

## Report in Brief

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Report No. A-05-16-00022

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

Congress has expressed concerns about the safety and well-being of children in foster care. These issues were highlighted in a media report that provided several examples of children who died while in foster care. Additionally, for a recent audit, we conducted unannounced site visits at various children's group homes throughout Ohio. We found that some Ohio group homes did not always comply with foster care health and safety requirements.

Our objective was to determine whether Ohio ensured that children residing in foster care group homes received case management services designed to protect their health and safety under Title IV-E of the Social Security Act (the Act) and that caseworkers were qualified to provide care.

### How OIG Did This Review

Of the 1,206 children residing in group homes that received Title IV-E foster care funding during 2015, we reviewed a random sample of 75 children. We reviewed the children's case files and the associated caseworker personnel files at 30 county agencies in Ohio from March 27 through May 25, 2017.

## Ohio Did Not Always Comply With Requirements Related to the Case Management of Children in Foster Care

### What OIG Found

Ohio did not always comply with State requirements for maintaining documentation that Title IV-E-eligible children residing in group homes received required case management services and that case workers were qualified to provide those services. As a result, Ohio did not always have assurance that (1) caseworkers provided all the required case management services appropriate for each child, (2) caseworkers were qualified to provide those services, and (3) caseworkers received the required criminal records checks.

Specifically, we found that 37 of the 75 children in our sample were associated with 1 or more case management documentation deficiencies. Additionally, we found that 3 of the 75 children in our sample received services from caseworkers who had not received the required criminal records checks.

Without adequate documentation in the case files and caseworker personnel files, Ohio could not be assured that children received necessary case management services from qualified caseworkers. On the basis of our sample results, we estimated that 611 of the 1,206 Title IV-E-eligible children residing in group homes may not have received necessary case management services or that they may have received services from caseworkers who did not meet the requirements to provide care.

### What OIG Recommends and Ohio's Comments

We recommend that Ohio (1) ensure that the appropriate internal controls are in place for maintaining the required documentation in the case files to substantiate that children in foster care are receiving the necessary services, (2) improve controls to ensure that critical incidents involving children in foster care residing in group homes are reported timely to the county agencies, (3) ensure that the county agencies maintain the required documentation in the caseworkers' personnel files, and (4) implement controls to ensure that the appropriate criminal record checks are completed for the caseworkers upon hire and that the minimum training requirements are met and documented.

In written comments on our draft report, Ohio concurred with all of our recommendations and provided information on actions that it had taken or plans to take to address our recommendations.