons with impairments of general intellectual functioning:

(B) is manifested before age 22

(C) is expected to continue indefinitely;

(D) results in substantial functional limitations in 2 or more of the following adaptive skill areas

1) communication;
2) self-care;
3) home living;
4) social skills;
5) community use;
6) self-direction;
7) health and safety;
8) functional academics;
9) leisure;
10) work; and

(E) reflects the need for lifelong and individually planned services.

Intellectual functioning and adaptive behavior is determined by using established standardized tests approved by the Division.

Effective 7-10-2000

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143rd General Assembly
House Bill # 329

Primary Sponsor: Roy **Additional Sponsor(s):** Sen. Sokola

CoSponsors: Reps. Hudson, Longhurst, Miro

Introduced on : 01/17/2006

Long Title: AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO RESTROOM ACCESS.

Synopsis: This Act creates the Restroom Access Act requiring a retail establishment that has a toilet facility for its employees to allow a customer to use that facility during normal business hours if the following conditions are met: (1) the customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device; (2) three (3) or more employees of the retail establishment are working at the time the request is made; (3) the retail establishment does not normally make a restroom available to the public; (4) the employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer; and (5) a public restroom is not immediately accessible to the customer.

This Act defines the circumstances under which the retail establishment or an employee thereof would not be civilly liable for any act or omission in allowing a customer to use an employee toilet facility and provides that a retail establishment is not required to make any physical changes to an employee toilet facility.

A retail establishment, or an employee of a retail establishment, that violates this Act shall be assessed a civil penalty of not more than $100.

Current Status: House Labor Committee **On** 01/18/2006

Fiscal Note: Not Required

Full text of Legislation: (in HTML format) Legis.html Email this Bill to a friend

Full text of Legislation: (in MS Word format) Legis.Doc (You need Microsoft Word to see this document.)

Actions History:

Jan 18, 2006 - Reassigned to Labor Committee in House
Jan 17, 2006 - Introduced and Assigned to Health & Human Development Committee in House

SPONSOR: Rep. Roy & Sen. Sokola;
Reps. Hudson, Longhurst, Miro

HOUSE OF REPRESENTATIVES

143rd GENERAL ASSEMBLY

HOUSE BILL NO. 329

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO RESTROOM ACCESS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by inserting therein a new Chapter as follows:

"Chapter 89. Restroom Access.

§ 8901. Short title.

This Chapter may be referred to and cited as the 'Restroom Access Act'.

§ 8902. Definitions.

In this Chapter, the following words and terms shall, unless the context otherwise requires, have the following meanings:

(1) 'Customer' means an individual who is lawfully on the premises of a retail establishment.

(2) 'Eligible medical condition' means Crohn's disease, ulcerative colitis, any other inflammatory bowel disease, irritable bowel syndrome, or any other medical condition that requires immediate access to a toilet facility.

(3) 'Retail establishment' means a place of business open to the general public for the sale of goods or services.

§ 8903. Retail establishment; customer access to restroom facilities.

A retail establishment that has a toilet facility for its employees shall allow a customer to use that facility during normal business hours if all of the following conditions are met:

(1) The customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device;

(2) Three (3) or more employees of the retail establishment are working at the time the customer requests use of the employee toilet facility;

(3) The retail establishment does not normally make a restroom available to the public;

Released: 01/12/2006 03:16 PM

LC : TJSIII : RAY
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(4) The employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer or an obvious security risk to the retail establishment; and

(5) A public restroom is not immediately accessible to the customer.

§ 8904. Retailer liability.

(a) A retail establishment or an employee of a retail establishment is not civilly liable for any act or omission in allowing a customer to use an employee toilet facility that is not a public restroom if the act or omission meets all of the following:

(1) It is not willful or grossly negligent;

(2) It occurs in an area of the retail establishment that is not accessible to the public; and

(3) It results in an injury to or death of the customer or any individual other than an employee accompanying the customer.

(b) A retail establishment is not required to make any physical changes to an employee toilet facility under this Act.

§ 8905. Violations.

A retail establishment, or an employee of a retail establishment, that violates this Chapter shall be assessed a civil penalty of not more than $100.".

Section 2. This Act shall become effective upon its enactment into law.

SYNOPSIS

This Act creates the Restroom Access Act requiring a retail establishment that has a toilet facility for its employees to allow a customer to use that facility during normal business hours if the following conditions are met: (1) the customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device; (2) three (3) or more employees of the retail establishment are working at the time the request is made; (3) the retail establishment does not normally make a restroom available to the public; (4) the employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer; and (5) a public restroom is not immediately accessible to the customer.

This Act defines the circumstances under which the retail establishment or an employee thereof would not be civilly liable for any act or omission in allowing a customer to use an employee toilet facility and provides that a retail establishment is not required to make any physical changes to an employee toilet facility.

A retail establishment, or an employee of a retail establishment, that violates this Act shall be assessed a civil penalty of not more than $100.

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144th General Assembly
House Bill # 3

Primary Sponsor: Booth **Additional Sponsor(s):** Sen. Adams

CoSponsors: { NONE...}

Introduced on : 01/04/2007

Long Title: AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO **RESTROOM** ACCESS.

Synopsis: This Act creates the **Restroom** Access Act requiring a retail establishment that has a toilet facility for its employees to allow a customer to use that facility during normal business hours if the following conditions are met: (1) the customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device; (2) ten (10) or more employees of the retail establishment are working at the time the request is made; (3) the retail establishment does not normally make a **restroom** available to the public; (4) the employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer; and (5) a public **restroom** is not immediately accessible to the customer.
This Act defines the circumstances under which the retail establishment or an employee thereof would not be civilly liable for any act or omission in allowing a customer to use an employee toilet facility and provides that a retail establishment is not required to make any physical changes to an employee toilet facility.
A retail establishment, or an employee of a retail establishment, that violates this Act shall receive a written warning upon the first violation and subsequent violations shall be assessed a civil penalty of not more than $100.

Current Status: Stricken **On** 06/05/2007

Fiscal Note: Not Required

Full text of Legislation: (in HTML format) Legis.html Email this Bill to a friend

Full text of Legislation: (in MS Word format) **Legis.Doc** (You need Microsoft Word to see this document.)

Committee Reports: House Committee Report 03/14/07 F=0 M=8 U=0--->

Actions History:
Jun 05, 2007 - Stricken
Mar 14, 2007 - Reported Out of Committee (HEALTH & HUMAN DEVELOPMENT) in House with 8 On Its Merits
Jan 16, 2007 - Re-Assigned to Health & Human Development Committee in House
Jan 04, 2007 - Introduced and Assigned to House Administration Committee in House

SPONSOR:Rep. Booth & Sen. Adams

HOUSE OF REPRESENTATIVES

144th GENERAL ASSEMBLY

HOUSE BILL NO. 3

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO RESTROOM ACCESS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by inserting therein a new Chapter as follows:

"Chapter 89. Restroom Access.

§ 8901. Short title.

This Chapter may be referred to and cited as the 'Restroom Access Act'.

§ 8902. Definitions.

In this Chapter, the following words and terms shall, unless the context otherwise requires, have the following meanings:

(1) 'Customer' means an individual who is lawfully on the premises of a retail establishment.

(2) 'Eligible medical condition' means Crohn's disease, ulcerative colitis, any other inflammatory bowel disease, irritable bowel syndrome, or any other medical condition that requires immediate access to a toilet facility.

(3) 'Retail establishment' means a place of business open to the general public for the sale of goods or services.

§ 8903. Retail establishment; customer access to restroom facilities.

A retail establishment that has a toilet facility for its employees shall allow a customer to use that facility during normal business hours if all of the following conditions are met:

(1) The customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device;

(2) Ten (10) or more employees of the retail establishment are working at the time the customer requests use of the employee toilet facility;

(3) The retail establishment does not normally make a restroom available to the public;

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(4) The employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer or an obvious security risk to the retail establishment; and

(5) A public restroom is not immediately accessible to the customer.

§ 8904. Retailer liability.

(a) A retail establishment or an employee of a retail establishment is not civilly liable for any act or omission in allowing a customer to use an employee toilet facility that is not a public restroom if the act or omission meets all of the following:

(1) It is not willful or grossly negligent;

(2) It occurs in an area of the retail establishment that is not accessible to the public; and

(3) It results in an injury to or death of the customer or any individual other than an employee accompanying the customer.

(b) A retail establishment is not required to make any physical changes to an employee toilet facility under this Act.

§ 8905. Violations.

A retail establishment, or an employee of a retail establishment, that violates this Chapter shall receive a written warning upon the first violation and subsequent violations shall be assessed a civil penalty of not more than $100.".

Section 2. This Act shall become effective upon its enactment into law.

SYNOPSIS

This Act creates the Restroom Access Act requiring a retail establishment that has a toilet facility for its employees to allow a customer to use that facility during normal business hours if the following conditions are met: (1) the customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device; (2) ten (10) or more employees of the retail establishment are working at the time the request is made; (3) the retail establishment does not normally make a restroom available to the public; (4) the employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer; and (5) a public restroom is not immediately accessible to the customer.

This Act defines the circumstances under which the retail establishment or an employee thereof would not be civilly liable for any act or omission in allowing a customer to use an employee toilet facility and provides that a retail establishment is not required to make any physical changes to an employee toilet facility.

A retail establishment, or an employee of a retail establishment, that violates this Act shall receive a written warning upon the first violation and subsequent violations shall be assessed a civil penalty of not more than $100.

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144th General Assembly
House Resolution # 18

Primary Sponsor: Booth **Additional Sponsor(s):** Rep. Hocker

CoSponsors: { NONE...}

Introduced on : 05/09/2007

Long Title: A RESOLUTION ENCOURAGING DELAWARE BUSINESSES TO MAKE **RESTROOM** ACCESS AVAILABLE TO CUSTOMERS WHO HAVE MEDICAL PROBLEMS.

