House of Representatives
Study Committee on Abandoned Child Placement Following Hospital Discharge

Final Report

Chairman Katie Dempsey
Representative, 13th District

The Honorable Mike Cameron
Representative, 1st District

The Honorable Sharon Cooper
Representative, 45th District

The Honorable Omari Crawford
Representative, 89th District

The Honorable Lee Hawkins
Representative, 27th District

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Prepared by the House Budget and Research Office

Introduction

The House Study Committee on Abandoned Child Placement Following Hospital Discharge was created by House Resolution 611 during the 2025 Legislative Session of the Georgia General Assembly. The primary purpose of this study committee is to provide a gap analysis of community services and resources provided by the public, nonprofit, and private sectors to better support minors being discharged from psychiatric hospitalization and acute hospital emergency rooms. The committee heard testimony from 25 experts from state agencies, hospitals and psychiatric facilities, advocacy groups, and family care organizations. Members reviewed the causes of abandonment, barriers to care, and potential solutions.

Testimonials

Monday, September 15, 2025 – Georgia State Capitol (Atlanta, GA)

- Audrey Brannen, Complex Care Coordinator, Department of Human Services
- Dana H. Carroll, Deputy General Counsel, Department of Human Services
- Dr. Christy Doyle, Senior Director of the Office of Children, Young Adults, and Families, Department of Behavioral Health and Developmental Disabilities
- Heather Stanley, MATCH Program Director, Department of Behavioral Health and Developmental Disabilities
- Emily Acker, President and CEO, Hillside
- Dr. Kimberly Young, Vice President of Residential Operations and Clinical Services, Hillside
- Amy Rene, Vice President of Community Operations and Clinical Services, Hillside
- Corey Jackson, CEO, Laurel Heights Hospital
- Sonya Rice, Business Development Director, Laurel Heights Hospital
- Lesley Kelley, Senior Policy Analyst, Voices for Georgia's Children
- Melissa Carter, Executive Director, Barton Child Law and Policy Center
- Stuart Portman, Executive Director for the Medical Assistance Plans Division, Department of Community Health

Tuesday, September 30, 2025 – Georgia State Capitol (Atlanta, GA)

- Dr. John Constantino, Chief of Behavioral and Mental Health, Children's Healthcare of Atlanta
- Marcus Graham, Manager of Behavioral and Mental Health Specialists, Children's Healthcare of Atlanta
- Abel Ortiz, Director of Program Development/Evaluation and Legal Affairs, Safe Families for Children
- Candice Broce, Commissioner, Georgia Department of Human Services
- Dr. Sue Smith, Chief of Peer Services Operations, Georgia Parent Support Network
- Joe Sarra, Children’s Freedom Initiative Director, Georgia Advocacy Office

Wednesday, October 22, 2025 – Georgia State Capitol (Atlanta, GA)

- Renee Johnson, Executive Director of MindWorks Georgia, Georgia Health Policy Center
- La'Keidra Mitchell, Senior Research Associate at Center of Excellence for Behavioral Health and Wellbeing, Georgia Health Policy Center

- Claire Cantrell, Deputy Director, Together Georgia
- Tanya Anderson, Executive Director, Youth Villages
- Don Nelson, Vice President of National Government Affairs, Magellan Health
- Dr. Jamie Hanna, National Medical Director of Children's Behavioral Health, Magellan Health
- Wayne Naugle, CEO and Founder, Families 4 Families

Committee Findings

Background and Data

Causes and Impact of Abandonment

Data on the number of children who have been or are at risk for abandonment at psychiatric residential treatment facilities (PRTF) and acute hospital emergency rooms varies. The Division of Family and Children Services (DFCS) shared that the number of kids with complex behavioral health needs has significantly grown in recent years and maintains a complex care tracking system that has about 500 children with complex behavioral health needs. Children's Healthcare of Atlanta (CHOA) shared that from January through September of 2025, 20 youth with behavioral health challenges were left at their emergency department (ED). Hillside, an Atlanta-based PRTF, had two youth abandoned in their care at the time they testified; Laurel Heights, another PRTF in Atlanta, has had 69 youth left in their care since 2023; and Youth Villages, a PRTF located in Douglassville, had five youth abandoned from 2023-2025. The longest reported time a child remained in a facility after discharge was over a year and the cost of uncompensated care exceeded $940,000 for facilities that testified.

