The Child/Teen Health Program (CTHP) promotes the provision of early and periodic screening services (well care examinations), with diagnosis and treatment of any health problems identified during the conduct of well care, to Medicaid eligible children under 21 years of age.

CTHP promotes a model of care in which every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified and treated early in their course in order to improve outcomes and reduce the likelihood of disease, disability and hospitalization.

The local district is responsible to inform Medicaid recipients that their managed care plans are required to offer CTHP. The managed care plan is also required to explain to their Medicaid recipients that the CTHP is one of the benefits they are entitled to as a member of the particular managed care program. The plan is also required to explain whether or not transportation is part of the plan. If the plan does not provide transportation, transportation remains the local district's responsibility.

All Medicaid enrolled physicians, nurse practitioners, and certain clinics, are eligible to provide well care to Medicaid recipients ages birth through twenty years of age, so long as the well care is in accordance with the standards set forth in this Section. You are no longer required to enroll as a CTHP Provider in order to bill Medicaid for well child care.

The care standards and periodicity schedule herein are provided by the New York State Department of Health and generally follow recommendations by the Committee on Standards of Child Health, American Academy of Pediatrics.

The periodicity schedule provides a minimum basis for the conduct of well care examinations. It is recognized that medically necessary interperiodic screenings may be provided between periodic well care examinations.

It is expected that well care examinations will include all recommended components; however, it is recognized that the practitioner may exercise medical judgment concerning modification of the content of the examination in consideration of the needs of the individual child and more recent change in the current recommended standards of medical practice.

CTHP encourages the provision of well care as part of a program of comprehensive health care including treatment during illness. Medicaid recipients under twenty-one
years of age are eligible to receive all medically necessary services available through Medicaid.

The managed care plan is responsible for providing health care, diagnosis, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. If the service is not included in the plan's benefit package, then the plan is responsible for arranging for such services outside the plan network. If a finding requires more extensive diagnosis and/or treatment than is immediately available, an appointment for these services must be scheduled by the plan within sixty (60) days of the well care examination. The plan is responsible for follow-up. Results of diagnostic evaluations, referrals, and treatment should be documented in the child's medical record.

Case Management provides the difference between fragmented care and comprehensive care. Managed care plans are responsible for collecting information on the health needs of the child, making and following-up on referrals as needed, maintaining a health history, and assuring that the examination/diagnosis/treatment sequence is completed. Notifying families at the time children are due to receive a screening exam is an integral part of case management. As individual recipients approach age levels when a well child screening is due, plans must notify them that it is the appropriate time to receive services and schedule the appointment.

Well care examination findings and results must be documented in the child's medical record. Medicaid record-keeping requirements are described in Section 2, Subsection 2.2 of this Manual.

In the course of well care examination or any Medicaid health service, one or more conditions may be discovered which are physically disabling or chronic in nature and likely to interfere significantly with normal growth and development. These conditions merit a complete diagnostic evaluation by a specialized provider. The Physically Handicapped Children's Program (PHCP) is a valuable resource. Through the PHCP a referral can be made to an appropriate specialty provider for a complete diagnostic evaluation with the development of a treatment plan. To locate a PHCP in your area call the NYS Department of Health's "Growing Up Healthy" toll-free hotline, 1-800-522-5006.

Vaccines for Children is a Federal program intended to improve childhood immunization levels nationwide. New York's Vaccines for Children (NY-VFC) is administered by the State and City Departments of Health. NY-VFC provides VFC registered public and private providers with free routine childhood vaccines to be used to immunize, among others, Medicaid recipients under nineteen (19) years of age. Medicaid pays an administration fee for each eligible immunization with VFC vaccine. On and after April 1, 1995, the physician must be VFC-registered in order to bill Medicaid for routine childhood immunizations administered to recipients under nineteen (19) years of age. For information and registration call NY-VFC at 1-800-KID-SHOTS (1-800-543-7468).

II. HEALTH SUPERVISION GUIDELINES
A. Periodicity of Visits
B. Periodicity of Visits for HIV Seropositive Infants and Children
C. Non-Scheduled Evaluations
D. Contents of Health Supervision Visit
E. Identification and Management of Suspected Child Abuse and Neglect
F. Guidelines for Identification and Primary Care of HIV Seropositive Infants and Children
G. Guidelines for the Ambulatory Care of At Risk and/or HIV Infected Adolescents
H. (1) IMMUNIZATION For HIV ANTIBODY-POSITIVE CHILDREN

This schedule applies to periodic health supervision evaluations:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 1 Year</td>
<td>2-4 wks.; 2-3 mos.; 4-5 mos.; 6-7 mos.; 9-10 mos.</td>
</tr>
<tr>
<td>1 to 6 Years</td>
<td>12-13 mos.; 14-15 mos.; 16-19 mos.; 23-25 mos.; 3 yrs.; 4 yrs.; 5 yrs.</td>
</tr>
<tr>
<td>6 to 21 Years</td>
<td>6 yrs; 8-9 yrs.; 10-11 yrs.; 12-13 yrs.; 14-15 yrs.; 16-17 yrs.; 18-19 yrs.; 20 yrs.</td>
</tr>
</tbody>
</table>

1. Summary of Contents of Health Supervision Visit (age 0-5)
2. Summary of Contents of Health Supervision Visit (age 6-20)

Footnotes
1. All children two years of age and over should be referred to a dentist or a dental program for diagnostic evaluation and necessary treatment and should continue to receive routine dental care as frequently as recommended by their dentist, with a minimum of one visit a year. See Subsection 4.2.5.9.
2. As indicated. See Subsection 4.2.5.8 (A).
3. Performed every two years after age of 5. See Subsection 4.2.5.8 (D).
4. At first encounter, obtain results of newborn screening tests for all children born in New York State. See Subsection 4.2.5.8 (B).
5. If not performed previously at birth or if newborn screening results cannot be obtained. See Subsection 4.2.5.8 (C).
6. At a minimum all children should be screened for lead at one and two years of age. Additional screenings may be needed as early as six months and at older ages based on lead exposure or risk as determined by risk assessment administered at routine well child visits. See Subsection 4.2.5.8 (E).
7. As indicated. See Subsection 4.2.5.8 (G).
8. Performed routinely for sexually active females. If examination cannot be done by the examining provider, patient should be referred to a gynecologist or gynecological clinic for tests. See subsection 4.2.5.8 (F).
9. HIV protection education should routinely be provided to adolescents. Pre-test counseling should be provided as indicated as well as testing with informed consent.

HIV antibody-positive infants of indeterminate HIV infection status should be seen monthly for the first 6 months of life, thereafter every 2 to 3 months until 18 months of age, and again at 2 years of age. Seroreverters (Children who are HIV at birth but
become HIV negative and are asymptomatic) do not require HIV-specialized care after 2 years of age. Most symptomatic children with HIV infection should be seen monthly; however, those who are clinically stable or have minimal or no symptomatology may require less frequent evaluations.

When a health supervision (well care) evaluation is requested for a child at an age which does not appear on the periodicity schedule, the provider should, at a minimum, perform those components which are required for the last periodic evaluation the child should have received. Additional laboratory procedures may be performed if the child presents history or symptoms necessitating their use. The procedure code indicating a well child evaluation for child's actual age should be used.

Example: If the child is 30 months of age and missed a previous evaluation, the provider should perform the evaluation components specified for the age group 23-25 months.

Every health supervision visit should include:

10. Comprehensive health and developmental history.
11. Comprehensive unclothed physical examination.
13. Assessment of immunization status and provision of immunizations.
14. Screening tests for sensory including vision and hearing tests, nutritional and social problems as indicated in 4.2.1 (a) and 4.2.1 (b) "Summary of Contents of Health Supervision Visit."
15. Appropriate laboratory testing.
16. Dental screening services and direct referral to a dentist for children 2 years of age and older.
17. Observation for child abuse and maltreatment which, is suspected, must be reported to the New York State central register of child abuse and maltreatment as mandated by New York State Law.
19. An updated problem list.
20. A plan for diagnosis, treatment, referral and follow-up must be developed.
21. Documentation of the contents of the visit in the medical record.

See relevant sections of this manual for more complete description of the above.

22. Comprehensive Health History
23. Comprehensive Physical Examination
24. Assessment of Physical Growth and Nutritional Status
25. Assessment of Immunization Status

A. (1) For a new patient, a complete family history, social history, past medical history and review of body systems must be obtained and recorded.
(2) When obtaining the past medical history of children five years of age or younger, the history must include details of pregnancy, delivery, birth weight and the neonatal period.

(3) When obtaining the past medical history of adolescents, a review of the body systems should include a psychosocial assessment, a history of substance abuse, personal violence, sexual activity and use of contraception, and a menstrual history for females.

(4) For a known patient, the history may be confined to the interval since the last health evaluation.

B. The histories may be obtained initially by health assistants. The examining provider must always review and a supplement the history at the time of his/her evaluation of the child.