Synopsis: A RESOLUTION ENCOURAGING DELAWARE BUSINESSES TO MAKE **RESTROOM** ACCESS AVAILABLE TO CUSTOMERS WHO HAVE MEDICAL PROBLEMS.

Current Status: House Passed **On** 06/05/2007

Fiscal Note: Not Required

Full text of Legislation: (in HTML format) Legis.html Email this Bill to a friend

Full text of Legislation: (in MS Word format) Legis.Doc (You need Microsoft Word to see this document.)

Voting Reports:

House Voice vote: Passed 6/5/07 2:28:21 PM------>

Actions History:

Jun 05, 2007 - Passed in House by Voice Vote
Jun 05, 2007 - Lifted From Table in House
Jun 05, 2007 - Necessary rules are suspended in House
May 09, 2007 - Laid On Table in House

SPONSOR: Rep. Booth & Rep. Hocker

HOUSE OF REPRESENTATIVES
144th GENERAL ASSEMBLY

HOUSE RESOLUTION NO. 18

A RESOLUTION ENCOURAGING DELAWARE BUSINESSES TO MAKE RESTROOM ACCESS AVAILABLE TO CUSTOMERS WHO HAVE MEDICAL PROBLEMS.

WHEREAS, many Delawareans suffer from medical conditions such as Crohn's disease, ulcerative colitis, any other inflammatory bowel disease (IBD), irritable bowel syndrome, or any other medical condition that requires immediate access to a toilet facility; and

WHEREAS, Delaware's retail establishment means a place of business open to the general public for the sale of goods or services; and

WHEREAS, a retail establishment that has a toilet facility for its employees should allow a customer to use that facility during normal business hours if all of the following conditions are met; and

WHEREAS, the customer requesting the use of the employee toilet facility suffers from an eligible medical condition or utilizes an ostomy device; and

WHEREAS, sometimes the retail establishment does not normally make a restroom available to the public; and

WHEREAS, but the employee toilet facility is not located in an area where providing access would create an obvious health or safety risk to the customer or an obvious security risk to the retail establishment; and

WHEREAS, where a public restroom is not immediately accessible to the customer; and

WHEREAS, it would be a public service for the retail establishment allow a customer to use an employee toilet facility that is not a public restroom; and

WHEREAS, a retail establishment would not be required to make any physical changes to an employee toilet facility under this Resolution.

NOW, THEREFORE:

BE IT RESOLVED by the House of Representatives of the 144th General Assembly of the State of Delaware acknowledges that one of the goals of Miss Delaware 2006, Jamie Ginn, a spokesperson for the Crohn's & Colitis Foundation of America (CCFA), is to further develop public awareness for CCFA and public use of business restrooms in a time of need. Her message, "A Cure for Crohn's and Colitis Can't Wait", will reach a variety of audiences. Her message to schools, workplaces and other public venues will be that people suffering with IBD can't wait to use a restroom, and she

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Released: 05/02/2007 05:01 PM

will encourage the public to help IBD sufferers find a restroom in an emergency. Overall, her message is universal. We are in a golden age of research for these diseases. The rate of discovery is the highest it's ever been, with more than 80 therapies in development now. With increased awareness and funding over the next year, the Miss Delaware Organization can be proud to be part of a potentially major scientific breakthrough. There are millions of Americans who just can't wait for this breakthrough to occur.

BE IT FURTHER RESOLVED, that suitably prepared copies of this Resolution be presented to Jamie Ginn, Miss Delaware 2006 and the Miss Delaware Organization.

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Crohn's Disease

The Restroom Access Act: A Major Victory for Crohn's Patients

Written by Jaime Weinstein | Published on August 13, 2012

A A A

Some of the best ideas occur to people while they are in the bathroom. In the case of Allyson Bain, it was a lack of restroom accessibility that helped launch critical legislation, websites, and several IPhone apps.

It all started a decade ago, when a then 14-year-old Bain was out shopping with her mother at Old Navy. Three years prior, the Vernon Hills, Ill., teenager was diagnosed with Crohn's disease, a chronic illness that affects the digestive system. While out shopping, her Crohn's flared up and she had only minutes to find a restroom. Unfortunately, employees denied her the use of their restroom—even after Bain and her mother explained that it was a medical emergency—and the young girl suffered an embarrassing accident.

Vowing that this would never happen to anyone again, Bain and her mother contacted Illinois State Representative Kathy Ryg, whom the young Bain had met on an eighth grade field trip to the State Capitol in Springfield just months before.

Check out the Top 13 Apps for Crohn's Disease

Soon, Allyson Bain found herself helping to write a bill and testifying before the House Judiciary Committee. The bill passed unanimously in the House of Representatives and the Senate, and was signed into law by then-Gov. Rod Blagojevich in August 2005. Known as the "Restroom Access Act" or "Ally's Law," this groundbreaking bill, which requires businesses to make employee bathrooms accessible to those with IBD, chronic medical conditions, and pregnancy, has since passed in 11 other states and is pending in several more.

The Restroom Access Act: A Major Victory for Crohn's Patients

Written by Jaime Weinstein | Published on August 13, 2012 A A A

Currently, Minnesota, Texas, Kentucky, Tennessee, Colorado, Ohio, Michigan, Washington, Oregon, Wisconsin, and Connecticut have all passed this act or one like it.

Most recently, a bill (H-2366) similar to Ally's Law is making the rounds in Massachusetts and is only waiting on the signature of Gov. Deval Patrick to pass. H-2366 was drafted by the father of Catherine Rutley, a Sharon, Mass., teenager and ulcerative colitis patient, who in the past had found herself in uncomfortable situations similar to Bain's. Before making its way to Gov. Patrick, the bill had gone through several changes to help address concerns brought up by retailers and the following will be required in order to access an "employee-only" restroom: written documentation from a doctor or identification card, and at least two employees have to be present in the store at the time the request is made. There will be a $100 fine for not complying.

A supporter of this act, The Foundation for Clinical Research in IBD, has created the Medical Alert Restroom Access Pass to help those affected by Crohn's and colitis around the nation. The card, available on the organization's site at myibd.org reads:

"The holder of this card has Crohn's disease or ulcerative colitis. Colitis is painful and requires immediate access to a toilet facility. This patient cannot physically 'hold it.' Please make your restroom available."

IBD, the ADA, and How to Report Noncompliance

Some of you may be curious as to why legislation such as the Restroom Access Act and Ally's Law needed to be passed if Inflammatory Bowel Diseases (IBDs) are now covered under the Americans with Disabilities Act (ADA). The reason is twofold: IBD protection under the umbrella of the ADA only recently went into effect (January 1, 2009), and the public is more familiar with the ADA's purpose of protecting employees with disabilities and is not necessarily familiar with the ADA's other functions.

With that said, the ADA explains its secondary function is to guarantee "equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications."

But if you think about what goes on in those critical moments between finding someone who will grant you restroom access to having them deny it to you and then trying to appeal to their moral compass that how you are a disabled individual with an invisible disease, time is of the essence. This is why legislation such as Ally's Law is crucial.

Now with the law in effect, all you will have to do is identify if there is more than one person working in the facility (the law's stipulation in most states), tell the clerk you need to use the facility and show them your IBD card or doctor's note. If you feel uncomfortable or guilty about using a facility without patronizing it, look for something small to purchase like a bottle of water or pack of gum.

For those who live in one of the states with the Restroom Access Act already in effect (MA's will go into effect in October) you may be wondering what to do if you are still denied access to a restroom. Call the police (non-emergency) and file a complaint. Denial of access to the restroom is considered a petty offense or misdemeanor.

Crohn's Disease

The Restroom Access Act: A Major Victory for Crohn's Patients

Written by Jaime Weinstein | Published on August 13, 2012

Yes, it may feel a tad like tattling on someone. Think of it this way, you are tattling on someone for doing wrong against a person with a physical ailment and possibly helping someone else with IBD face a similar situation if not worse. Also, if you are feeling up to the challenge you can contact your state's attorney general's office to file a complaint. According to the MA attorney general's office's civil resources division, they welcome these types of calls to track incidences and are open to researching the matter to see if mediation with the facility is necessary.

Find Out If Your State Is Potty Friendly

While little data exists on most public restroom-friendly cities, it's widely accepted that New York City is the least, while Portland ranks the highest.

Whereas San Francisco and Seattle fair somewhere in between, both cities rolled out automated public toilets (in 1995 and 2004, respectively), only to see the majority become dirty, unsafe, and inoperable within a few years. Los Angeles, Boston, New York, Pittsburgh, Atlanta, Washington DC, and San Antonio have also experimented with APTs with various degrees of success.

Chicago restaurants received criticism last year after an exposé showed that they violated city code by not providing customers with restrooms. On the other hand, the Windy City also houses the most acclaimed public restroom in the country. In fact, the Field Museum's public restroom boasts a ceiling, decorated with renderings of Van Gogh's Starry Night, which also happens to absorb sounds, lending an air of tranquility. The women's bathroom also provides a nursing mother's room and special tot-friendly toilets, according to Cintas, a restroom facility supplier, that also ranks the best lavatories in the country.

Portland is considered a model city, offering adequate signage for restrooms in public buildings, several freestanding, open-space comfort stations, and a number of innovative, sustainable, solar-powered, vandalism-resistant, regularly-cleaned, and (most importantly) safe Portland Loos.

No matter what city you live in, popular food chains such as Starbucks and McDonalds, department stores including Macy's and Bloomingdales, and big box stores like Bed, Bath & Beyond and Wal-Mart, as well as a myriad of hotels are typically a sure bet if you're experiencing a flare and need to find a restroom quickly.

Yep, There's a Website and an App for That, Too

For Crohn's sufferers who don't live in cities with adequate public washrooms, there are still several websites and apps devoted to discovering accessible toilets to help you when you need to "go!"

NYrestroom.com provides users with public restroom information for The Big Apple with hours and amenities information for each location.