The causes of abandonment are multi-layered and complex. Providers and advocates testified that parents do not wish to give up custody of their children, however they have run out of options to care for and manage their child's behavioral health needs. Abandonment is often preceded by previous hospitalization or inpatient psychiatric stays, navigating complicated and limited health and insurance systems, and destructive and dangerous behaviors that lead to safety concerns for the child, their parents, and other siblings in the home. PRTFs shared that when parents do not participate in their child's treatment, family therapy, and discharge planning, that is a predictor for abandonment. By this point parents are exhausted and feel guilty or isolated, highlighting the need to not only treat the child, but provide their families with the tools and resources for them to feel prepared to care for their child upon discharge. Joe Sarra from the Georgia Advocacy Office shared the 40-year-old term of "trading custody for care" as an alternative to "abandonment" in describing the difficult decision parents make when their resources are exacerbated.

Dr. Sue Smith with the Georgia Parent Support Network and Joe Sarra discussed the isolation experienced by families who have been managing as best they can with their child's behavioral health needs. Parents have to navigate taking their child to treatment, calls from school, destructive and dangerous behaviors at home, and accessing resources. This can lead to having to call off, reducing work hours, or leaving the workforce completely. The behaviors may also cause families to withdraw from social and community activities, such as church or grocery shopping, further isolating them from support networks.

Adoptive and foster youth as well as youth with co-occurring disorders, especially autism spectrum disorder (ASD), made up a significant portion of those that were abandoned. For adoptive and foster youth, parents are often unaware of previous behavioral health issues or histories of childhood/family trauma. Treating youth with co-occurring disorders is an increasing need and very few programs provide

services for dual diagnoses. Laurel Heights, a PRTF in Atlanta, shared that 50% of their acute and 70% of their inpatient beds are patients with ASD.

Facilities shared their experiences in caring for youth who have been abandoned. When a child is in a facility beyond their date of discharge, that is one less bed available exacerbating the existing bed shortage and growing waitlists in Georgia. Additionally, within a month, progress that has been achieved through treatment is undone and the patient regresses back to pre-admission behaviors or they worsen given they feel rejected after making efforts to be discharge ready. This is complicated by the fact that facilities cannot make decisions on behalf of the child as they are not the authorized guardian and the family has stopped participating, so the original treatment plan has to be adhered to even when circumstances and symptoms change.

Role of the State

The role of the state in relation to assuming custody of a child and responding to abandonment is outlined throughout Georgia Code. O.C.G.A. § 15-11-30 establishes parents' right to "physical custody of a child, the right to determine the nature of the care and treatment of such child, including ordinary medical care, and the right and duty to provide for the care, protection, training, and education and the physical, mental, and moral welfare of such child…" O.C.G.A. § 19-7-2 explains the obligation parents have to provide for the "maintenance, protection, and education of his or her child..." O.C.G.A. § 15-11-2 defines abandonment as "any conduct on the part of a parent, guardian, or legal custodian showing an intent to forgo parental duties or relinquish parental claims." This Code section outlines a number of circumstances in which a child is considered abandoned with a minimum of six months needed for state intervention, or three months when a child is left "without affording means of identifying such child or his or her parent, guardian, or legal custodian" and efforts to identify them have been exhausted and no one has come forward to claim the child. DFCS shared that a minimum amount of time is necessary to protect the rights of the child and parent. O.C.G.A. § 19-10-1 defines abandonment as a misdemeanor, though presenters shared this is rarely applied to parents when a child is left at a facility.

Facilities shared they often have to seek legal remedies for DFCS to take legal custody of the child and that once a child is abandoned, it can take 45-60 days for court proceedings to take place. In discussing the five cases of abandonment they experienced, Youth Villages shared the difficulty that arises when working with different jurisdictions. Each patient came from a different county, so responses from local DFCS offices and courts varied further complicating resolution.

Several advocates and providers shared that sometimes parents are encouraged to surrender their child to DFCS by providers, educators, or first responders under the assumption this will guarantee their child receives needed care. However, as DFCS representatives testified, foster care is not meant to or equipped to provide behavioral health care and even DFCS experiences the same gaps and barriers as parents when seeking care for youth in their custody.

The federal 'Family First Prevention Services Act' (FFPSA), enacted in 2018, was meant to reduce child welfare involvement by expanding prevention services, however funding pathways have been underutilized and limited. Lesley Kelley and Melissa Carter discussed voluntary placement agreements,

which can be used by parents to give their children to the state without relinquishing their rights. Currently this option is used when youth aged 18 years and older need to return to state care.