The examination must be performed by a licensed physician, a nurse practitioner or by a physician's assistant or registered professional nurse qualified to provide primary care services under a physician's supervision, and is to consist of a systematic examination of all parts of the body, including appropriate neurological, dental, otoscopic and funduscopic examinations and observation of the back for scoliosis. Results of the physical examination must be recorded in the medical record by body regions. Blood pressure measurements must be taken for all children 3 years of age and older. All children and adolescents must receive a genital exam. Adolescent males should receive a testicular exam and females a breast exam. Sexually active females should also be offered a gynecological examination.

Height and weight must be measured and recorded at each visit. Head circumference must be measured and recorded at each visit during the first year and again at two years of age. Height-for-age, weight-for-age, weight-for-height and head circumference must be plotted on a standard growth chart which is to be incorporated into the medical record. Body Mass Index (BMI) should be used to assess weight status for children ten years of age and older. Adolescent sexual development should be assessed by Tanner staging.

An assessment of the record of immunizations given in the past for diphtheria, pertussis, tetanus, polio, rubella, measles, mumps, Haemophilus influenza type b (Hib) and hepatitis B vaccine for children must be recorded. If the date of the child's previous immunizations are available, they should be recorded in the child's medical chart. If the immunization history is based on parents' reports, efforts to verify this information must be made. Such efforts must be recorded. If there is any uncertainty regarding immunization status, the child should be immunized. Ultimately, the date of immunization must be recorded for all doses, or the immunization must be given again. Each patient must be provided with a completed immunization card and instructed about the importance of bringing the card to all medical visits.

The simultaneous administration of OPV, MMR, DTP/Td/DT, Hib, and hepatitis B vaccine at different injection sites, is both safe and effective. If a live virus vaccine,
such as yellow fever or cholera vaccine, is not administered simultaneously with another live virus vaccine, such as MMR, the second live virus vaccine should be spaced at least thirty days after the first to avoid potential interference with antibody protection. The exception is that OPV and MMR can be administered at anytime before, with, or after each other.

When an interruption in the immunization schedule occurs, resume the schedule where it was left, appropriate for age (see the following schedules). Where multiple doses of DTP/DT or OPV vaccine are needed for school or day care attendance, these may be spaced appropriately following schedule B, C, or F.

Persons under 21 years of age should be immunized in accordance with the following schedules:

http://www.cdc.gov/vaccines/recs/schedules/default.htm

vi. Vision Testing
vii. Auditory Testing
viii. Routine Laboratory and Diagnostic Testing Service
ix. Dental Care Assessment
x. Nutritional Assessment
xi. Developmental Assessment
xii. Health Education (Anticipatory Guidance)

A. For children less than 3 years of age, testing should include the following elements:

1. Red reflex.
2. Observation of the infant's/child's reaction to an object of interest such as a light or familiar toy for gross indication of vision. Each eye is required to be observed separately.
3. Motility screening, including gross inspection of the eye to determine the presence of any obvious strabismus, and the cover/uncover test, which is especially valuable in patients with a small deviation from the norm.

B. For children 3 years and older, testing for visual acuity is to be performed and repeated at each examination and must include a distant visual acuity test, which can be performed using the Snellen letter or Symbol E chart. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Alien Pictures) should be considered for those preschoolers who cannot be tested by the Snellen letter or Symbol E Chart.

C. If a child wears eyeglasses, an assessment regarding the need for referral for optometric reevaluation should be made based on screening the child with eyeglasses and the length of time since the last optometric evaluation.

The early detection of hearing impairment in children is essential in order to initiate the medical and educational intervention critical for developing optimal communication and social skills.
The following should be regarded as guidelines for practice, not standards. It is recognized that each child presents unique characteristics that may influence the approach to each evaluation.

D. Children less than 3 years of age:

1. Infants who exhibit one or more of the following risk criteria should be screened as soon as possible but no later than three months after the child has been identified as "at-risk."

- Parent/care giver concern regarding hearing, speech, language and/or developmental delay.
- History of bacterial meningitis.
- History of neonatal events associated with hearing loss (e.g., cytomegalovirus, prolonged mechanical ventilation and inheritable disorders).
- History of head trauma, especially with fracture of the temporal bone.
- Recognizable syndromes associated with hearing loss.
- History of ototoxic medications, such as aminoglycosides used for more than five days.
- Children with neurodegenerative disorders.
- History of childhood infectious diseases associated with hearing loss (e.g., mumps, measles).

2. Methods of Screening

For infants and children older than 6 months, behavioral testing using a conditioned response or auditory brainstem response (ABR) testing are appropriate approaches.

Infants who fail the screen should be referred for a comprehensive audiological evaluation as soon as possible.

E. Children should have pure tone screening performed at ages 4 years, 5 years, 12 years and 18 years.

F. When hearing impairment or progressive hearing loss is suspected, the medical provider should promptly refer the child for an approved speech and hearing evaluation.

If a particular test (e.g., lead screening) is not suggested for a specific age group (or any age group) but the child presents history of symptoms calling for the test's use, the test should be performed.

G. Tuberculin Risk Assessment

Individual Assessment

**Annual assessment of individual risk, and annual skin testing (PPD not a tine test) of children with high individual risk:** Children should receive an
annual assessment of their risk of tuberculosis infection or disease. This risk assessment includes questions about the child’s potential exposure to others with active tuberculosis or evidence of current disease in the child. Any further physical examination or laboratory testing (including chest x-ray examination or tuberculin skin testing) should be based on the results of this risk assessment. In general, a child with an individual risk should be read by qualified medical personnel.

**Periodic tuberculin skin testing based on community risk:** Some children who have no individual risk factor may benefit from periodic (or interval) skin testing, such as testing at age 1; once between ages 4 to 6; and once between the ages of 11 to 16. Such children include those who have no individual risk factors but who reside in high-prevalence regions*; children whose history for risk factors is incomplete or unreliable; or children who are frequently exposed to the following adults: HIV, homeless, users of IV or street drugs, poor and medically indigent city dwellers, residents of nursing homes, migrant farm workers.

**Low-risk children in low prevalence communities:** Routine tuberculosis skin testing in children with no individual risk factors in low-prevalence communities is not indicated, based on evidence of great variation in tuberculosis infection risk within New York State, and on the difficulty in correct interpretation of the results of tuberculin skin testing in low risk children.

You may find out if a location is within a high prevalence area by calling the local/county department of health. See Subsection 4.3.6 for telephone numbers of local departments of health.

**Community Risk Assessment**

All children regardless of individual or community risk factors, should be tested once between the ages of 4 to 6, to establish community risk of TB infection. A high rate of TB infection in this age range should prompt an increase in the periodicity of testing in other children in the community.

**Infants, Children, and Adolescents who are at High Risk for M tuberculosis infection are those who:**

- Have contacts with adults with infectious tuberculosis;
- Are from, or have parents from, regions of the world with high prevalence of tuberculosis;
- Have abnormalities on chest roentgenogram suggestive of tuberculosis;
- Have clinical evidence of tuberculosis;
- Are HIV-seropositive persons;
- Have immunosuppressive conditions;
- Have other medical risk factors: Hodgkin’s disease, lymphoma, diabetes mellitus, chronic renal failure, malnutrition; and
- Are incarcerated adolescents.

**H. Newborn Screening**

If a newborn screening test was not performed at birth because, for example, the baby was born out of state, an appropriate filter paper specimen should be
obtained at the first well care exam (two-four weeks) and submitted to the state laboratory.

If the results of the Newborn screening tests are not known, they may be obtained from the DOH Newborn Screening Program. For children born in 1990 and earlier, call 518-473-7552, for children born in 1991 and later, call 800-535-3079.

I. Sickle Cell Screening

Those infants and children who are at risk of sickle cell disease must receive sickle cell screening. If the clinician makes the judgement that the child is not at risk (by ethnicity or previous screening), a statement of the assessment should appear in the child's medical record. Children born in hospitals within New York State after 1975 are assumed to be adequately screened for sickle cell diseases as part of routine newborn testing. The clinician must attempt to obtain the results and provide appropriate follow-up. If the child is at risk of sickle cell disease and there is any doubt about previous testing, sickle cell screening should be provided as part of the exam.

J. Anemia Screening

A test for anemia must be done at age 9-10 months, 23-25 months, 3 years, 4 years, 5 years, 6 years and repeated routinely at each age interval set forth in the periodicity schedule. High risk infants under nine months should also be tested. When a child's history indicates a higher risk, the test should be performed more frequently.

K. Lead Toxicity Screening

Childhood lead poisoning continues to be one of the most prevalent yet preventable health problems in New York State. The Centers for Disease Control (CDC) recently redefined an elevated blood lead level as equal to or greater than 10 micrograms per deciliter (ug/dL) based on the fact that research has shown that blood lead levels at least as low as 10 ug/dL can result in adverse health consequences in children. Appropriate screening for lower levels of lead toxicity requires a direct blood lead measurement. Current New York State Department of Health guidelines recommend blood lead screening and reporting and follow-up of levels greater than 10 ug/dL. Providers can refer to the New York State Department of Health/American Academy of Pediatrics Physician's Reference Card for information on lead screening and follow-up of elevated blood lead levels. Reference cards can be obtained by calling your local health department.
0. Anticipatory Guidance and Risk Assessment

Starting at 6 months of age and at each regular office visit thereafter to age 6, the provider should discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for high-dose exposure. The guidance and risk assessment should emphasize the sources and exposures that are of greatest concern in the child's community. Because lead-based paint has been used in housing throughout the United States, in most communities it will be necessary to focus on this source. At a minimum the following types of questions should be asked. Does your child:

- Live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, the home of a babysitter or relative, etc.
- Live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?
- Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (that is, blood level > 10 ug/dL)?
- Live with an adult whose job or hobby involves exposure to lead?
- Live near an active smelter, battery recycling plant, or other industry likely to release lead?