The Bathroom Diaries has provided users with the locations of thousands of bathrooms worldwide, since 2000. Readers submit their favorite bathrooms and can even rank them according to spotlessness, safety, and beauty. Additional pertinent information such as handicap access and changing table availability is also included. Top toilets—think ultramodern, eco-friendly, LED-lit, and even gold leaf-painted—receive the site's top honor, the Golden Plunger Award.

DELAWARE HOUSE DEMOCRATS

Paradee to Introduce Restroom Access Bill for Crohn's Sufferers

DOVER – Delawareans who suffer from Crohn's disease, ulcerative colitis and other serious bowel conditions could receive assistance from a measure sponsored by **Rep. Trey Paradee**.

The measure, which will be House Bill 245 when it is filed this week, would allow people with documented medical needs access to restrooms in retail businesses where restrooms are not normally open to the public. The bill also protects businesses by waiving any civil liability related to the restroom access provided for in the legislation. **Sen. Bethany Hall-Long** will sponsor the legislation in the Senate.

Smyrna resident **Morgan Burnett**, along with her parents Amy and Jonathan, brought this issue to Rep. Paradee's attention. Morgan, 15, was diagnosed with Crohn's two years ago and has learned just how difficult it can be to find a nearby public restroom when her symptoms arise. Morgan, like thousands of others with Crohn's and related conditions, also knows what it's like to be denied the use of a restroom reserved for 'employees only,' even in the midst of a medical emergency.

"Far too often, my disease can turn me into an unwilling homebody, afraid to leave the house and risk putting myself in a situation where I won't have easy access to a restroom," Morgan said. "For me, this bill represents freedom from worry, freedom to go the places I want to go, and freedom to do the things a teenager should be doing in her free time."

Rep. Paradee said he is proud to take up this cause on behalf of Morgan and her family, who have become true ambassadors for Crohn's and colitis awareness.

"As a parent, I can imagine how terrible it must feel to know your child is suffering from a serious disease and, in some situations, may not be able to make it to a restroom when necessary," said Rep. Paradee, D-Dover West. "People with Crohn's and other similar conditions, as well as their families, deserve some peace of mind, compassion and dignity when it comes to their medical needs."

Sen. Hall-Long said she understands the need for this legislation given the seriousness of conditions like Crohn's and ulcerative colitis.

"As a nurse, I know the symptoms of these conditions can strike at any time and often without warning," said Sen. Hall-Long, D-Middletown. "It's our duty as legislators to promote the health and wellbeing of our constituents, and this is a situation where we can educate and work with businesses owners of their role in assisting potential patrons or those in need."

Morgan's mother Amy said the Burnetts don't go anywhere unless they know there will be access to a restroom, but House Bill 245 would take that burden away.

"Constantly checking for a nearby bathroom is a terrible obsession to have," she said. "This legislation, if it becomes law, will make our lives and the lives of so many other families dealing with Crohn's just a little bit easier."

Inflammatory bowel diseases, such as Crohn's, affect thousands of people of all ages. Symptoms of the conditions include persistent diarrhea, cramps and abdominal pain, and the urgent need to move the bowels. Often, these symptoms are sudden and unexpected, following long periods when the person has experienced no symptoms at all.

The restroom access provisions would apply to people with "Crohn's disease or ulcerative colitis, celiac disease, any other inflammatory bowel disease, irritable bowel syndrome, or any other medical condition that requires immediate access to a restroom facility," as defined in the bill. It would also cover people using ostomy devices.

The measure would allow businesses to ask a customer requesting restroom access to show documentation of his or her medical condition, either in the form a doctor's note or an identification card issued by a nationally-recognized health organization or health department. The rules would apply only to retail businesses during their regular hours of operation, when at least two employees are on duty, and when no public restrooms are present. Businesses also would not be required to make any changes or upgrades to restrooms that are not normally accessible to the public.

Thirteen states have similar statutes granting access to non-public restrooms for medical reasons, including Connecticut, Illinois, Kentucky, Massachusetts, Texas and Washington. Many of those laws also offer protections to businesses and allow them to ask for documented proof of an eligible condition. These statutes are often referred to as "Ally's Law" in honor of Allyson Bain, an Illinois teen who was denied access to an employee-only restroom when her IBD-related symptoms struck. She spearheaded the drafting and passage of the legislation in her home state.

House Bill 245 is scheduled to be included in Thursday's House prefile. It currently has seven cosponsors in the General Assembly.

###

147TH GENERAL ASSEMBLY

FISCAL NOTE

BILL:	HOUSE BILL NO. 249
SPONSOR:	Representative Ramone
DESCRIPTION:	AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO CARDIOPULMONARY RESUSCITATION EDUCATION.

ASSUMPTIONS:

1. Effective upon signature of the Governor.

2. This bill requires Delaware students in public and non-public schools to learn CPR to be granted a high school diploma from a Delaware high school beginning with the Class of 2017 (current year freshman).

3. The American Heart Association produces CPR in Schools Training Kits that can be used to meet the requirements of the legislation at a cost of $599/per kit. The kits can serve 10 students at a time where each manikin can withstand a maximum of 300,000 compressions lasting at least 3 years.

4. Public schools with an enrollment of 200 students or greater are assumed to receive 2 CPR kits while public schools with an enrollment of less than 200 students are assumed to receive 1 CPR kit. Non-public schools are not included in the estimated cost given the legislation is unclear whether they should receive state support to implement the training.

	Total 9th Grade Enrollment	**# of CPR kits for schools with greater than 200 students**	**# of CPR kits for schools with less than 200 students**	**Total # of CPR Kits**
Public Schools	9,755	52 (26 schools)	13 (13 schools)	65 (39 schools)

5. Based on feedback from the American Heart Association, costs may be minimized if public schools are able to work with local emergency medical service agencies, health care providers, and other organizations to obtain loaned equipment.

Cost:

Fiscal Year 2015:	$38,935
Fiscal Year 2016:	$0
Fiscal Year 2017:	$0

Office of Controller General
March 20, 2014
MJ:MJ
0271470016

(Amounts are shown in whole dollars)

147TH GENERAL ASSEMBLY

FISCAL NOTE

BILL:	HOUSE BILL NO. 263
SPONSOR:	Representative Jaques
DESCRIPTION:	AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO SCHOOL NURSES.

ASSUMPTIONS:

1. Effective upon signature of the Governor.

2. Delaware Code requires at least one school nurse per facility where state funding is provided at a rate equal to 1 nurse for each 40 state units of pupils. School districts and charter schools also qualify for partial funding for nurses at the rate of 30% of the fractional part of 40 state units of pupils. This formula does not sufficiently provide the full state share of funding to support at least one school nurse per facility, and when this occurs, districts are directed to meet the requirement through discretionary local operating funds or state equalization or academic excellence funds.

3. This legislation will provide the appropriate state share of funding for school districts and charter schools when the existing state funding formula does not provide for the requirement of one school nurse per facility. School districts that receive such state funding will be able to provide the local funding through the match tax pursuant to 14 Del. C. §1902(b).

4. This legislation will generate an additional 17.73 state units of funding for nurses at an average state share of salary of $41,835 and an average local share of salary of $24,268. Other employment costs are equal to 30.44% and health insurance costs at $11,400 per employee.

5. Overall salary and employment costs are assumed to grow 3% annually.

Cost:

	State Share	**Local Share**
Fiscal Year 2015:	$1,169,647	$561,243
Fiscal Year 2016:	$1,204,737	$578,080
Fiscal Year 2017:	$1,240,880	$595,423

(Amounts are shown in whole dollars)

Office of Controller General
March 19, 2014
MJ:MJ
0271470015

§ 1310 Salary schedules for school nurses.

(a) All nurses who hold appropriate certificates shall be paid in accordance with § 1305 of this title effective July 1, 1979.

(b) A reorganized school district may employ personnel to be paid for 10 months per year from state funds pursuant to this section in a number equal to 1 for each 40 state units of pupils, except that in schools for the physically handicapped within the district the allocation shall be in accordance with the rules and regulations adopted by the Department with the approval of the State Board of Education; provided further, that each reorganized school district shall ensure that it has at least 1 school nurse per facility. To the extent that the funding formula outlined above does not provide for 1 school nurse per facility, each reorganized school district shall meet this requirement out of funding provided under § 1707 or § 1716 of the title, or out of discretionary local current operating expense funds. Districts shall qualify for partial funding at the rate of 30% of the fractional part of 40 state units of pupils.

46 Del. Laws, c. 48, § 3; 47 Del. Laws, c. 195, § 1; 48 Del. Laws, Sp. Sess., c. 489, § 3; 14 Del. C. 1953, § 1310; 50 Del. Laws, c. 261, § 4; 50 Del. Laws, c. 602, § 1; 52 Del. Laws, c. 344, § 8; 54 Del. Laws, c. 43, § 6; 55 Del. Laws, c. 409, § 4; 56 Del. Laws, c. 143, § 3; 56 Del. Laws, c. 292, § 13; 56 Del. Laws, c. 470, § 3; 57 Del. Laws, c. 333, § 8; 58 Del. Laws, c. 189, § 3; 58 Del. Laws, c. 305, §§ 3, 8, 9; 58 Del. Laws, c. 553; 59 Del. Laws, c. 34; 60 Del. Laws, c. 31, § 1; 61 Del. Laws, c. 407, § 3; 61 Del. Laws, c. 409, § 106; 62 Del. Laws, c. 36, § 1; 62 Del. Laws, c. 68, §§ 42(e), 105; 62 Del. Laws, c. 86, § 39; 70 Del. Laws, c. 118, § 317; 70 Del. Laws, c. 210, § 90; 70 Del. Laws, c. 290, §§ 38, 39; 71 Del. Laws, c. 180, § 68; 75 Del. Laws, c. 350, § 382.;

Gov signed
7-9-81

SPONSOR: Sens. Sharp, McDowell, Zimmerman, Vaughn, Hughes, Citro; Reps. Riddagh

DELAWARE STATE SENATE

131ST GENERAL ASSEMBLY

JUL 9 1981 63 133

SENATE BILL NO. 247 MAY 19 1981

AN ACT TO AMEND SECTION 925, TITLE 10, DELAWARE CODE, GIVING FAMILY COURT CONCURRENT JURISDICTION WITH THE COURT OF CHANCERY TO APPOINT GUARDIANS OF THE PERSON OVER MINORS UNDER 18 YEARS OF AGE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Section 925, Title 10, Delaware Code, by adding a subsection (16) thereto, to read as follows:

"(16) To appoint guardians of the person over minors under 18 years of age."