Limited Services to Address High Behavioral Health Needs Among Youth

There are six PRTFs across the state, which have limited bed capacity and weeks-long waitlists. Similarly, hospitals and crisis stabilization units have limited space and are not meant for more long-term care. Stepdown facilities are needed as options for youth who no longer require inpatient care, yet are not ready to return home. This can give parents additional time to prepare for their child to come home and continue to provide them with critical resources and skills while their child is under care. Unfortunately, the availability and coverage options for stepdown facilities are limited. Qualified residential treatment programs (QRTPs), a trauma-informed model that provides an alternative placement, are expected to be a suitable stepdown option and have been piloted by DFCS in Cedartown and a second pilot is expected to be announced soon.

The issue of out-of-state youth in Georgia beds was raised throughout the study committee. It is estimated that at least 40% of residential psychiatric beds in Georgia were occupied by out-of-state residents. Despite increases in the rates paid to psychiatric facilities by the state, other states continue to pay at higher rates than Georgia, so out-of-state youth are accepted by the facilities. This worsens the bed shortage and sometimes causes Georgia youth to be sent out of state for care, which can be costly.

Facilities, agencies, and advocates alike described the current system of behavioral health care for youth as fragmented. Limited community-based care and child psychiatric provider shortages create barriers for families seeking outpatient care for their children, further exhausting them as they navigate the system. PRTFs shared that the system was even complicated for their staff as they were passed around by different organizations with incorrect contact information and unclear eligibility criteria as they tried to secure outpatient resources for patients.

Lack of data between agencies, healthcare systems, and providers leads to further fragmentation of care. There is no comprehensive tracking of youth as they move through care systems, so stakeholders often do not have records of past treatment, critical patient history, and services that have been previously offered or successful. DFCS, which is legally entitled to records of the youth in their care, shared that the lack of a centralized data system creates barriers and has launched Communicare, a data-sharing system for caseworkers, parents, foster care providers, and court appointed special advocates.

Obtaining and continuing coverage for critical services has created additional barriers for both families and facilities. Every insurer has a different approval process, which makes finding and providing care difficult and can be an immense administrative burden. Patients are often prioritized for placement when they have lower needs due to the likelihood of successful discharge and less time in care, leaving youth with higher needs with fewer options. DFCS shared that since they often have high need or dual diagnosis (e.g., ASD, developmental disabilities) youth in their care, they are restricted in finding care and coverage options often having to use state funds when Medicaid is not an option.

Denials and required case reviews also present an issue for facilities. When a child is no longer a danger to themselves or others, coverage is ended even if psychiatric symptoms persist and inpatient care is still needed. Payment typically stops within 30 days, a cost that facilities sometimes absorb. Payors conduct periodic case reviews to evaluate the medical necessity of inpatient treatment to determine whether or not they will continue paying for a patient's stay. Laurel Heights shared that these reviews take place within 24 hours for short-term and five to seven days for long-term care, which does not give providers enough time to properly assess the patient leading to denial. While they have been successful in overturning 70% of their denials, these appeals take resources and time at the expense of the patient. CHOA also testified about the constant reassessments required by payors and that 47% of their patients with fee-for-service Medicaid were denied for inpatient psychiatric care. Payors also deny if a family did not exhaust all options prior to seeking inpatient care, despite the fact options are not always available or accessible.

The importance of treating both the patient and the family was highlighted by several presenters. Given the guilt, fear, isolation, and exhaustion families experience prior to an inpatient stay, they may not feel confident, ready, or safe enough to receive their child upon discharge. Additionally, negative behaviors in the home do not always present in the inpatient setting and skills taught at facilities do not always translate to the home environment, especially when there are other children present. PRTFs and CHOA shared a range of services they provide the family, which include linkages to outpatient care, social service referral, in-home visits, skill building, family therapy, and peer support. Unfortunately, these services are usually not eligible for coverage while the child is receiving inpatient care as they are deemed by payors to be duplicative and not medically necessary, causing them to be another cost facilities pay for themselves out of pocket or through specialized medical codes, which can be unsustainable and not available to all providers.

Programs and Initiatives

The study committee heard from several facilities and programs that provide care and work to address the previously mentioned system gaps including three PRTFs, CHOA, the Department of Community Health (DCH), the Multi-Agency Treatment for Children, local interagency planning teams (LIPT), and other models of care.