Ask any additional questions that may be specific to situations which exist in a particular community.

1. Screening Schedule

If the answers to all questions are negative, a child is considered at low risk for high dose lead exposure, and must receive screening by a blood lead test at 12 months of age and a second test at 24 months. If the answer to any questions is positive, a child is considered at high risk for high dose lead exposure. A blood lead test must be obtained at the time a child is determined to be at high risk, beginning at six months of age. If a child between the ages of 24 months and 72 months has never had a blood lead test, then that child must be screened, regardless of exposure risk. Subsequent risk assessments may change a child's risk category. Any information suggesting increased lead exposure for children previously at low risk must be followed up with a blood lead test.

2. Screening Method

Direct measurement of blood lead levels must replace the EP test as the primary screening method since erythrocyte protoporphyrin (EP) is not sensitive enough to identify more than a small percentage of children with blood lead levels between 10 and 25 ug/dL. Elevated blood lead results of 15
ug/dL or greater obtained on capillary specimens should be considered presumptive and must be confirmed using venous blood.

3. Diagnosis, Treatment and Follow-Up

If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to treat in accordance with the 1991 CDC "Preventing Lead Poisoning in Young Children". Sections on patient management and treatment recommend follow-up blood tests and, for children with a blood lead level equal to or greater than 20 ug/dL, further medical evaluation and environmental investigations to identify the source of lead (available through the local health unit), followed by abatement. Children with confirmed blood lead levels of 20 ug/dL or greater must receive a developmental assessment since children with elevated blood lead levels are at risk of developmental delay. Children under three years of age should be referred to the local Infant Health Assessment Program. Children over three years of age should be provided with a developmental assessment. The results of the assessment should be provided to the Local Health Department. If the provider is unable to administer a developmental assessment, a request for assistance should be made to the Local Lead Program. A list of local and regional childhood Lead Poisoning Prevention Programs is provided in Subsection 4.3.4 (a) and 4.3.4 (b).

4. Lead Screening of Pregnant Adolescent Teens

At the initial prenatal visit, an adolescent should be assessed for current high dose lead exposure. A pregnant adolescent found to be at risk for current high dose exposure should be screened for blood lead and counseled on how to reduce current exposure.

Since there is currently no intervention recommended during pregnancy other than exposure reduction, testing of women who have no ongoing exposure is not indicated. Providers can refer to New York State Department of Health/American College of Obstetricians and Gynecologists, District II Prenatal Care Provider's Reference Card for Lead Poisoning. Reference cards can be obtained by calling your local health department.

5. Coordination With Other Agencies

There should be coordination with WIC, Head Start, and other private and public programs to avoid unnecessary duplicate testing and ensure comprehensive follow-up of children with elevated blood lead levels.

Lead levels equal to or greater than 10 ug/dL must be reported to the local county/city health unit's Childhood Lead Poisoning Prevention Program. These agencies are authorized to initiate an investigation of the environment...
of a child with a confirmed blood lead level of greater or equal to 20 ug/dL to require remediation of identified hazards.

6. Patient Education

Patient education materials can be obtained by contacting your local health unit or the Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health, New York State Department of Health, Coming Tower Room 208, Empire State Plaza, Albany, New York 12237-0618, (518) 473-4602.

L. Papanicolaou Smear

All sexually active females should have pap smears at least annually. Those at increased risk for sexually transmitted diseases should have pap smears every six months, or more frequently if abnormalities are present.

M. Sexually Transmitted Disease and Pregnancy Screening

All sexually active adolescents (and those contemplating sexual activity) should be counseled regarding the prevention of unplanned pregnancy, HIV infection and other sexually transmitted diseases. They should routinely be offered pregnancy testing and HIV testing, as appropriate, as well as serological screening for syphilis. All sexually active females should be offered a routine gynecologic examination, including tests for gonorrhea and chlamydia, as well as a pap smear. If the provider is not properly equipped to perform these services, referral to a gynecologist, family planning, or obstetrical/gynecological clinic should be made.

N. Urine Screening

A urinalysis must be performed at age 3 years and repeated at each age interval set forth in the periodicity schedule. Sexually active males should have urine screening for leukocytes. Those found to be positive should be evaluated for urethritis.

When the routine examination of the mouth shows dental problems or if the child has not seen a dentist within the last year, the child should be referred for dental care. All children 2 years of age and over should be referred to a dentist or dental program for routine preventive and restorative dental care. Children should continue to receive routine dental care as frequently as recommended by their
dentist, with a minimum of one visit a year. Fluoride supplements should be prescribed where indicated.

Children of all ages should be assessed for nutritional risk at each medical examination. Screening for nutritional risk conditions (e.g. overweight, underweight, stunting, iron deficiency, hyperlipidemia, inappropriate feeding practices) should include evaluation of physical growth (as defined in Subsection 4.2.5.3), laboratory tests, dietary practices, and findings from the health history and physical examination. Infants/children found to be at nutritional risk should be referred to a registered dietitian for further assessment, an individualized, age-appropriate nutritional care plan, and follow-up.

All infants, children under age 5, pregnant, breast-feeding or post partum adolescents are eligible for participation in the Special Nutrition Program for Women, Infants and Children (WIC). For infants, children and pregnant adolescents not currently enrolled in WIC, the Growing Up Healthy WIC/Medicaid Combined Application should be used to facilitate the application for WIC Program services.

O. For children through 5 years of age, a detailed developmental history of the infant or child must be obtained and documented in the child's medical record at each visit. The history should include information relating to communication (language/speech), cognitive, social/emotional, gross and fine motor, and adaptive (self-help) skills/achievement. A developmental screening should be routinely performed.

Administration of a standardized (formal) developmental screening test such as the revised Denver Developmental Screening Test (DDST II) or the revised Developmental Screening Inventory based on the revised Gesell Development Examination is strongly recommended for children up to three years old. It is suggested that developmental screenings for infants and toddlers be performed at six, twelve, eighteen, twenty-four and thirty months of age and at alternate times as deemed appropriate. For children three to five years of age, the Early Screening Inventory developed by Meisels is a reliable, standardized developmental screening tool. (Also available in Spanish). For more information on developmental screening instruments call the New York State Department of Health, Bureau of Child and Adolescent Health Early Intervention Program, (518) 473-7016. Use of a psychometric instrument does not preclude the need for multiple sources of data and/or clinical information as well. Since very few tests are actually known to be free of cultural bias, care should be taken in administering tests to members of culturally diverse groups. Children at known risk for developmental delay, including HIV-infected children should have formal developmental assessments at regular intervals in order to identify
developmental delays as early as possible. The first should be at 6 months of age and repeated every 6 months until the child is 2 years of age, after which it should be performed annually.

P. Referral to the local health department for registration in the Infant Child Health Assessment Program should be made for infants and toddlers up to 3 years of age who bear one or more of the following characteristics: maternal age less than 16 years; birth weight less than 1801 grams; gestational age less than 33 weeks; major congenital anomaly (ies); inherited metabolic disease(s) or hemoglobinopathy (ies); discharged from intensive nursery care for serious illness requiring 10 or more days of hospitalization; prenatal maternal substance abuse; identified risk for or diagnosis of a congenital/perinatally transmitted infection, including HIV, syphilis, toxoplasmosis, rubella, cytomegalic inclusion disease (CMV), and herpes; elevated venous blood lead levels (above 19 mg/dl) and other conditions at the county’s discretion or as identified by the Commissioner of Health.

Children under 3 who are identified as having a suspected or confirmed developmental delay or disability must be referred to the designated municipal early intervention agency or corresponding to the child's residence. Early intervention legislation designates all child health care providers as mandated primary referral sources. As such, physicians associated with managed care plans are obligated to identify infants and toddlers with, or at risk of, developmental delay or disability and to make the required referrals within two working days of identification unless the child has already been refereed or the parents objects.

Children age 3-5 who are identified as having a developmental delay or disability should be referred to the local committee on Preschool Special Education.

Q. For children 6 to 12 years of age, an assessment of developmental status and psychosocial adjustment should include a discussion of school performance, peer and family relationships, and an evaluation of physical development.

R. For adolescents 10 years of age and older, an assessment of developmental status and psychosocial adjustment should include a discussion of peer and family relationships, school/job performance, use of drugs, alcohol or tobacco, sexual development and activity, and an evaluation of physical development including Tanner staging.