SYNOPSIS

This act gives Family Court concurrent authority to appoint guardians of the person over minors under 18 years of age with the Court of Chancery. Author - Sen. Sharp

Attachment "A"

LC/X/RAW
4163A

EFiled: Jul 31 2012 2:22PM EDT
Transaction ID [redacted]
Case No. GM[redacted]-VCN

COURT OF CHANCERY
OF THE
STATE OF DELAWARE

JOHN W. NOBLE
VICE CHANCELLOR

417 SOUTH STATE STREET
DOVER, DELAWARE 19901
TELEPHONE: (302) 739-4397

July 31, 2012

Suzanne I. Seubert, Esquire
Suzanne I. Seubert, P.A.
1328 King Street
Wilmington, DE 19801

Lexie S. McFassel, Esquire
Office of the Public Guardian
100 Sunnyside Road
Smyrna, DE 19977

Re: *IMO* [redacted]
C.M. No. [redacted]-VCN
Date Submitted: April 9, 2012

Dear Counsel:

The Office of Public Guardian ("OPG") was appointed guardian of the person of [redacted] in 2007. Ms. [redacted] has petitioned for termination of the guardianship.[1] This Letter Opinion sets forth the Court's post-trial findings of fact and conclusions of law.[2]

[1] Ms. Seubert has volunteered her services on Ms. [redacted] behalf. The Court appreciates her contributions.

[2] The question is whether Ms. [redacted] needs a guardian for her person. There is no room for doubt that OPG is an appropriate guardian for her, if she, indeed, does need a guardian.

* * *

Ms. [redacted] in her late 20s, suffers from Type 1 diabetes and end-stage renal failure.[3] She resides at the [redacted] where she receives sustained professional medical care. OPG was appointed her guardian shortly after a hypoglycemic episode that resulted in a coma. Her inability, at the time, to understand the risks and consequences of failing to manage her significant health problems formed the basis for OPG's appointment. In the interim, she has gained a better understanding of the potential outcome of a gap of attention to her sugar levels. She states that her death might be an outcome. She also has made progress in learning how to manage her blood sugar levels, including the effects and importance of diet.

There is no doubt, at least for now, that Ms. [redacted] requires essentially full-time access to medical care that is most readily obtained in a residential setting, such as that at [redacted]. OPG has sought alternate living arrangements for her; that has been an effort without success. Thus, [redacted] appears to be the only viable care option for Ms. [redacted] At the core of the debate is the all-too-facilely phrased

[3] Ms. [redacted]'s cognitive function falls within the extremely low range of the adult population her age, and her abstract thinking skills are quite limited.

question: should Ms. [redacted] be at [redacted] as a matter of her own desire or as the result of a decision by a court-appointed guardian, such as OPG? In terms of day-to-day living, the answer may not seem, for some, to make much difference, but an individual's right to decide questions of this nature is an important and fundamental one both for the individual and for our society. The question is a significant one, not only at the individual, personal level, but also at the more abstract level of an individual's freedom of choice within a specific societal context.

* * *

The source of this Court's authority to appoint guardians of the person for adults is found in statute:[4]

> The Court of Chancery shall have the power to appoint guardians for the person . . . of any disabled person . . . . "Disabled person" means any person who: . . . [b]y reason or mental of physical incapacity is unable properly to . . . care for their own person . . . and, in consequence thereof, . . . such person is in danger of substantially endangering [the] person's own health, . . .[5]

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[4] *Severns v. Wilmington Medical Ctr., Inc.*, 421 A.2d 1334 (Del. 1980).
[5] 12 *Del. C.* § 3901(a)(2).

Appointing a guardian of the person deprives that person of some of our society's most fundamental individual rights—where we live; what we eat; and what we do. In Ms. [redacted]'s case, the OPG placed her at [redacted] in what may be considered a custodial care arrangement. That arrangement may be—and likely is—in her best interest, but it still deprives her of freedom of choice. The placement not only prevents her from choosing where to live, but it also subjects her to [redacted]'s internal operating rules—such as phone access, who can visit, and the like.

Most states recognize the consequences that result from the appointment of a guardian and have responded by imposing, through statute, a clear and convincing evidentiary standard.[6] Delaware's statutory scheme for adult guardianships does not prescribe any particular standard, and there are cases which have applied a preponderance of the evidence standard.[7] Because of the fundamental liberty interests at stake, the standard applicable to protecting those interests naturally has

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[6] Sally Balch Hurme and ABA Comm'n. on Law and Aging. *Conduct and Findings of Guardianship Proceedings* (2012), *available at* http://www.americanbar.org/content/dam/aba/uncategorized/2012_aging_gship_chrt_conduct_06_12.authcheckdam.pdf.

[7] *See, e.g., In re Snow*, 2006 WL 223598 (Del. Ch. Jan 17, 2006); *Brittingham v. Robertson*, 280 A.2d 741 (Del. Ch. 1971); *In re Conner*, 226 A.2d 126 (Del. Ch. 1967).

constitutional overtones.[8] The United States Supreme Court has taught that, for a wide range of government actions limiting personal choice, the proper standard is clear and convincing. These personal interests include parental rights, civil commitment, deportation, and denaturalization.[9] The appointment of a guardian falls in line with the circumstances of these examples. Indeed, the limitations on individual rights may be more serious when a guardian is appointed.[10] Thus, the

[8] The earlier Delaware cases dealing with the appointment of a guardian did not develop any analysis to support the selection of any particular standard of proof.

[9] *See Santosky v. Kramer*, 455 U.S. 745, 747-48 (1982) ("Before a State may sever completely and irrevocably the rights of parents in their natural child, due process requires that the State support its allegations by at least clear and convincing evidence."); *Addington v. Texas*, 441 U.S. 418, 424 (1979) ("We noted earlier that the trial court employed the standard of 'clear, unequivocal and convincing' evidence in appellant's [civil] commitment hearing before a jury. That instruction was constitutionally adequate. However, determination of the precise burden equal to or greater than the 'clear and convincing' standard which we hold is required to meet due process guarantees is a matter of state law which we leave to the Texas Supreme Court."); *Woodby v. INS*, 385 U.S. 276, 286 (1966) ("We hold that no deportation order may be entered unless it is found by clear, unequivocal, and convincing evidence that the facts alleged as grounds for deportation are true."); *Chaunt v. United States*, 364 U.S. 350, 353 (1960) ("[I]n view of the grave consequences to the citizen, naturalization decrees are not lightly to be set aside-the evidence must indeed be 'clear, unequivocal, and convincing' and not leave 'the issue in doubt.'") (citations omitted).

[10] Some states have gone so far as to require proof beyond a reasonable doubt for the appointment of a guardian. *See* Hume, *supra* note 6. *See also In re Kapitula*, 889 A.2d 250, 253 (N.H. 2006) ("The probate court may appoint a guardian over the person if it makes the findings set forth in paragraph III(a) through (d). These findings must be in the record, and must have been based upon evidence supporting them beyond a reasonable doubt.").

OPG must demonstrate by clear and convincing evidence that Ms. [redacted] continues to need a guardian of her person.[11]

* * *

[redacted], M.D., a psychiatrist whose practice focuses on a patient's capacity to understand and to consent to a course of treatment, evaluated Ms. [redacted] and concluded that she could, and thus should be allowed to, make her own decisions. Dr. [redacted] acknowledged Ms. [redacted]'s low cognitive skills, but his conversations with her and her score of 28 on the mini-mental status exam, persuaded him that she has the capacity to deal with her difficult medical issues.[12] After five years at [redacted], Ms. [redacted] has learned about her medical problems and she has come to understand the appropriate strategies for addressing them. Dr. [redacted] pointed out that noncompliance with medical instructions is common in more than half of seriously ill patients, most of whom would pass any mental capacity assessment. He conceded that Ms. [redacted]'s fragile condition increased

[11] Thus, although Ms. [redacted] is the moving party in terms of seeking termination of the guardianship, the burden is on OPG to demonstrate that continuing the guardianship is proper.

[12] The mini-mental status exam is a standard tool for screening cognitive impairment. A perfect score is 30. Both in 2007 when OPG was appointed her guardian (25) and more recently (28), [redacted] score would support her claim to understand her circumstances appropriately. The mini-mental status exam, however, is not dispositive. It is one factor guiding the diagnostic process.

the risks associated with noncompliance, but he maintained that a guardianship was not necessary to minimize those risks. [redacted] houses voluntary patients as well, and remaining at [redacted] would be an option for Ms. [redacted].

[redacted], a social worker at [redacted], provides care management services to Ms. [redacted]. She has observed Ms. [redacted]'s efforts to monitor and to learn more about her diabetes. She also has helped Ms. [redacted] with paperwork for a possible kidney/pancreas transplant.[13] Ms. [redacted] reports that Ms. [redacted] is very social, helps other [redacted] residents, and meets her own personal care needs. It is obvious to Ms. [redacted] that Ms. [redacted] does not want to be at [redacted]; she wants to live the life of a typical 29-year old. Yet, Ms. [redacted] has told Ms. [redacted] that she would remain at [redacted] until her sugar levels could be stabilized.

[redacted], M.D. is Ms. [redacted]'s treating physician at [redacted], a role that gives him the benefit of repetitive contact with her and allows him the opportunity to assess her strengths and weaknesses over time.[14] He emphasized that her very brittle case of Type 1 diabetes requires incessant care,

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[13] OPG is generally supportive of the effort, but there are numerous issues to resolve as part of the process.