Psychiatric Residential Treatment Facilities (PRTF)

There are six psychiatric residential treatment facilities located throughout Georgia that provide residential, in-home, and community-based treatment for youth with complex behavioral health conditions. PRTFs provide services for not only the youth patient, but their whole family including family therapy, case management, and resource referral. The committee heard from three PRTFs including Hillside, Laurel Heights Hospital, and Youth Villages.

Hillside is a PRTF located in Atlanta and also provides in-home care in metro Atlanta and Savannah. The average length of stay for patients is 100-109 days. Among their patient population, 62% have two to three mental health diagnoses, 80% have engaged in non-suicidal self-harm behaviors, 56% have at least one previous suicide attempt, and most have about seven previous inpatient stays. As of September 15,

2025, there were 90 youth in their care, 18 of which were under DFCS custody. Over the last year, Hillside has had two cases of abandonment which resulted in $40,000 in uncompensated care. To assist with difficult cases, the facility has hired a complex care discharge planner with their own funds as it is not a reimbursable position, but essential to youth recovery and transition.

Laurel Heights Hospital is a PRTF in Atlanta that treats youth in acute and long-term crisis. Of their patients, about 50% of acute and 70% of residential beds are occupied by patients with autism spectrum disorder. In 2024, the facility incurred over $535,000 in property damage from patients. Since 2023, 69 children have been abandoned at the facility, one year being the longest time in care, leading to $715,567 in uncompensated care. Of these patients, 22 had autism spectrum disorder. The options available to youth who are abandoned are finding another facility for them, requesting DFCS take custody, or retaining the child without reimbursement until they can be returned home and given outpatient services.

Youth Villages, located in Douglassville, provides inpatient and outpatient services for youth in the child welfare system and those experiencing behavioral health issues. Their Lifeset program supports youth aged 17-22 years old transitioning out of foster care as they enter young adulthood, serving 214 youth in FY 2025. The Intercept program provides intensive in-home services for youth at risk for child welfare involvement with 120 youth aged 0-18 years old served in FY 2025. Their PRTF has a 144-bed capacity and had 141 patients as of October 21, 2025, and served 304 youth in FY 2025. From 2023-2025, there were five youth abandoned at their facility and one remained at the facility at the time of testimony. Four youth came from adoptive families and the one remaining child was from a biological family. Three youth were eventually placed in DFCS custody, with the quickest response being for a child whose parent had formally begun termination of their parental rights. Combined, the five patients accounted for over 363 days of abandonment with 195 days being the longest time in care post-discharge, resulting in a total of over $235,608 in uncompensated care and $5,611 in legal counsel, which had to be absorbed by the facility. They shared that sometimes DFCS will reimburse for care when they take custody, but usually not.

Children's Healthcare of Atlanta (CHOA)

Children's Healthcare of Atlanta (CHOA) provides behavioral healthcare to about 5,000 youth every year. Among their patients, 49.7% had no prior outpatient mental health care and many used the ED as their form of behavioral health services and about 50% of those admitted were suicidal. From January through September 2025, 20 children were left at CHOA's ED. Of those children, 10 were entered into DFCS custody (seven for the first time) and ten were placed in alternative/kinship placement. These youth stayed in the ED for an average of 45 hours and combined 37.5 days.

Overall, most patients (60%) discharged for behavioral health crises did not receive the recommended outpatient follow-up care for a variety of reasons. In response, CHOA has established a number of initiatives to ensure that youth and their families are connected to appropriate outpatient options to prevent future inpatient stays. The CHOA Crisis Recovery Care program prevents inpatient care by identifying patient needs at admission and providing outpatient care with a two-generation model, simultaneously serving the patient and their families. The program led to a 60% reduction in ED

recidivism due to the linkage to outpatient care. CHOA has also invested in the child psychiatry workforce by addressing the shortage of providers, particularly child psychiatrists. They recruit recent graduates with adequate pay and workforce support to prevent burnout, while being intentional in not taking from the local workforce. CHOA has also utilized psychiatric nurse practitioners to supplement the child psychiatrist shortage. Additionally, providers with specialized treatment experience (e.g., dialectical behavior therapy) are retained ensuring that they take insurance.