Age appropriate health education should be provided at each visit for the parent, with increased involvement of the child as the child becomes older. Early health education should focus on such issues as crying, sleep patterns, caring for the child, parental interactions with the child (holding, cuddling, vocalization, etc.), and nutrition (breast/bottle feeding, vitamin supplements, fluoride, table food, etc.).

Early injury prevention should stress the use of child safety seats, measures to prevent child abuse, and the importance of not leaving a child unattended. Information regarding the major sources of lead poisoning and means of preventing lead exposure shall be pertinent to the environment of the child or pregnant woman.
As the child crawls and then begins to walk, injury prevention should be extended to include such areas as protection against falls, care with hot liquids, including burns from food, especially those heated in a microwave oven, stairs, ingestants, electrical outlets, machinery, water safety, poisoning prevention, safe toys, and hazards of infant walkers.

Note: Health education materials are available through the NYS/DOH (See "Resources" part 4.3 for ordering instruction)

As the child becomes a toddler and enters the pre-school years, injury prevention should also include such topics as safety stair gates, window guards, bumps and scalds, supervised play, strangers and strange dogs, bicycle safety (including the proper use of a bicycle helmet), and car safety. The use of child safety seats and, subsequently, seat belts, should be stressed at each visit.

After age 5, health education should begin to include good health habits such as hygiene, pedestrian safety and social interactions. Topics such as sexuality and academic and vocational activities should be introduced in early adolescence.

During adolescence, motor vehicle crashes are the major cause of injury and death. Responsible behavior as both driver and vehicle passenger, and the avoidance of alcohol use while driving should be stressed. Discussion of behavior with medical consequences and appropriate counseling should be provided (e.g. sexual activity reflecting the need for contraception, sexually transmitted disease prevention, HIV prevention, pregnancy prevention, drug and alcohol abuse, and personal violence). Instruction in breast self-examination and testicular self-examination should be provided.

In situations where possible child abuse or maltreatment is suspected, the examining provider should immediately attempt to confirm the diagnosis by conducting a thorough medical examination. All findings should be completely recorded. In addition, the provider should make referrals for psychiatric, social work, nursing or other evaluations as appropriate.

For presumed abuse involving a parent, guardian or someone with formal responsibility for the child, mandated reporters, which includes all health care professionals, should call:

Central Register for Child Abuse and Maltreatment:

1-800-635-1522

Reports from all other sources should use the following statewide number:

1-800-342-3720

All other reports should be made to the police.

For more detailed information regarding diagnosis and reporting of suspected child abuse and maltreatment, please refer to the Official Guidelines of the State of New York Department of Health and Department of Social Services.
The diagnosis of HIV infection as soon as possible after birth is a critical priority in the care of HIV positive children. The earlier the diagnosis is made, the better the prognosis: provision of appropriate care improves the child's chances of a longer and higher-quality life. Because of the high HIV seroprevalence in New York State, the NYSDOH recommends universal HIV counseling and active encouragement of HIV testing as a standard of care for all pregnant and postpartum women. Every pediatric history should include information about whether HIV counseling and testing occurred. If HIV testing was not done prenatally, HIV testing (with written consent) should be routinely recommended for every newborn. DSS policy and guidelines recommend that all children and adolescents entering foster care be assessed for risk of HIV infection and capacity to consent. If determined not to have capacity to consent, the children identified as at risk should be referred for testing. For further information regarding these regulations, contact your Local Department of Social Services.

All infants born to HIV-infected mothers initially test seropositive due to maternal antibodies; however, most are not themselves infected. HIV-seropositive infants need to be monitored closely to determine whether they are infected. Maternal HIV antibodies disappear by 18 months of age; persistence of antibodies past the age of 18 months indicates that the child is HIV infected.

The NYSDOH has implemented a Pediatric HIV PCR Testing Service to assist in the diagnosis of these infants. Through a pilot pediatric HIV testing program, the Department's Wadsworth Laboratory determined that essentially all infected infants are PCR (polymerase chain reaction) positive by one month of age. The Pediatric HIV PCR Testing Service is available free of charge for all infants known to be HIV positive or whose mothers are known HIV infected. It is anticipated that 2 to 3 specimens will be needed to definitively diagnose the HIV infection status of an infant; special kits must be used to submit specimens. To obtain a kit, please contact the Pediatric/Adolescent/Maternal HIV Services Section, AIDS Institute, NYSDOH at (518) 486-6048.

The identification and primary care of HIV seropositive children should be provided in medical facilities that have the capacity to provide comprehensive, family-centered primary health care. Children, as well as adults, may be HIV infected without becoming symptomatic for years. For these individuals, routine, frequent monitoring is essential and can be provided in settings other than medical facilities that offer HIV-specific health care. Referral to facilities offering more HIV-specific comprehensive health care should take place when warranted by the care needs of the child. The HIV-seropositive child should be referred to a facility where he/she will receive such services, as well as continuity of care and case management. See Subsection 4.3.2, for a list of pediatric AIDS Centers in New York State.
The assessment and medical management of HIV seropositive infants and children should include:

- Care consistent with guidelines 4.2.5.1 thru 4.2.5.12, except as indicated differently, i.e.: immunizations.
- An explanation of HIV transmission and prevention (including lack of transmission in the household, day care and school).
- A general review of the medical care of HIV-positive children and preventive strategies (e.g., good nutrition, surveillance for infections, pneumocystis carinii pneumonia (PCP) prophylaxis, special immunizations, and guidelines of when to call the doctor).
- A review of HIV-related confidentiality and disclosure issues.
- A review of the child's HIV serostatus/CDC classification. The CDC classification system for children was revised in 1994.
- A review of available treatments, pros and cons of clinical trials, and child's current treatment plan.
- In addition to the routine laboratory tests done for all children (screening for sickle cell, lead, iron deficiency anemia), the following should be done for HIV-positive children:

- HIV antibody testing (ELISA and confirmatory Western Blot) at the first visit. If the child is over 18 months of age, a positive result indicates the child is HIV infected. If less than 18 months, a positive result indicates the child was exposed and may be infected. Because of the presence of maternal HIV antibodies, the children under 18 months should have viral diagnostic testing done. The NYSDOH has made PCR testing available free of charge for these infants. The optimal time for the first specimen is between four and six weeks of age, with follow-up specimens determined by the result of the first specimen. The Wadsworth Laboratory will indicate the needed follow-up when notifying the physician of the result. HIV positive children less than 18 months should have antibody testing (ELISA) done at six month intervals to confirm when they seroreverted. Call (518) 486-6048 for information, PCR specimen kits and mailing kits.
- Lymphocyte studies (CD4 count; CD4/CD8 ratio) in asymptotic, seropositive infants beginning at one month of age or at first visit if older than one month and repeated at three month intervals, or until seroreversion occurs. HIV-infected children should continue to have lymphocyte studies done at three month intervals.
- Immunoglobulins (IgG, IgA, IgM) at three months of age or at first visit if older than three months and at six month intervals until hypergammaglobulemia is documented or seroreversion occurs.
- CBC with differential and a platelet count at first visit and at six month intervals, unless the child is on PCP Prophylaxis or Antiretroviral therapy which indicates more frequent CBC monitoring.
- A urinalysis at first visit and at six month intervals.
Because women with HIV infection have a high rate of coinfection with syphilis, screening should be done for any child whose syphilis serology at birth is undocumented. Infants who were treated for congenital syphilis should have serial nontreponemal tests (e.g., VDRL or RPR) every 3 months until they become nonreactive; those with stable but persistent titers should be considered for retreatment.

Hepatitis B serology at 9-12 months of age if infant received hepatitis B immunization in the neonatal period (2-3 months following last dose of vaccine).

Tuberculosis screening, using 0.1 cc of intradermal purified protein derivative (PPD), should be done annually; anergy testing with one or more antigens for cutaneous delayed hypersensitivity should always accompany the PPD. The PPD and controls should be read 48 to 72 hours later by a clinic nurse or physician.

A positive PPD is defined as:

- greater than or equal to 5 mm induration in a child with HIV infection.
- greater than or equal to 10 mm induration in a child without HIV infection who has close contact with adults with, or a high risk for, tuberculosis.

Children with HIV infection and with known exposure to tuberculosis whose PPD test results are negative but whose control results are positive should be retested with PPD 8 to 10 weeks later. The management of anergic, TB-exposed children with HIV infection depends on the likelihood of multiple-drug-resistant TB; prophylaxis or treatment, whichever is indicated, should be implemented in consultation with an infectious disease specialist. The anergic child does not require PPD testing but should have an annual chest X-ray.

Annual screening for renal disease every 6 months in children with symptomatic HIV infection.

Serum liver enzymes every 2-4 months. (Every 6 months if asymptomatic and stable.)

Because of the high incidence of pulmonary disease, cardiomyopathy, and encephalopathy in children with HIV infection, a baseline chest X-ray, electrocardiogram, and a noncontrast CT scan of the head should be performed for every child with symptomatic disease. (Some clinicians obtain these studies in every infected child, irrespective of symptomatology.)