[14] At the time of trial, he had only been her treating physician for a period of approximately three months.

involving the constant evaluation of her blood sugars, especially because she is very sensitive to insulin. In his forty years of practice, Dr. [redacted] has never seen a patient with the fluctuations that Ms. [redacted] has experienced in her blood sugars—a range from 27 mg/dl to above 600 mg/dl.[15] His concerns include anoxic encephalatrophy which can result from low or high blood sugars at the levels Ms. [redacted] has reached. Brain damage—or worse—may result.

Dr. [redacted] holds the opinion that Ms. [redacted] is not ready to be in the community free from protection and supervision of a guardian. At the core of his worries are doubts about Ms. [redacted] capacity to control herself and her understandable, but counterproductive, desires. There certainly are times when she follows medical recommendations, but there is not the regular compliance that would be essential to her health if she were acting independently. Noncompliance is the term that Dr. [redacted] used to describe her general reaction to important medical guidance. Because she is not adherent to those instructions, there is a sizable risk that her actions will result in a situation of dangerous consequences. It is not merely a matter of compliance; there is also genuine doubt about Ms.

[15] The normal range is between 70 mg/dl and 110 mg/dl.

[redacted]'s capacity to make the right judgment. Dr. [redacted]'s ultimate judgment—and one that is difficult to disagree with—is that she is not fit to make decisions about her medical condition that will lead her to act in an appropriate way to salvage her life.

Although Dr. [redacted] and Dr. [redacted] come to different conclusions as to whether Ms. [redacted] is able to be responsible for her health care issues, their views are not that far apart. Dr. Pereira-Ogan is keenly aware of the unique problems that arise from the confluence of Ms. [redacted] limited capacity and her pernicious disease. Dr. Padmalingam is sensitive to a guardian's impingement on individual decision making when it comes to health care. They—like the Court—were ultimately required to balance difficult and conflicting considerations.

* * *

Ms. [redacted] has, more or less, mastered the ability to say some of the right things. She acknowledges the need to watch diet, to monitor blood sugars, and to react appropriately. She also can tell of the potential adverse consequences if she does not take proper care of herself. Being able to talk about these topics,

however, does not show that she really appreciates what is going on or that she has the capacity and understanding to live as she must in order to survive. Her desire to live a "normal" life is readily understood[16]; it is skepticism about her ability to withstand the temptation to do so—with all of its adverse consequences for her in light of her medical conditions—that persuades the Court, by clear and convincing evidence, that a guardian is necessary.

It is not her health and the difficult challenges that it presents that alone justify the need for a guardian. It is not merely a matter of the doubt about her appreciation and understanding of the potential consequences that might result from a slight deviation away from the necessary, but narrow, path of maintenance. It is not only the experiential history which, when she has been unsupervised, has resulted in conduct leading to extremely dangerous circumstances and where, with the benefit of a guardian—and, perhaps more importantly, institutional assistance—her condition has remained stable. It is the confluence of all these factors—as unusual and extreme as they are—that compels the conclusion that she currently lacks the capacity to take the necessary and, undoubtedly, burdensome

[16] *See* Aff. of [redacted], Ph.D. ¶:5 ("A major issue for [redacted] has been managing disappointments, frustrations and accepting the restrictions that apply to diabetic patients or other residents at [redacted] and those set by her guardian.").

steps to protect her fragile health. Perhaps these circumstances will change with time, and she can be relieved of the limitations inevitably associated with a Court-appointed guardian. That time, based on the trial evidence, has, unfortunately, not yet arrived. OPG has demonstrated by clear and convincing evidence that a guardian of the person is necessary for the care of Ms. [redacted] person.[17] Otherwise, her minimal mental capacity would impair her ability to care for herself and place her at risk of substantially endangering her health.[18]

* * *

Ms. [redacted] application for termination of the guardianship must be denied. OPG will continue as guardian of her person.[19]

IT IS SO ORDERED.

Very truly yours,

/s/ John W. Noble

JWN/cap
cc: Register in Chancery-K

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[17] Ms. [redacted] life has been difficult in ways extending well beyond her health. It does not appear that she has family or friends who can be counted on to help to provide the support that she needs to deal with her serious medical issues.

[18] In short, the Court accepts Dr. [redacted]'s testimony, and, for that and other reasons, finds that Ms. [redacted] is a disabled person within the meaning of 12 *Del. C.* § 3901(a).

[19] The Court is not persuaded that it would be practicable or beneficial to attempt to restrict (or to set special rules to guide) the guardian.

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
UGPPA	305(a), 405(a) Shall set a date and time for hearing	308(a), 408(a) May be held in location convenient to respondent	308(a), 408(a) Respondent and proposed guardian or conservator shall appear unless excused for good cause	*Not stated*	311(a)(1) Clear & convincing 409(b) A basis exists	311(a)(1) Is incapacitated person, needs cannot be met by less restrictive means 409(b) A basis exists for conservatorship, make least restrictive order consistent with findings	311(b) Make orders necessitated by limitations and needs, that encourage self reliance and independence 409(b) Make orders necessitated by limitations and needs, that encourage self reliance and independence
Alabama:	26-2A-135(b) Court set hearing date when petition filed 26-2A-102	*Not stated*	26-2A-102(c) Entitled to be present	26-2A-35 Entitled to jury trial 26-2A-102(c) Trial by jury, upon demand	*Not stated*	26-2A-105(a) Court authority only to extent necessitated by condition or limitations	26-2A-154 26-2A-136 26-2A-144
Alaska: Statute	13.26.106 (a) Conducted within 120 days from filing the petition	*Not stated*	13.26.113(a)(5) Unless disruptive	13.26.113(a)(6) Entitled to jury trial	13.26.113 (b) Clear & convincing	13.26.090 Used only as is necessary	13.26.116
Arizona: Rev. Stat. Ann.	14-5303 Upon filing petition, court shall set hearing date	*Not stated*	14-5303(C) Entitled to be present	14-5303(C) Entitled to jury trial	14-5304(A) Clear & convincing	14-5304(B) Appointment is necessary & needs cannot be met by less restrictive means including technological assistance	14-5312(A) Statutory powers unless modified by court 14-5304(C) May appoint limited guardian & specify time limits & limits on powers

Attachment "C"

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Arkansas: Code Ann.	28-65-213(a)	*Not stated*	28-65-211(b)(3) May require presence in court 28-65-213(a)(5) Right to attend	*Not stated*	28-65-213(b) Clear & convincing	28-65-105 Ordered only to extent necessitated by individual's limitations	28-65-105 28-65-106 Ward retains all rights except those expressly granted to guardian
California: Prob. Code	1822 Set at least 15 days before the hearing	*Not stated*	1825(a) Present except medical inability 1823(b)(5) Right to attend	1827 If demanded	1801(e) Clear & convincing	*Not stated*	2351 Court discretion to limit 1801 For developmentally disabled
Colorado: Rev. Stat. Ann.	15-14-308	*Not stated*	15-14-308(1) Shall attend unless good cause	15-14-303(4) On written demand	15-14-311(1) Clear & convincing	15-14-311(1) Court make appointment only to extent necessitated by condition or limitation; no less restrictive means	15-14-311 Shall consider least restrictive alternative; may limit powers

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Connecticut: Gen. Stat. Ann.	45a-649 45a-650	45a-649(e) May hold at place that would facilitate attendance by respondent	45a-650(a) Right to attend	*Not stated*	45a-650(f)(1), (2) Clear & convincing	45a-650(f)(1) Incapable of managing affairs, cannot be managed without appointment, appointment is least restrictive 45a-650(f)(2) Incapable of caring for self, cannot be cared for adequately without appointment, appointment is least restrictive 45a-650(g) Comprehensive list of factors court must consider	33-15-4 Shall clearly indicate scope of powers and duties; certificate shall clearly state is limited
Delaware: Code Ann. tit. 12	12 3901(c)	*Not stated*	*Not stated*	*Not stated*	*Not stated*	*Not stated*	12 3922 To extent court may direct
District of Columbia: Code Ann.	21-2054 (a)	*Not stated*	21-2041(h) Unless good cause shown		21-2003 Clear & convincing	21-2044(b) Appointment necessary for care & supervision	21-2047(b)(6) 21-2072
Florida: Stat. Ann.	744.331(4)	*Not stated*	744.331(5) (b) Waived for good cause	*Not stated*	744.331(6) Clear & convincing	744.331(6)(a) Nature and scope of capacities, areas lack capacity, specific legal disabilities, specific rights incapable of exercising and if alternative	744.3215(1) 744.334(2)

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Georgia: Code Ann.	29-4-12	29-4-12(d) Courtroom or where the judge may choose	29-4-12(d) May be waived for good cause	*Not stated*	29-4-12(d) Clear & convincing	29-4-1(c) Determination that LRA not available or appropriate	29-4-12(d) List powers to be retained 29-4-13(3) Limits in order 29-4-20(6) Right to least restrictive assistance
Hawaii: Rev. Stat.	560:5-308 Guardian shall attend	560:5-308, -408 Convenient, closed if requested	560:5-308 Shall attend and participate unless excluded 560:5-408 shall attend and participate unless excused for good cause	*Not stated*	560:5-311(a) Clear & convincing 560:5-401(2) Clear & convincing that unable to manage and preponderance that be wasted unless managed by conservator	560:5-311(a), - Needs not met by least restrictive alternative 560:5-401 Property be wasted unless managed	560:5-311 Shall grant only what necessitated by ward's limitations and needs, encourage maximum self-reliance and independence
Idaho: Code	15-5-303(b)	*Not stated*	15-5-303(c) Required unless good cause	15-5-307 For removal of guardian	15-5-304 (b) If court satisfied	15-5-304(a) Court shall appoint only to extent necessitated by condition and limitations	15-5-426 15-5-408 15-5-304 To extent necessary
Illinois: 75/5 Ill. Comp Stat.	5/11a-10(a)	*Not stated*	5/11a-11(a) unless respondent refuses	5/11a-11(a)	5/11a-3(a) Clear & convincing	5/11a-12(b) If respondent lacks some but not all capacity and court finds guardianship necessary for protection or person or estate, the court may appoint a limited guardian	5/11a-12(b) Court shall appoint a limited guardian and specify duties and powers of the guardian and the legal disabilities of the disabled person