Department of Community Health Models

The Georgia Department of Community Health (DCH) presented an innovative model. The in lieu of services community sustainability model (ILOS-CSM) ensures youth can remain in the community when appropriate while receiving psychiatric care and increasing parent and guardian confidence to participate in care. Through this model, children and their families will receive holistic, multigenerational services in settings appropriate to their needs which can include the family home, psychiatric residential treatment facilities, and community-based stepdown placements. In addition to treatment, these services will include case management, respite care, behavior aid services, parent peers, and caregiver therapy. This approach is hoped to deter abandonment by ensuring that during and following the child's treatment, families are connected to critical resources so they feel confident and supported in caring for their child. This provides Georgia an opportunity to be one of the first states to implement such a unique model of care.

Currently, DCH operates the Rapid Response Process (RPP) in collaboration with Amerigroup Families 360, which serves youth in foster care, the juvenile justice system, and adoptive families. RPP ensures that youth are placed in appropriate clinical settings and successfully reintegrated back into the community after discharge through care coordination, case management, and compliance. The program has resulted in a 75% to 80% decrease in out-of-state placements since June 2025.

Multi-Agency Treatment Team (MATCH)

The Multi-Agency Treatment for Children (MATCH) program was established in 2022 by House Bill 1013 to coordinate resources and services for youth with complex behavioral health needs when the level of care needed extends beyond the capacity of local resources. MATCH operates under the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) facilitating collaboration between child-serving state agencies, providers, and community partners to serve identified youth and their families. The MATCH clinical team is made of representatives from DBHDD, DCH, the Department of Human Services (DHS)/DFCS, the Department of Corrections (DOC), the Department of Education (DOE), the Department of Juvenile Justice (DJJ), the Department of Public Health (DPH), and the Office of the Child Advocate (OCA) with participation from Medicaid care management organizations (CMO) and providers when needed.

Youth are referred to MATCH by a variety of sources (e.g., schools, LIPTs, agencies, facilities). Consent is obtained from their parent or guardian and relevant information, such as clinical summaries and treatment history, is prepared for clinical team review. The team addresses immediate concerns and payor issues and develops a care plan, which includes inpatient or stepdown care, wraparound services,

and family support. Periodic follow-up is conducted and changes to the care plan are implemented when needed. As of the end of FY 2025, MATCH reviewed 198 youth, 80 of which were staffed by the full clinical team. Among MATCH youth, 91% had a mental health diagnosis, 59% had co-occurring ASD, 63% had DFCS involvement, and 24% were in a PRTF at the time of referral.

In addition to providing care coordination, MATCH has also created several block grant funded pilots to further help youth in crisis. Devereux Short-Term Transitional Treatment Program serves males with co-occurring intellectual disabilities and complex behavioral needs aged 18 to 21 years old. This pilot has provided a stepdown option for 13 youth, while working with their families to increase support. The CHOA/View Point Behavioral Health ED Case Management pilot placed caseworkers from Viewpoint in CHOA EDs to provide wraparound services to patients with behavioral health needs. The pilot made 234 referrals and has since concluded due to its success and CHOA assuming the responsibility for wraparound referrals. The previously mentioned Youth Villages Intercept program is also a MATCH pilot.

Local Interagency Planning Teams (LIPTs)

Local interagency planning teams (LIPTs) were established by O.C.G.A. § 49-5-225 as a way to improve and facilitate coordination of services for youth with behavioral health issues. Mandated partners include DBHDD, DPH, DFCS, DJJ, local school systems, Georgia Vocational Rehabilitation Agency (GVRA), and local mental health agencies, usually a community service board (CSB). There are 109 active LIPTs that serve 124 counties with a volunteer chairperson and they meet monthly or on an as-needed basis. Families are referred from schools, community organizations, state agencies, or clinicians. The LIPT process is explained to the family and they can decide if they would like to participate or not. During meetings with partners and the family, a care coordination plan is developed which involves connections with local resources and services.

The LIPTs work in coordination with MATCH, referring to MATCH when local resources have been exhausted and vice-versa when they have not been exhausted. LIPTs also lead the Infant and Early Childhood Mental Health pilot under Georgia Department of Early Care and Learning (DECAL), which coordinates and improves services for children aged 0-5 years old. Lack of compensation for chairpersons has caused turnover among the LIPTs. To address this, other local interdisciplinary teams are being approached to serve in areas without a LIPT.