Studies should be repeated annually for children with moderate-to-severe symptomatic disease or more frequently if clinically indicated. Such tests are useful in measuring clinical deterioration and also may be helpful in measuring the patient's response to therapy. Echocardiography should be performed in children with abnormal ECGs, cardiomegaly on CXR, or symptomatology suggestive of cardiac disease.

The primary care provider should assure that adolescents are provided age and developmentally appropriate HIV education and prevention. The CTHP provider should also assure that adolescents have access to adolescent specific, confidential
HIV counseling and testing. Supportive services should be available to help the adolescent deal with issues surrounding test results. Such services should include peer groups, mental health counseling, etc..

For adolescents who have been confirmed as HIV-infected through Western Blot, their assessment and medical management should include:

- Care consistent with 4.2.5.1 thru 4.2.5.12, except as indicated differently. OR

- Laboratory studies:
  - Serum/Blood
    - WBC count with differential count
      - Platelet count
      - Hemoglobin/hematocrit
      - Liver function tests, creatinine, BUN, total protein/albumin
      - Rubella liter
      - Screening test for syphilis
      - Hepatitis B screen (antibody and antigen)
      - Hgb Electrophoresis
      - Toxoplasma gondii titer
  - Other Tests:
    - CD4, total number and percentage of total lymphocyte count and CD4/CD8 ratio; quantitative immunoglobulins (optional)
      - Urinalysis
      - Urine culture as needed
      - PPD test for tuberculosis (intradermal)
      - Anergy screen at same time as PPD
      - Chest x-ray if PPD or anergic
      - For sexually active:
        - Pap Smear; colposcopy if dysplasia noted
        - Pregnancy test as indicated
        - STD testing (GC, chlamydia, trichomonis)
  - An HIV-infected adolescent should be clinically evaluated at least once every three months, and appropriate laboratory studies conducted and therapies initiated. Treatment decisions should also be guided by Centers for Disease Control guidelines and most recent findings of clinical drug trials.

  - If the examining provider is unable to provide the HIV-infected adolescent with comprehensive HIV primary care, treatment with antiretroviral therapy, pneumocystis carinii pneumonia (PCP) prophylaxis and access to clinical trials, the adolescent should be referred to a facility offering these services. The referral should be to a facility with a focus on serving HIV- infected
adolescents. (Please refer to Subsection 4.3.3 for the Adolescent HIV/AIDS Clinical Resource Directory).

Psychosocial interventions include individual counseling, family counseling, and group therapy for support and risk reduction. Refer the patient to drug treatment programs, welfare agencies, community agencies, and counseling and support programs as needed. Many adolescents who are HIV-positive are estranged from their parents or do not want to disclose their HIV status to their families. They should be encouraged to identify a supportive adult to whom disclosure may be made.

For adolescents, medical interventions may include a range of current preventive, therapeutic, and antiretroviral treatments for HIV-related infections and illnesses. The dose, route of administration, and duration of treatment may differ from those for young children. Most protocols for new therapeutic agents have not been tested in adolescents. Make treatment decisions in conjunction with the relevant pediatric, adolescent, and adult subspecialists. As a general guideline, adolescents in Tanner growth stage I should be begun on pediatric dose schedules and those in Tanner stage V on adult schedules. Adolescents in Tanner stage II, III, and IV should be monitored particularly carefully, since they are at the time of the growth spurt of hormonal changes.

Specific infections, such as tuberculosis, syphilis, vaginal candidiasis, and pelvic inflammatory disease may require prolonged or alternative modes of treatment. Monitor carefully, adolescents may require hospitalization to ensure adequate compliance.

Adolescents with HIV infection need flexible health care that is available 24 hours a day and an answering service that can provide contact with primary care providers and HIV specialists after hours and on weekends and holidays.

Programs that care for adolescents with HIV infection should provide access to clinical trials either directly or by referral.

The immunizations for children with HIV infection are the same as those for children without HIV infection, with three exceptions: Inactivated polio virus (IPV) is given instead of oral polio virus (OPV); the pneumovax is given at 2 years of age; and the influenza vaccine is given annually**. IPV should continue to be given to seroreverters because of the likelihood of their contact with family members who are infected with HIV, it should also be given to all household members if one or more of them are infected with HIV.

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<tr>
<td>Diphtheria-tetanus-pertussis</td>
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<tr>
<td>Inactivated polio virus?</td>
<td>Normal schedule</td>
</tr>
<tr>
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<td>Normal schedule</td>
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<tr>
<td>Measles-mumps-rubella</td>
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<tr>
<td>Pneumococcal vaccine</td>
<td>2 years of age</td>
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<tr>
<td>Influenza vaccine</td>
<td>Annually (from 6 mo)</td>
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</table>

* As recommended by the American Academy of Pediatrics Committee on Immunizations.

? Instead of the oral polio virus, IPV should continue to be given to seroreverters and all household members where an individual with HIV infection is in residence.


(2) Preventive Strategies for Seropositive Infants and Children

Prophylaxis for PCP is indicated after 1 month of age, and should be continued until 1 year of age, for all children with HIV infection (or those of indeterminate status in whom HIV has not been excluded by virologic testing), irrespective of absolute CD4 lymphocyte count and percentage. If the infant is on zidovudine (ZDV) for six weeks post birth to reduce perinatal transmission, PCP prophylaxis should not start until the ZDV stops at six weeks due to the possibility of increased anemia. After 1 year of age, PCP prophylaxis should be continued for children with severe immunosuppression and for any child who previously had PCP. The preferred regimen for prophylaxis is oral trimethoprim- sulfamethoxazole twice daily, three days per week. Oral dapsone and pentamidine (intravenous or aerosolized) can be used for children intolerant of trimethoprim/sulfamethoxazole.

Monthly IVIG (400 mg/kg of body weight) has been reported to reduce the rate of serious and minor bacterial infection in children with HIV infection, although prophylaxis with antibiotics may be as effective. IVIG, however, has also been reported to reduce viral infections and to slow the decline in CD4 lymphocytes. It appears to have no effect on opportunistic infections. Many clinicians use IVIG for children with HIV infection who have recurrent serious bacterial infection (including chronic or recurrent sinusitis), recurrent severe upper respiratory infections, hypogammaglobulinemia, or chronic bronchiectasis. Also, high-dose IVIG for several days is indicated for the treatment of HIV-related thrombocytopenia.

In general, the lower a patient's CD4 lymphocyte count, the higher is the risk of disseminated MAC infection, although this relationship has not been thoroughly studied in children. MAC prophylaxis with rifabutin (5mg/kg daily) may be appropriate for any child with HIV infection who has an extremely low age- specific CD4 lymphocyte count (e.g., less than 100 to 200 cells/mma). Some experts in the care of adults with the HIV infection recommend that the possible risk of producing drug-resistant strains of M. tuberculosis caused by the crossreactivity between rifabutin and rifampin. Because the prevalence of tuberculosis appears to be much lower in children with HIV infection than in adults with HIV infection, such a concern may be less relevant to pediatric practice.
All children with HIV infection without a history of varicella who have had household or face-to-face indoor play exposure to varicella or have had intimate (i.e., touching or hugging) contact with a person with herpes zoster should receive varicella-zoster immunoglobulin (VZIG), ideally within 2 days but not more than 4 days after exposure to prevent or ameliorate the development of clinical disease. If a child has received IVIG during the 3 weeks prior to exposure, VZIG is unnecessary. Those children who develop clinical disease should be treated with acyclovir, either oral or intravenous, depending on the severity of illness.

Recurrent oral thrush usually responds to oral clotrimazole (for young infants, oral trowches can be mashed with water or nystatin suspension to make a paste that can be applied to affected areas); if topical treatment fails, treatment with fluconazole or ketoconazole daily or every other day is usually effective.

Recurrent herpes simplex lesions may require suppression with oral acyclovir daily or every other day.

HIV-positive children should receive prophylaxis immediately after exposure to Haemophilus influenza type B (rifampin); measles (human serum immune globulin); pertussis (erythromycin); or diphtheria (diphtheria toxoid and penicillin).

More detailed guidance regarding the primary care needs of HIV positive infants, children, and adolescents can be found in the NYSDOH AIDS Institute's Guidelines for the Care of Children and Adolescents With HIV Infection. Copies of the guidelines are available by writing to the Medical Director, AIDS Institute, New York State Department of Health, 5 Perm Plaza, NY, NY 10001, or by calling (212) 613-2428.