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Indiana: Code Ann.	29-3-5-19 (c)	*Not stated*	29-3-5-1(d) 29-3-5-1(d) Impossible, impractical, threat to health, safety	29-3-5-1(e) If requested	*Not stated*	29-3-5-3(a)(2) Providing care & supervision	29-3-5-3(b) 29-3-7-3(c) 29-3-8-8 29-3-5-1 Community volunteer advocate for 55+ for 60 days max. 29-3-5-3 Can represent and protect interests, gather information, facilitate care, advocate for rights 29-3-8-5—9 No medical decisions if spouse, other surrogate available
Iowa: Code Ann.	*Not stated*	*Not stated*	633.561(2) Right to be present	633.555 IF demanded	633.551(1) Clear & convincing	*Not stated*	633.551(A) 633.556(2) 633.635(3)
Kansas: Rev. Stat. Ann.	59-3063(a)(1) Trial in as informal a manner as consistent with orderly procedure	59-3063(a)(1) Courtroom, treatment facility or other suitable place	59-3063(a)(2) Required to appear unless injurious to health or welfare or could not meaningfully participate or waived	59-3066(a)(8) &(9); 59-3067(b) & (c) Right to demand	59-3067(e) Clear & convincing	59-3067(e) Court must find need for guardian, conservator, or both	59-3075 Guardian exercise authority as necessitated by ward's limitations; 59-3075 Guardianship plan
Kentucky: Rev. Stat. Ann.	387.550	*Not stated*	387.570(3) Waived only if serious risk of harm	387.570(1) Mandatory	387.570(5) Clear & convincing	*Not stated*	387.500

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Louisiana: Civ. Code Ann.; Code Civ. Pro.; Rev. Stat. Ann.	CCP Art. 4547	CCP 4547 Judge may hold hearing where respondent located	CCP 4547 Right to be present. Court shall not conduct hearing in absence unless good cause.	*Not stated*	CCP 4548 Clear & convincing	389 Interests cannot be protected by less restrictive means	390; 455 1(B); Only powers necessitated CCP 4541 Petition names powers sought to be removed
Maine: Me. Rev. Stat. Ann. tit. 18	18-A 5-303(b)	*Not stated*	18-A 5-303(c) entitled to be present, see and hear all evidence 18-A 5-304(b)(2) If individual does not appear, court must determine if inquiry was made as to whether individual wished to appear	*Not stated*	18-A 5-304(b) Clear & convincing	18-A 5-304(a) Court shall appoint only if necessitated by limitations or condition	18-A 5-105 18-A 5-408 18-A 3-304 (a)
Maryland: Code Ann., Est. & Trusts; MD Rules	R77(b)(2)	*Not stated*	13-705(c) At ward's option	13-705(e) Ward's option in guardianship 13-211 No jury trial in protective proceedings	13-705 Clear & convincing	13-705(b) No less restrictive form is available	13-708(a) As necessary
Massachusetts; Gen. Laws ch. 190B	*Not stated*	*Not stated*	5-106(c) Entitled to be present at any proceeding	*Not stated*	*Not stated*	5-306(b) That guardianship is desirable to provide care and supervision and needs not met by lesser restrictive alternative	5-306(c) May limit powers granted

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Michigan: Comp. Laws Ann.	700.5303a 700.5406	700.5306a(1)(b) 700.5406(5) Conduct hearing were present	700.5304(4) 700.5406(5) Entitled to be present	700.5304(5) 700.5406(5) Entitled to jury	700.5306(1) 700.5406(7) Clear & convincing	700.5306 (1) If necessary for providing care & supervision	700.5306 700.5407 Only those powers necessary, encourage self-reliance, shall specify powers and time limit
Minnesota: Stat. Ann.	524.5-307(a) & 408(a)	524.5-307(a) & 408(a) Location convenient to respondent	524.5-307(a) & 408(a) Shall attend & participate unless excused for good cause	*Not stated*	524.5-310(a) & 409(a) Clear & convincing; 409(a)(2) Preponderance that resources be wasted or dissipated or needed for support, care	524.5-310(a) Needs cannot be met by least restrictive alternative	524.5-310(a) Llimited or not; 310(c); 409(c) Only power necessitated by demonstrated need & encourage self-reliance; retain rights not specifically granted
Mississippi: Code Ann.	93-13-121	*Not stated*	*Not stated*	*Not stated*	*Not stated*	*Not stated*	93-13-38 Court has power as over executor
Missouri: Ann. Stat.	475.075.1	*Not stated*	475.075(8) Right to be present	475.075(8)(2) Right to jury	475.075.7 Clear & convincing	475.075(10) Shall apply least restrictive environment principle	*Not stated*
Montana: Code Ann.	72-5-315	*Not stated*	72-5-315(4) Entitled to be present	72-5-315(4) Entitled to jury	72-5-316(1) If court satisfied	72-5-316 Necessary to promote & protect wellbeing	72-5-320 72-5-430 72-5-321 72-5-306
Nebraska: Rev. Stat.	30-2619(b)	*Not stated*	30-2619(d) Entitled to be present	*Not stated*	30-2620 Clear & convincing	30-2620 Necessary or desirable as least restrictive alternative	

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Nevada: Rev. Stat	159.047	159.0535(2) Video conference if cannot attend and in state	159.0535(1) Must attend, unless physician or other qualified professional certifies condition & that cannot attend, if attendance be detrimental and if inform of rights	*Not stated*	159.055(1) Clear & convincing proof that guardianship necessary	159.055 Evidence sufficient & guardian should be appointed	159.054(2) Shall specify powers & duties if limited capacity
New Hampshire: Rev. Stat. Ann.	464-A:5	*Not stated*	464-A:8 Must be present unless excused under provisions of this chapter	*Not stated*	464-A:8IV Beyond reasonable doubt	464-A:1 Only to extent necessitated by individual's functional limits	464-A:1 464-A:9(III0(d) 464-A:25(II)
New Jersey: Stat. Ann.; N.J. Rules	3B:12-5	*Not stated*	3B:12-24.1(e) Shall appear unless plaintiff & ct. appointed attorney certify unable	3B:12-24 May be had without jury unless demanded by alleged incapacitated person	*Not stated*	*Not stated*	3B:12-24.1(b) Court can appoint limited guardian
New Mexico: Stat. Ann.	45-5-303(C)	45-5-303(G) At the location of alleged incapacitated person who is unable to appear in court	45-5-303(F) Shall be present at hearing	45-5-303(L) Upon request of petitioner or alleged incapacitated person	45-5-303(H) Clear & convincing	45-5-301.1 Only as necessary to promote and protect well being of the person	45-5-301.1 45-5-304(c) 45-5-312 45-5-303(A)(10)
New York: Mental Hyg. Law	81.11	81.11 At courthouse or where person resides	81.11 Hearing must be conducted in presence of person alleged to be incapacitated	81.07(e)	81.12 Clear & convincing	81.02 Least restrictive form of intervention	81.01

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
North Carolina: Gen. Stat.	35A-1112	*Not stated*	*Not stated*	35A-1110 Right, upon request	35A-1112(d) Clear, cogent & convincing	*Not stated*	35A-1212 Clerk may order limited guardianship; 35A-1215(b) Clerk my order that ward retain certain rights & privileges
North Dakota: Cent. Code	30.1-29-07(2) 30.1-28-03(3)	30.1-28-03(8) At any other location in best interest of proposed ward	30.1-28-03(7) Must be present unless good cause shown	*Not stated*	30.1-29-7(2)(b) Clear & convincing	30.1-28-04(1) Only to extent necessitated	
Ohio: Rev. Code Ann.	2111.02(c)	*Not stated*	2111.04(A)(2) Right to be present	*Not stated*	2111.02(c)(3) Clear & convincing	2111.02(c)(5) Evidence of least restrictive alternative may be introduced and considered	2111.02(B)(1) Limited guardian if in best interest
Oklahoma: Stat. Ann. tit. 30	30-3-109	30 1-116(A) At such place as court directs	30 3-106 Right to be present	*Not stated*	30-3-111 Clear & convincing	30 3-111(B) Court shall explain reasons not to impose less restrictive alternatives	30 3-111(B) Full or limited guardian.
Oregon: Rev. Stat.	125.080 On petition or motion if respondent objects	*Not stated*	125.080 May appear in person or by counsel	*Not stated*	125.305 Clear & convincing	125.300 As necessary to promote and protect well-being of protected person	125.305
Pennsylvania: Cons. Stat. Ann.	20-5511(a)	20-5511(a) May be held at residence	20-5511(a) Shall be present unless would harm proposed ward or out of state	20-5511(a) If requested	20-5511(a) Clear & convincing	*Not stated*	20-5502

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Rhode Island: Gen. Laws	33-15-5 Before probate judge of city where petition was filed	*Not stated*	33-15-5(1) Right to be present	*Not stated*	33-15-5(3) Clear & convincing	33-15-4 Not appoint if needs can be met with least restrictive alternative	33-15-4 Guardian makes decisions only in areas where person lacks capacity
South Carolina: Code Ann.	62-5-407(b) Upon receipt of petition, shall set date	*Not stated*	62-5-303(b) Entitled to be present	*Not stated*	62-5-304(B) If court satisfied that appointment necessary	62-5-304(A) Only to extent necessitated by mental and adaptive limitations	62-5-416 62-5-312
South Dakota: Codified Laws Ann.	29A-5-308 Within 60 days of filing and at least 14 days before hearing	29A-5-312 Convenient place as court determines	29A-5-312 Shall attend except for good cause	29A-5-308 Entitled to demand jury trial	29A-5-312 Clear & convincing	29A-5-312 Extent necessary to prevent neglect, abuse, or exploitation	29A-5-312
Tennessee: Code Ann.	34-3-106 Right to a hearing 34-1-108 More than 7, but less than 60 days after notice to respondent or GAL	*Not stated*	34-3-106(4) Right to attend	*Not stated*	34-1-126 Clear & convincing	34-1-127 Affirmative duty to impose least restrictive	34-3-107 Shall enumerate powers removed, retains all other powers