Non-Profits

Abel Ortiz with Safe Families for Children (SFFC) presented their model to prevent child welfare involvement. SFFC is a national church-based non-profit that uses a network of volunteers to provide peer support and resources to families with children at risk for child welfare placement. Nationwide and in seven countries, SFFC has served more than 50,000 families with 25,000 volunteers. Masters-level clinicians provide oversight and coordinate wraparound services with volunteers from the same communities who are aware of the local resources and services such as transportation, childcare, housing, employment, and the healthcare system. SFFC has a pilot in Westside Atlanta across three churches that has served 17 families, 38 children, and is looking to expand to an additional 16 churches.

Wayne Naugle from Families 4 Families, a foster and adoption placement non-profit, discussed their services and how they prevent burnout of foster and adoptive families. They work with churches to recruit foster and adoptive parents and support these families with date nights, respite care, support groups, meals, training, and resources.

Other State Models

Voices for Georgia's Children shared models from other states in addressing the issue of abandonment or psychiatric lockout. Illinois' Specialized Family Support Program (SFSP) is a multi-agency team that provides a 90-day voluntary placement agreement for the child and their parent or guardian. Intensive case management, crisis services, outpatient behavioral health care, and family support services are provided with a mix of funding including private and public insurance, social security, parents, and other state funds. Washington has a state-funded Rapid Care Team (RCT), which is a multi-agency team using parent peer liaisons and behavioral health providers for care and wraparound services. These programs are similar to MATCH and LIPTs, except SFSP and RCT are authorized to direct an agency to take action if needed and have designated sources of state funding.

Louisiana's Magellan Health is also similar in the continuum of care they provide. However, they testified that when youth are abandoned at their facility, child welfare responds quickly due to differences in their state code. Additionally, the program uses section 1915 waivers as a funding pathway for FFPSA and treating youth with co-occurring disorders.

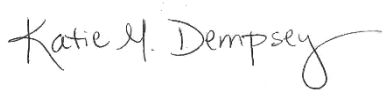
Committee Recommendations

Upon review of the information presented, the House Study Committee on Abandoned Child Placement Following Hospital Discharge recommends the following:

1. Revise the Georgia Code on abandonment and work with appropriate state agencies to develop a clear, unified policy to establish guardianship of youth who have been abandoned at facilities.
2. Explore and submit necessary waivers that would allow for family-centered care services such as parent education, family therapy, and home visits to be covered while the child is inpatient to help families feel confident and equipped with the skills to care for their children upon discharge. Additionally, ensure payors authorize prevention services to keep children in the home.
3. Encourage investment in behavioral health case management to help families navigate complex care systems, social determinants of health, and insurance processes. This can include discharge planners, parent peers, and care coordinators.
4. Encourage funding additional discharge planners for the state's psychiatric residential treatment facilities so families are connected with community-based resources when their child is released.
5. Support the Department of Community Health's in-lieu of services community sustainability model, which will provide a range of appropriate inpatient, home, and community-based treatment options for patients. Additionally, explore non-Medicaid models that create similar stepdown options for youth.
6. Increase the number of psychiatric residential treatment facility beds for high-acuity patients.
7. Create a data-sharing infrastructure between agencies, facilities, and providers that are responsible for the welfare and behavioral health services for youth for quality monitoring, continuum of care, and appropriate treatment.
8. Leverage Title IV-E funds for prevention services in line with the Families First Prevention Services Act to support at-risk families, especially two-generational services.
9. Explore funding options that reimburse facilities for the uncompensated care they provide youth who have been abandoned.
10. Strengthen existing mechanisms and solutions such as the Multi-Agency Treatment Team, local interagency planning teams, and non-profits.
11. Encourage funding respite care for high need youth to reduce burnout of families.
12. Reform insurance policies to prevent denial of critical inpatient care and family support services.
13. Encourage increased capacity for transitional services for youth exiting care, including stepdown facilities, in-home services, and respite.
14. Encourage increased Medicaid rates for psychiatric residential treatment facilities to reduce the utilization of Georgia beds for out-of-state youth.
15. Hold facilities accountable for data reporting.
16. Continue funding DFCS for costs incurred by youth with behavioral health challenges when Medicaid is not an option.
17. Coordinate services for co-occurring disorders with autism and intellectual and developmental disabilities.

Mr. Speaker, these are the findings and recommendations of the Study Committee on Abandoned Child Placement Following Hospital Discharge.

Respectfully Submitted,



The Honorable Chairman,
Representative Katie Dempsey
District 13

Prepared By:
Amber Mack
Senior Budget and Policy Analyst
House Budget and Research Office