(3) Recommended Immunizations for At-risk and/or HIV Infected Adolescents

- Routine for Adolescents (not HIV-infected)
  - MMR
  - Hepatitis B (if not immune)
  - Tetanus booster (Td)

- For HIV-infected adolescents
  - MMR
  - Hepatitis B (if not immune)
  - Tetanus booster (Td)
  - Pneumococcal vaccine
  - Yearly influenza vaccine

III. RESOURCES

A. TOLL-FREE 800 NUMBERS
B. PEDIATRIC HIV/AIDS CLINICAL RESOURCE DIRECTORY
C. ADOLESCENT HIV/AIDS CLINICAL RESOURCE DIRECTORY
D. LOCAL CHILDHOOD LEAD POISONING PREVENTION PROGRAMS
E. REGIONAL LEAD RESOURCE CENTERS
F. REGIONAL LEAD RESOURCE CENTERS
G. REGIONAL LEAD RESOURCE CENTERS
H. REGIONAL LEAD RESOURCE CENTERS
<table>
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<th>Regional</th>
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<tbody>
<tr>
<td>Albany Regional</td>
<td>(518) 473-8910</td>
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<tr>
<td>Syracuse Region</td>
<td>(315) 426-7628</td>
</tr>
<tr>
<td>Rochester Region</td>
<td>(716) 423-8090</td>
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<tr>
<td>Western Region</td>
<td>(716) 847-4502</td>
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<tr>
<td>New Rochelle Region</td>
<td>(914) 632-4133</td>
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</table>
Long Island Region
(516) 952-6883

New York City
(212) 349-2664

M. LOCAL DEPARTMENTS OF HEALTH
N. LOCAL DEPARTMENTS OF HEALTH
O. LOCAL DEPARTMENTS OF HEALTH
P. LOCAL DEPARTMENTS OF HEALTH

ALBANY - (518) 447-4695
Health Commissioner
Albany County Health Dept.
South Ferry & Green Streets
Albany, NY 12201
(FAX - 518/447-4573)

ONONDAGA - (315) 435-3252
Health Commissioner
Onondaga County Health Dept.
PO Box 1325
421 Montgomery Street
Syracuse, NY 13202
(FAX - 315/435-5720)

ALLEGANY - (716) 268-9247
Public Health Director
 Allegany County Health Department
Courthouse - County Ofc. Bldg.
Belmont, NY 14813
(FAX - 716/268-9264)

ONTARIO - (716) 396-4343
Dir. Of Community -Pub. Health
Ontario County
County Office Building #2
3907 County Road, R.D. 2
Canandaigua, NY 14424
(FAX - 716/396-4551)

BROOME - (607) 778-8885
Public Health Director
Broome County Health Department
One Wall Street
Binghamton, NY 13901
(FAX - 607/778-2044)

ORANGE - (914) 294-7961
Health Commissioner
Orange County Health Department
124 Main Street
Goshen, NY 10924
(FAX - 914/294-6371)

CATTARAUGUS - (716) 373-8050
Public Health Director
Cattaraugus County Health Dept.
1701 Lincoln Avenue, Suite 4010
Olean, NY 14760-1154
(FAX - 716/375-5994)

ORLEANS - (716) 589-7004
Public Health Director
Orleans County Health Department
14012 Route 31 West
Albion, NY 14411
(FAX - 716/589-6647)

CAYUGA - (315) 253-1404

OSWEGO - (315) 349-3539
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http://www.health.state.ny.us/about/publichealth.htm
70 North Third Street
Hudson, NY 12534
(FAX - 518/828-0124)

Public Health
PO Box 5157
Potsdam, NY 13676
(FAX - 315/265-1013)

CORTLAND - (607) 753-5036
Public Health Director
Cortland County Office Building
PO Box 5590 - 60 Central Avenue
Cortland, NY 13045-5590
(FAX - 607/753-5209)

SARATOGA - (518) 584-7460
Public Health Director
Saratoga County
31 Woodlawn Avenue
Saratoga Springs, NY 12866
(FAX - 518/583-2498)

DELAWARE - (607) 746-3166
Public Health Director
Delaware County Office Building
111 Main Street
Delhi, NY 13753
(FAX - 607/746-3962)

SCHENECTADY - (518) 386-2824
Health Commissioner
Schenectady County
One Broadway Center - 8th Floor
Schenectady, NY 12305
(FAX - 518/386-2822)

DUTCHESS - (914) 431-1500
Health Commissioner
Dutchess County Health Department
387-391 Main Mall
Poughkeepsie, NY 12601
(FAX - 914/431-1537)

SCHENECTADY - (518) 386-2824
Health Commissioner
Schenectady County
One Broadway Center - 8th Floor
Schenectady, NY 12305
(FAX - 518/386-2822)

ERIE - (716) 858-7660
Health Commissioner
Erie County Health Department
Rath Office Building
95 Franklin Street
Buffalo, NY 14202
(FAX - 716/858-8654)

SCHUYLER - (607) 535-2704
Public Health Director
Schuyler County
105 Ninth Street
Watkins Glen, NY 14891
(FAX - 607/535-7002)

ESSEX - (518) 873-3500
Public Health Director
Essex County
100 Court Street
Elizabethtown, NY 12932
(FAX - 518/873-6615)

SENeca - (315) 539-9294
Public Health Director
Seneca County Health Dept.
31 Thurber Drive
Waterloo, NY 13165
(FAX - 315/539-9493)
FRANKLIN - (518) 483-6767
Public Health Director
Franklin County
63 West Main Street
Malone, NY 12953
(FAX - 518/483-0141)

FULTON - (518) 762-0720
Public Health Director
Fulton County
PO Box 415 - Route 29
Johnstown, NY 12095
(FAX - 518/762-1630)

GENESEE - (716) 344-8506
Public Health Director
Genesee County Health Dept.
3837 West Main Street
Batavia, NY 14020
(FAX - 716/344-4713)

GREENE - (518) 943-5201
Public Health Director
Greene County
PO Box 811
Catskill, NY 12414
(FAX - 518/943-6721)

HAMILTON - (518) 648-6141
Public Health Director
Hamilton County Nursing Servs.
PO Box 250
Indian Lake, NY 12842
(FAX - 518/648-5257)

HERKIMER - (315) 867-1176
Public Health Director
Herkimer County
257 No. Main St., PO Box 672
Herkimer, NY 13350

STEUBEN - (607) 776-9631
Director of Public Health
Steuuben County
1 East Pulteney Square
Bath, NY 14810
(FAX - 607/776-3334)

SUFFOLK - (516) 853-3005
Health Commissioner
Suffolk County Health Services
225 Rabro Drive East
Hauppauge, NY 11787
(FAX - 516/853-2927)

SULLIVAN - (914) 292-0100
Public Health Director
Sullivan County
Infirmary Road, PO Box 590
Liberty, NY 12754
(FAX - 607/292-1417)

TIOGA - (607) 687-0623
Public Health Director
Tioga County Health Dept.
231 Main Street
Owego, NY 13827
(FAX - 607/687-9668)

TOMPKINS - (607) 274-6674
Public Health Director
Tompkins County Health Dept.
"H" Bldg 401 Harris B. Dates Dr.
Ithaca, NY 14850-1386
(FAX - 607/274-6695)

ULSTER - (914) 338-7019
Public Health Director
Ulster County Health Department
300 Flatbush Avenue
Kingston, NY 12401
Public Health Director
Montgomery County
County Office Building #2
Park Street
Fonda, NY 12068
(FAX - 518/853-8218)

Director of Patient Services
Yates County
431 Liberty Street
Penn Yan, NY 14527
(FAX - 315/536-5149)

NASSAU - (516) 571-2260

Health Commissioner
Nassau County Health Dept.
240 Old Country Road
Mineola, NY 11501
(FAX - 516/571-3369)

NEW YORK CITY - (212) 788-5261

Health Commissioner
New York City Health Department
125 Worth Street
New York, NY 10012
(FAX - 212/964-0472)

NIAGARA - (716) 439-7435

Public Health Director
Niagara County Health Dept.
5467 Upper Mountain Road
Lockport, NY 14094
(FAX - 716/439-7440)

NEW YORK STATE ASSOCIATION OF COUNTIES - (518) 465-1473

ONEIDA - (315) 798-5634

Public Health Director
Oneida County Health Department
County Office Bldg-800 Park Ave
Utica, NY 13501
(FAX - 315/798-5022)

Q. PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM BUREAU OF CHILD AND ADOLESCENT HEALTH
R. PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM BUREAU OF CHILD AND ADOLESCENT HEALTH
S. PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM BUREAU OF CHILD AND ADOLESCENT HEALTH
T. PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM BUREAU OF CHILD AND ADOLESCENT HEALTH

Approved Centers for Hearing and Speech
** Speech Therapy Only
** Speech Therapy on Referral Only

** ALBANY COUNTY **

Albany Medical Center Hospital  
New Scotland Avenue  
Albany, New York 12208

St. Peter’s Hospital  
315 South Manning Boulevard  
Albany, New York 12208

Capital Area Speech Center  
525 Washington Avenue  
Albany, New York 12206

** ALLEGANY COUNTY **

Cattaraugus County Rehabilitation Center/Carroll Clinic  
3799 South Nine Mile Road  
Allegany, New York 14706

** BROOME COUNTY **

Rehabilitation Services, Inc.  
204 Court Street  
Binghamton, New York 13902

The Handicapped Children's Association of NY, Inc.  
18 Broad Street  
Johnson City, New York 10701

** CHAUTAUQUA COUNTY **

Women's Christian Assoc. Hosp.  
207 Foote Avenue  
Jamestown, New York 14701

** CHEMUNG COUNTY **

United Cerebral Palsy and Handicapped Children's Assoc.  
1118 Charles Street

** ULSTER COUNTY **

United Cerebral Palsy of Ulster Cty. (Children's Rehabilitation Center)  
Webster Street  
PO Box 488  
Kingston, New York 12401