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
Texas: Prob. Code Ann.	685	652 May be held at any suitable location not likely to have harmful effect on respondent	685 Must be present unless ct deems not necessary on the record	643 Entitled on request in contested proceeding 685 Entitled on request	684 Clear & convincing	684 person is incapacitated, that in best interest to appoint G, and that rights or property be protected by appointing a guardian	693 May appoint full guardian if unable to care for self, manage property, vote, operate motor vehicle 693(b) If lacks capacity in some but not all areas, grant limited powers and permit respondent to care for self or manage property according to ability
Utah: Code Ann.	75-5-302	*Not stated*	75-5-303(4) Shall be present	75-5-303(4)	*Not stated*	75-5-304 Necessary or desirable	75-5-304(2) Limited guardian preferred
Vermont: Stat. Ann. tit. 14	14-3068	14-3068(b) Setting not likely to have harmful effect on mental and physical health	14-3068(a) may attend	*Not stated*	14-3068(f) Clear & convincing	14-3068(f) Respondent is in need of guardianship	14-3069
Virginia: Code Ann.	37.2-1004(A) Promptly set time and date	37.2-1007 Convenient place	37.2-1007 Entitled to be present	37.2-1007 Entitled upon request	37.2-1007 Clear & convincing	37.2-1007 Extent necessary for protection; ct. consider listed factors	37.2-1009 Nature and extent of powers
Washington: Rev. Code Ann.	11.88.030 Within 60 days of petition	11.88.040(4) May remove to place of residence	11.88.040(4) Shall be present	11.88.045(3)	11.88.045(3) Clear & convincing	11.88.005 Minimum extent necessary	11.88.010(2)

Conduct and Findings of Guardianship Proceedings
(As of statutory revisions December 31, 2012)

State	Hearing	Convenient Location	Presence in Court	Jury Trial	Standard of Proof	Required Findings	Tailored Order
West Virginia: Code	44A-2-9(a)	44A-2-9(b) At convenient place	44A-2-9(c) Shall not proceed without good cause affidavit	44A-2-9(c) Not entitled	44A-2-9 Clear & convincing	44A-2-10(c) Not beyond what is absolutely necessary	44A-2-11
Wisconsin: Stat. Ann.	54.44	54.42(6) Shall hold at place person may attend 54.44(3) By telephone	54.42(5) 54.44(3) 54.38(2)(a) Petitioner shall ensure attends unless GAL specifies reasons in writing	54.42(2) If demanded	54.10(3)(a) 54.44(2) Clear & convincing	54.46(1)(a) Find if incompetent or spendthrift; advance planning renders unnecessary	54.18 Only exercise powers as authorized by order; granted powers are necessary and are LRA
Wyoming: Stat.	3-1-205	*Not stated*	3-1-205 Be present at any hearing	3-2-103 May demand jury trial	3-2-104(a) Preponderance	3-2-104(b) Order states reasons guardian needed	3-1-206 Least restrictive & most appropriate order

147TH GENERAL ASSEMBLY

FISCAL NOTE

BILL:	HOUSE BILL NO. 256
SPONSOR:	Representative Heffernan
DESCRIPTION:	AN ACT TO AMEND TITLE 11 OF THE DELAWARE CODE RELATING TO THE OFFENSES OF SEXUAL SOLICITATION OF A CHILD AND PROMOTING SEXUAL SOLICITATION OF A CHILD.

ASSUMPTIONS:

1. This Act makes changes to the current Sexual Solicitation of a Child statute and increases the penalties when a solicitor meets or attempts to meet in person with a child.
2. The Statistical Analysis Center (SAC) has reviewed this Act for potential bed-space impact on the Department of Correction. Analyzing arrest and sentencing data, SAC estimates an impact is 3 DOC beds per year. Full bed impact will be realized within the first year of implementation.
3. The annual cost of housing a Level V inmate is approximately $8,000 for medical and food costs only. The total cost per bed is $36,000 when all costs, such as staffing and utilities, are included.
4. The annual cost (medical and food) for housing 3 inmates is $24,000. The total cost (including fixed costs, such as staffing and utilities) for 3 inmates is $108,000.
5. No inflation is assumed.

Cost:

Fiscal Year 2015	$24,000
Fiscal Year 2016	$24,000
Fiscal Year 2017	$24,000

Office of Controller General
March 21, 2014
en:en
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(Amounts are shown in whole dollars)

Bill to strengthen state's child predator laws introduced

Sean O'Sullivan, The News Journal *10:49 p.m. EDT March 17, 2014*

(Photo: GARY EMEIGH/THE NEWS JOURNAL)

A bill introduced in the General Assembly is set to strengthen the state's child sexual predator laws to make it easier to convict offenders and keep them in prison longer.

The measure, introduced last week by Kids Caucus co-chairs Rep. Debra Heffernan, D-Brandywine Hundred South, and Sen. Harris McDowell, D-Wilmington, would also fund a new investigator and a prosecutor in the attorney general's Child Predator Unit.

Heffernan said the proposals came from an October retreat with Delaware prosecutors about how to better protect kids online. "It used to be you only had to worry about them walking through the park alone, now they are online and they can be solicited when they are sitting in their room at home," she said.

The measure, HB-256, both updates the existing statute to include new forms of online communication and increases penalties for predators who attempt to meet with children after soliciting them online.

A key feature of the legislation, according to Deputy Attorney General Abigail Layton, is to take away the defense of "fantasy," where an alleged predator claims that their online solicitation was role-playing and that they never had any intention of following through on improper acts.

Layton said the state recently lost a child solicitation case in Kent County because the defendant made that very argument at trial and a jury acquitted him.

She said the proposed law makes clear that the act of sexually soliciting a child – whether or not the recipient is an actual child or an undercover officer – is a crime and no further overt action is required for a conviction.

Layton said the proposal seeks to raise the penalties if an alleged predator meets a child, they would face a mandatory two-year sentenceand up to 25 years in prison.

Under the current law, Layton said "travelers" face no additional punishment and some convicted "travelers" have been sentenced of probation.

Defense attorney Joe Hurley, who won the acquittal in the Kent County case, said if the state and prosecutors trust Delaware judges, then there is no need to increase the penalties and set a minimum mandatory sentence.

"No judge on the bench in Delaware would fail to recognize when someone ought to go to prison for two years for trying to mess with kids," he said, adding the proposed changes take discretion away from judges and further crowd state prisons.

Hurley said in the case where a man he represented was acquitted, the jury recognized from the evidence and testimony that the man had no intention of ever touching a child and was engaging in fantasy. Hurley said the undercover officer in the case, posing as an underage child, tried again and again to arrange a meeting with the man but the man repeatedly made excuses to call them off.

"Actions speak louder than words," Hurley said, adding the appropriate decision was reached by the jury.

"The whole thing is baloney," said Hurley, adding the changes smell of politics.

The other change seeks to clarify that online solicitation can involve any electronic communication through a number of devices, including phones, and is not limited to computers and email.

Heffernan said the bill has a good chance of passing. "I think that we will do whatever we can to make sure we can protect Delaware children," she said.

Sen. Greg Lavelle, R-Sharpley, said it is a difficult issue to be against "because to oppose it implies you are somehow for this activity."

Contact Sean O'Sullivan at (302) 324-2777 or sosullivan@delawareonline.com or on Twitter @SeanGOSullivan

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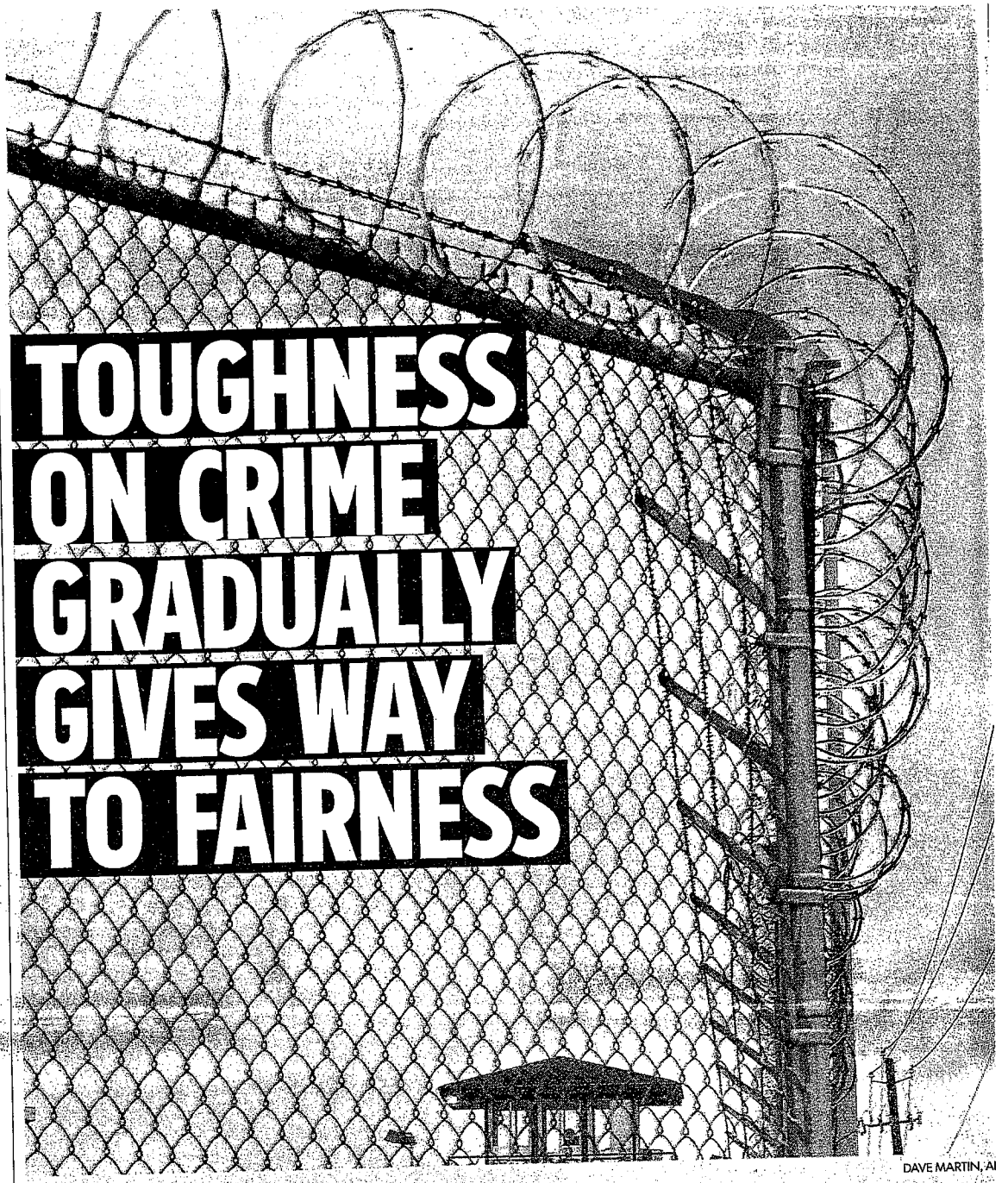