Benedictine Hospital  
105 Mary's Avenue  
Kingston, New York 12401

** WARREN COUNTY **

Glens Falls Hospital  
100 Park Street  
Glens Falls, New York 12801

** WESTCHESTER COUNTY **

Westchester County Medical Center  
Valhalla, New York 10595

New Rochelle Hospital Medical Ctr.  
16 Guion Place  
New Rochelle, New York 10802

Donald R. Reed Speech Center*  
Phelps Memorial Hospital  
North Broadway  
North Tarrytown. New York 10591

The Burke Rehabilitation Ctr.  
785 Mamaroneck Avenue  
White Plains, New York 10605
DUTCHESS COUNTY
Northern Dutchess Hospital
10 Springbrook Avenue
Rhinebeck, New York 12572

St. Francis Hospital
Speech and Hearing Department
North Road
Poughkeepsie, New York 12601

ERIE COUNTY
Children's Hospital of Buffalo
Speech and Hearing Clinic
219 Bryant Street
Buffalo, NY 14222

Buffalo Hearing and Speech Ctr., Inc.
325 Summer Street
Buffalo, New York 14222

JEFFERSON COUNTY
Mercy Hospital of Watertown
218 Stone Street
Watertown, New York 14222

MONROE COUNTY
Hearing and Speech Center of Rochester, Inc.
1000 Elmwood Avenue
Rochester, New York 14620

Northwest Hearing and Speech
550 Latona Road - Building B
Rochester, New York 14642

Strong Memorial Hospital of the University of Rochester
601 Elmwood Avenue
Rochester, New York 14642

Blythedale Children's Speech and Hearing Center
Valhalla, New York 10595

NEW YORK CITY
Bronx
Bronx Municipal Hospital Center
Pelham Parkway South and Eastchester Road
Bronx, New York 10461

Montefiore Medical Center
Henry and Lucy Moses Division
111 East 210th Street
Bronx, New York 14067

Montefiore Medical Center
Jack D. Weiller Hospital of the Albert Einstein College of Medicine
1825 Eastchester Avenue
Bronx, New York 14061

Mt. St. Ursula Speech Center*
200th Street and Marion Avenue
Bronx, New York 10458

Rose F. Kennedy Center
Speech and Hearing Center
1410 Pelham Parkway, South
Bronx, New York 10461

St. Barnabas Hospital*
183rd Street and 3rd Avenue
Bronx, New York 10457

Kings
Brookdale Hospital Medical Center
Linden Blvd. and Brookdale Plaza
Brooklyn, New York 11212

Brooklyn Hosp.-Caledonia Hosp.**
121 DeKalb Avenue
Brooklyn, New York 11202
MONTGOMERY COUNTY
Amsterdam Memorial Hospital
Upper Market Street
Amsterdam, New York 12010

NASSAU COUNTY
Bethpage Speech and Hearing*
2938 Hempstead Turnpike
Levittown, New York 11756
Franklin General Hospital
900 Franklin Avenue
Valley Stream, New York 11582
Nassau County Medical Center
2210 Hempstead Turnpike
East Meadow, New York 11554
Long Island Jewish-Hillside Med.
Hearing and Speech Center
270-05 76th Avenue
New Hyde Park, New York 11042
North Shore University Hospital
Hearing and Speech Center
300 Community Drive
Manhasset, New York 11030

NIAGARA COUNTY
Niagara Cnty. Hearing and Speech
Upper Mountain Road
Lockport, New York 14094

ONEIDA COUNTY
Faxton Children's Hospital
Gruppe Hearing and Speech
1676 Sunset Avenue
Utica, New York 13502

ONONDAGA COUNTY
SUNY Health Sciences Center
Kings County Hospital Center
Hearing and Speech Center
451 Clarkson Avenue
Brooklyn, New York 11203
Kingsbrook Jewish Medical Center
585 Schenectady Avenue
Brooklyn, New York 11203
Long Island College Hospital
340 Henry Street
Brooklyn, New York 11201

New York
Bellevue Hospital Center
First Avenue and 27th Street
New York, New York 10016
Beth Israel Medical Center
10 Nathan D. Perlman Place
New York, New York 10003
Harlem Hospital Center
Hearing and Speech Center
506 Lenox Avenue
New York, New York 10037
ICD International Ctr. For the Disabled*
340 East 24th Street
New York, New York 10010
Lenox Hill Hospital
100 East 77th Street
New York, New York 10021
Manhattan Eye, Ear & Throat Hospital
Hearing and Speech Center
210 East 64th Street
New York, New York 10021
Mount Sinai Hospital
One Gustave L. Levy Place
New York, New York 10029
New York Eye and Ear Infirmary
310 East 14th Street
at Syracuse University Hospital
750 East Adams Street
Syracuse, New York 13210

New York, New York 10003

N Y League for Hard of Hearing
71 West 23rd Street
New York, New York 10010

**OTSEGO COUNTY**

Mary Imogene Bassett Hospital
Atwell Road
Cooperstown, New York 13326

N Y University Med. Center
560 First Avenue
New York, New York 10016

**PUTNAM COUNTY**

UCP Association of NYS
Hudson Valley Community Serv.
Robin Hill Community Park
Route 22
Patterson, New York 12563

Presbyterian Hosp. In the City of
New York
Columbia-Presbyterian Med Ctr
622 West 168th Street
New York, New York 10032

**RENSSELAER COUNTY**

St. Mary's Hospital
Hearing and Speech Center
1300 Massachusetts Avenue

St. Luke's Roosevelt Hosp Ctr
(Roosevelt Division)
428 West 59th Street
New York, New York 10019

**ROCKLAND COUNTY**

Helen Hayes Hospital
Route 9W
West Haverstraw, New York 10993

St. Luke's Roosevelt Hosp Ctr
Hearing and Speech Center
Amsterdam and 114th Street
New York, New York 10028

Rockland Cnty. Center For Physically
Handicapped, Inc. (Jawonio, Inc.)
260 Little Tor Road
New City, New York 10959

Society of the New York Hospital
Speech and Hearing Center
525 East 68th Street
New York, New York 10021

Queens
City Hospital at Elmhurst
79-01 Broadway
Elmhurst, New York 11373

Richmond Hearing Center*
30th Avenue and 75th Street
Jackson Heights, New York 11370

Queens Hearing and Speech Center*
Queens College
6522 Kissena Boulevard
Flushing, New York 11367

**SCHENECTADY COUNTY**

Sunnyview Hosp. And Rehab.
1270 Belmont Avenue
Schenectady, New York 12308

Lexington Hearing Center*
30th Avenue and 75th Street
Jackson Heights, New York 11370

**SUFFOLK COUNTY**

St. Charles Hospital
200 Belle Terre Road
Port Jefferson, New York 11777

Queens Hearing and Speech Center*
Queens College
6522 Kissena Boulevard
Flushing, New York 11367

**Richmond**
Here are some phone numbers which may help you find services for your patients. You may get a busy signal the first or second time you try to call. Keep trying Someone will answer soon and you will get the help or advice you need. THESE CALLS ARE FREE.

**HOTLINES**

**AIDS**
1-800-462-1884  
M-F 8 AM-8 PM, Sat-Sun 10 AM-6 PM

Information on testing and local services for AIDS victims and their families.

**Disabilities**
1-800-522-4369  
M-F 9 AM-5 PM

Information about services, legal rights, and protection for disabled persons and their families.

**Domestic Violence**
English 1-800-942-6906  
7 Days 24 Hours  
Spanish 1-800-942-6908  
M-F 9 AM-5 PM

Information and referrals to battered women shelters, safe homes, counseling, support groups, social services, and legal assistance.

**Early Help**
1-800-462-7653
Information about services for children birth to 5 years of age with special needs and local Early Childhood Detection centers. (ie: Developmentally disabled, physically disabled, technologically dependent...)

**Health Baby**

1-800-522-5006  
M-F 8 AM-4 PM

Information about pregnancy testing, prenatal care, postnatal care, well baby and child care, WIC, family planning, social services, and child abuse prevention programs.

**Income Maintenance and Food Stamps**

1-800-342-3009  
M-F 8 AM-5 PM

Information on the Home Energy Assistance Program, Food Stamps, WIC, School Meals Program, Home-Delivered Meals, and Federal Disability Benefit Program.

**Prevention Information Resource Center (PIRG)**

1-800-342-PIRC  
M-F 10 AM-3 PM

Information about child abuse and neglect. Referrals to local parent programs and services. Distributes pamphlets and other materials.

**Substance Abuse & Alcohol**

1-800-522-5353  
7 Days 24 Hours

Information, assistance, and services for individuals and family members who need help with CRACK and other drug-related problems.

**To Report Suspected Child Abuse and Neglect**

**Child Abuse and Maltreatment Register**

1-800-342-3720  
7 Days 24-Hours

Handles reports of child abuse and neglect. Call only to report instances of suspected child abuse and neglect.