TOUGHNESS ON CRIME GRADUALLY GIVES WAY TO FAIRNESS

DAVE MARTIN, AI

Kevin Johnson
USA TODAY

Costly facilities to back law and order are being taken apart

WILTON, N.Y. For more than three decades, the only people who could appreciate the most dramatic views in Saratoga County near the mountain cottage where former president Ulysses S. Grant drew his last breath have been convicts and the uniformed officers who ensured their prisoners never strayed from the gated summit of Mount McGregor.

Few blinked at the idea of the state commandeering such prized real estate when Mount McGregor opened in 1981 as a medium-security state prison, a precursor to a corrections boom that lasted for nearly 20 years as New York's inmate population soared to 71,600 and punitive crime policies swept the nation.

"We could not build new prisons fast enough," acting New York Corrections Commissioner Anthony Annucci told state lawmakers last month, describing the chaotic period when offenders flooded the criminal justice system.

In recent weeks, busloads of McGregor inmates have taken the opposite route down the steep mountain road as part of an unprecedented prison exodus that is helping to permanently alter the face of the nation's criminal justice system. By July, when McGregor and three other state lockups close for good, New York will have shuttered 24 prison fa-

▷ STORY CONTINUES ON 2B

Support keeps eroding for hard-line justice

▶ CONTINUED FROM 1B

cilities since 2011.

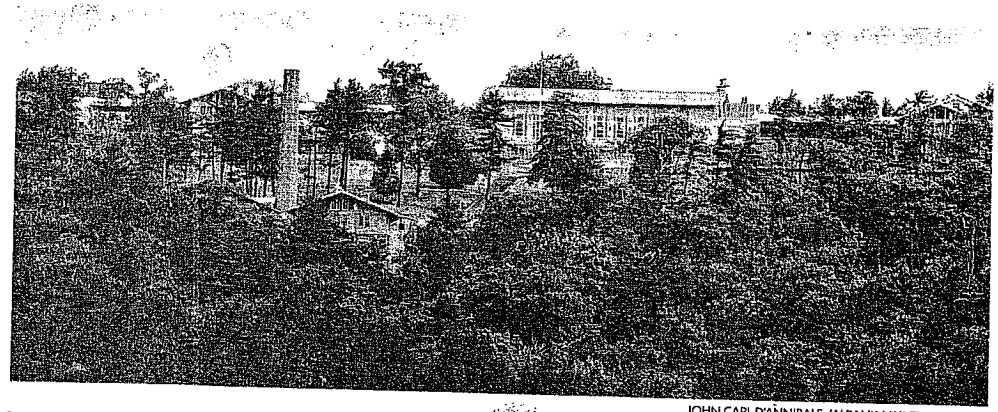
During that same time, 16 other states have either closed or proposed prison closings of their own in a bid to slice about 30,000 beds — more than the entire Ohio inmate population — from the vast penal system nationwide.

Prisons represent only one pillar of the costly justice system being dismantled or rolled back. Drug addicts, swept up en masse in the aftermath of New York's so-called Rockefeller Drug Laws of 1973 and the federal Anti-Drug Abuse Act of 1986, are being treated as medical patients rather than criminals. Marijuana, once regarded as the gateway substance in the drug war, is increasingly being decriminalized. Stiff sentences for repeat offenders, meted out in dozens of states, have been eased, as has the application of solitary confinement.

In perhaps the most symbolic development in this erosion of support for hard-line justice policies, six states have abolished the death penalty in the past seven years. It is a movement fueled in part by the exoneration since 2008 of 20 people who had been languishing on death row for crimes they did not commit. The latest one: Glenn Ford, freed this month after 30 years awaiting death at the Louisiana State Penitentiary at Angola.

What happened? Dwindling public resources jump-started a movement as stressed government budgets were unable to keep pace with the rates of prosecution and incarceration. It costs the U.S. about $80 billion per year to house more than 2 million in jails and prisons.

Lawmakers, criminal justice officials and analysts say there is a growing philosophical component to this seismic shift that is raising fundamental questions of fairness. The vanguard of the movement — which includes such unlikely partners as Sen. Rand Paul, R-Ky., and Sen. Patrick Leahy, D-Vt., — for the first time in a generation is collectively acknowledging that some of the most extreme punishment policies have largely failed.



JOHN CARL D'ANNIBALE, (ALBANY, N.Y.) TIMES UNION

Mount McGregor Correctional Facility is one of four New York prisons which will close in July.

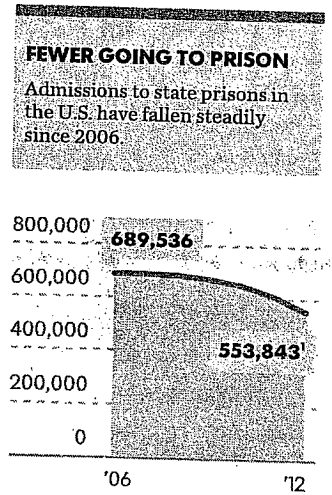
"If I told you that one out of three African-American males are still prevented from voting because of the 'war on drugs,' you might think I was talking about Jim Crow 50 years ago," Paul told a Senate panel last September, referring to long-standing voting bans for convicted felons, extending far beyond their release.

"There is something really profound going on," said David Kennedy, director of the Center for Crime Prevention and Control at John Jay College of Criminal Justice. "There is movement on mandatory minimums (sentencing), there is movement on solitary confinement, there is movement on the death penalty.

"What ties them all together," he said, "is the basic recognition that the application of power without justice is brutal. And there is nothing democratic about brutality."

NEW YORK CRACKDOWN

Perhaps no other state has had more time to consider the consequences of tough justice than New York. In an effort to counter growing drug abuse, the state launched a crackdown in 1973 that sent shivers throughout the nation. Named for then-Gov. Nelson Rockefeller, the Rockefeller laws set punishment for some simple drug possession offenses at 15 years to life in prison.



1 – Lowest number of admissions since 1997

Source Bureau of Justice Statistics

KARL GELLES, USA TODAY

The result was overwhelming as the state prison population surged beyond capacity. A generation of offenders was provided little hope of release.

New York has been unwinding the costly convergence of extreme penal policy ever since.

"This has been an evolutionary process," said Alphonso David, New York state's deputy secretary for civil rights. "People are now recognizing that the business of corrections is not really limited to incarceration."

Indeed, the state's prison population has been plummeting since 1999, dropping from 72,649 to 54,196 last year. The decline has been accelerated by a decline in violent crime, along with a continued emphasis on diverting non-violent drug and other low-risk offenders from the costly confines of prison to treatment or other outside supervision.

At the same time, state officials have pledged to restructure the use of solitary confinement, a form of extreme internal discipline used across the country.

In an agreement announced last month with the New York Civil Liberties Union, state authorities will remove juveniles, pregnant offenders and the mentally ill from isolation.

The settlement — reached after a class-action lawsuit brought by the NYCLU — makes New York the largest prison system in the nation to ban juveniles from disciplinary solitary confinement.

"New York is taking a substantial step in the right direction, and we hope it will ultimately join the many other states who have recognized that lengthy isolation sentences cause serious harm while accomplishing little, if any, goals of a rational corrections system," said Alexander Reinert, a Benjamin Cardozo School of Law professor who was part of the legal team that brought the lawsuit.

Reinert referred in part to Colorado, as well as the federal Bureau of Prisons, the nation's largest prison system, which is rethinking the use of solitary confinement.

Beyond the changes in penal philosophy, New York officials project that their actions will save huge amounts of money.

Thomas Abt, the state's deputy secretary for public safety, said New York will bank $221 million in savings a year from closing 24 prisons, including Mount McGregor.

NATIONAL FOCUS

Last summer, when he announced a plan to do away with mandatory minimum sentences that had condemned scores of non-violent offenders to lengthy federal prison terms, Attorney General Eric Holder brought a national focus to the debate about punitive criminal justice policies that had been largely playing out in state capitals.

Holder's entry into the national discussion thrust the issue to the top tier of the Justice agenda.

Last month, Holder continued the campaign of highlighting what he described as "unnecessarily punitive" policy when he called for the repeal of state laws that restrict the voting rights of millions of former inmates.

He cited the estimated 5.8 million Americans banned from voting because of felony convictions.

Holder is not the only high-profile figure calling attention to inequities, some them potentially deadly, in the justice system.

Washington Gov. Jay Inslee, a Democrat and former proponent of capital punishment, surprised some of his own supporters last month when he imposed a moratorium on executions. Last year, Maryland became the sixth state in as many years to abolish capital punishment.

"There have been too many doubts raised about capital punishment," Inslee said. "There are too many flaws in the system."