**Other**

**Advocacy for the Developmentally Disabled, Inc.**

1-800-462-4347  
M-F 8:30 AM-5 PM

Information about services for people with developmental disabilities.

**Lamaze/ASPO**

1-800-368-4404  
M-F 9 AM-5 PM

Distributes a list of local certified childbirth educators.

**National Child Safety Council Childwatch**

1-800-222-1464  
M-F 7 AM-3:30 PM

Answers questions about safety, household dangers, and drug abuse.
Below are listed the telephone numbers for the appropriate unit providing care to children with HIV infection at their facility.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Telephone Number</th>
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</thead>
<tbody>
<tr>
<td><strong>MANHATTAN</strong></td>
<td></td>
</tr>
<tr>
<td>Bellevue Hospital Center</td>
<td>(212) 263-6954</td>
</tr>
<tr>
<td>Beth Israel Medical Center</td>
<td>(212) 420-2400</td>
</tr>
<tr>
<td>Harlem Hospital Center</td>
<td>(212) 939-4040</td>
</tr>
<tr>
<td>Metropolitan Hospital Center</td>
<td>(212) 423-6228</td>
</tr>
<tr>
<td>Mount Sinai Medical Center</td>
<td>(212) 241-6159</td>
</tr>
<tr>
<td>New York Hospital - Cornell Medical Center</td>
<td>(212) 746-3326</td>
</tr>
<tr>
<td>Presbyterian Hospital</td>
<td>(212) 305-7222/5000</td>
</tr>
<tr>
<td>St. Luke's - Roosevelt Hospital Special Programs</td>
<td>(212) 523-5818</td>
</tr>
<tr>
<td>St. Vincent's Hospital of New York</td>
<td>(212) 604-7884</td>
</tr>
<tr>
<td><strong>BROOKLYN</strong></td>
<td></td>
</tr>
<tr>
<td>Brookdale Hospital Medical Center</td>
<td>(718) 240-5880</td>
</tr>
<tr>
<td>Brooklyn Hospital Center (Caledonian Division)</td>
<td>(718) 250-8965</td>
</tr>
<tr>
<td>Interfaith Medical Center</td>
<td>(718) 604-6411</td>
</tr>
<tr>
<td>Kings County Hospital Center</td>
<td>(718) 245-2562/2563</td>
</tr>
<tr>
<td>Lutheran Medical Center</td>
<td>(718) 630-8233</td>
</tr>
<tr>
<td>University Hospital of Brooklyn</td>
<td>(718) 270-2370</td>
</tr>
<tr>
<td>SUNY Health Science Center</td>
<td>(718) 963-7981</td>
</tr>
<tr>
<td>Woodhull Medical and Mental Health Center</td>
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<tr>
<td><strong>BRONX</strong></td>
<td></td>
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<tr>
<td>Bronx-Lebanon Hospital Center</td>
<td>(718) 960-1010</td>
</tr>
<tr>
<td>*Bronx Municipal Hospital Center</td>
<td>(718) 918-4903</td>
</tr>
<tr>
<td><em>(Pediatric Consultant Service Only)</em></td>
<td></td>
</tr>
<tr>
<td>Lincoln Medical and Mental Health Center</td>
<td>(718) 579-5141</td>
</tr>
<tr>
<td><strong>QUEENS</strong></td>
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</tbody>
</table>
Elmhurst Hospital Center (718) 334-5390
Long Island College Hospital (718) 780-1321
New York Hospital Medical Center of Queens (718) 670-1802
(Formerly Booth Memorial Medical Center)
Queens Hospital Center (718) 883-3349

STATEN ISLAND

St. Vincent’s Medical Center of Richmond (718) 876-2520
Staten Island University Hospital (718) 226-6226

LONG ISLAND

Nassau County Medical Center (516) 572-8811
North Shore University Hospital (516) 773-7376
University Hospital (516) 444-2728
SUNY Health Science Center at Stony Brook

UPSTATE NEW YORK

Albany Medical Center Hospital (518) 262-6888
Children’s Hospital of Buffalo (716) 878-7908
Nyack Hospital (914) 348-2587
Strong Memorial Hospital (716) 275-5944
{Provider Hotline - (716) 275-8418}
University Hospital (315) 464-6331
SUNY Health Science Center at Syracuse
Westchester County Medical Center (914) 285-1379/8333

The following hospitals and facilities have developed special programs for adolescents with HIV infection:

<table>
<thead>
<tr>
<th>Hospital/Facility</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>MANHATTAN</td>
<td></td>
</tr>
<tr>
<td>Community Health Project</td>
<td>(212) 675-3559 or (212) 675-3557</td>
</tr>
<tr>
<td>Mount Sinai Medical Center</td>
<td>(212) 241-7214</td>
</tr>
<tr>
<td>St. Luke's-Roosevelt Hospital</td>
<td>(212) 523-6306</td>
</tr>
<tr>
<td>BROOKLYN</td>
<td></td>
</tr>
<tr>
<td>Kings County Hospital Center (Brooklyn Pediatric AIDS Network)</td>
<td>(718) 270-3825</td>
</tr>
</tbody>
</table>
BRONX

Albert Einstein College of Medicine (Bronx Pediatric AIDS Consortium - BPAC) (718) 430-2940
Montefiore Medical Center (Adolescent Program) (718) 882-0232

QUEENS

Elmhurst Hospital Center (718) 334-5040

STATEN ISLAND

Staten Island University Hospital (718) 790-8034/1576

LONG ISLAND

North Shore University Hospital (516) 773-7669
Suffolk County Department of Health Services (516) 853-3138

MID-HUDSON

Westchester County Medical Center (914) 285-7696

MOBILE MEDICAL VANS

Community Family Planning Council (212) 979-9014 or (212) 366-4500
William F. Ryan Community Health Center (212) 316-7956

County Listing

<table>
<thead>
<tr>
<th>County</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Albany County Lead</td>
<td>(518) 477-4612</td>
</tr>
<tr>
<td>Allegany County Lead Program</td>
<td>716-268-9250</td>
</tr>
<tr>
<td>Broome County Lead Program</td>
<td>607-778-2887</td>
</tr>
<tr>
<td>Cattaraugus County Lead Program</td>
<td>716-373-8050</td>
</tr>
<tr>
<td>Cayuga County Lead Program</td>
<td>315-253-1449</td>
</tr>
<tr>
<td>Chautauqua County Lead Program</td>
<td>716-753-4780</td>
</tr>
<tr>
<td>Chemung County Lead Program</td>
<td>607-737-2028</td>
</tr>
<tr>
<td>Chenango County Lead Program</td>
<td>607-337-1660</td>
</tr>
<tr>
<td>Clinton County Lead Program</td>
<td>518-565-4848</td>
</tr>
<tr>
<td>Columbia County Lead Program</td>
<td>518-828-3358</td>
</tr>
</tbody>
</table>
Cortland County Lead Program 607-753-5203
Delaware County Lead Program 607-746-3166
Dutchess County Lead Program 914-831-0502
Erie County Lead Program 716-885-0800
Essex County Lead Program 518-873-6301
Franklin County Lead Program 518-483-6767
Fulton County Lead Program 518-762-0720
Genesee County Lead Program 716-344-8506
Greene County Lead Program 518-943-5201
Hamilton County Lead Program 518-648-6141
Herkimer County Lead Program 315-866-7122
Jefferson County Lead Program 315-782-9289
Lewis County Lead Program 315-376-5449
Livingston County Lead Program 716-243-7290
Madison County Lead Program 315-366-2361
Monroe County Lead Program 716-274-6089
Montgomery County Lead Program 518-853-3531
Nassau County Lead Program 516-571-2310
New York City Lead Program 212-BAN-LEAD
Niagara County Lead Program 716-694-5454
Oneida County Lead Program 315-798-5220
Onondaga County Lead Program 315-435-3271
Ontario County Lead Program 716-396-4343
Orange County Lead Program 914-569-1571
Orleans County Lead Program 716-589-7004
Oswego County Lead Program 315-349-3547
Otsego County Lead Program 607-547-6468
Putnam County Lead Program 914-278-6558
Rensselaer County Lead Program 518-270-2651
Rockland County Lead Program 914-364-2508
Saratoga County Lead Program 518-584-7460
Schenectady County Lead Program 518-386-2824
Schoharie County Lead Program 518-295-8382
Schuyler County Lead Program 607-535-2704
Seneca County Lead Program 315-539-9294
St. Lawrence County Lead Program 315-265-3730
Steuben County Lead Program 607-776-9631
Suffolk County Lead Program 516-853-2926
Sullivan County Lead Program 914-292-0100
Tioga County Lead Program 607-687-0623
Tompkins County Lead Program 607-274-6604
Ulster County Lead Program 914-338-9130
Warren County Lead Program 518-761-6415
Washington County Lead Program 518-746-2400
Wayne County Lead Program 315-946-5749
Westchester County Lead Program 914-593-5203
Wyoming County Lead Program 716-786-8890
Yates County Lead Program 315-536-5160