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compared Tennessee abortion data reported by providers to the Tennessee Department of Public Health with data reported for the state by The Alan Guttmacher Institute (AGI), which collects abortion data by surveying providers directly.⁵For 1974, the Tennessee Department of Public Health reported only half the number of abortions that AGI reported.

The authors concluded that "underreporting, or more specifically, nonreporting, by some facilities in Tennessee, has occurred because clinic and hospital administrators did not know that they were responsible for reporting abortions performed at their facilities and they have relied on physicians to do so." In subsequent years, according to the authors, department of health staff informed nonreporting clinics of the law, and by 1976 the department reported 74% of the number of abortions that AGI reported.

The second study illustrates the problems that arise both from measuring rare events and from human error: A few misrecorded abortions in Georgia dramatically altered the state's data on third-trimester abortions. The authors analyzed the accuracy of data on reported third-trimester abortions in Georgia by comparing the reported information with actual medical records for each case.⁶Upon reviewing 86 third-trimester induced abortions reported to the Georgia Department of Health and Human Services in 1979 and 1980, the authors found that the vast majority of the abortions were misreported. Only three procedures could be verified as actual third-trimester induced abortions; 58 of those reported were actually fetal deaths in utero, and 15 more were first- or second-trimester abortions that had been misclassified as third-trimester. The researchers concluded that the correct rate of third-trimester abortions for Georgia in 1979 and 1980 was 4.3 per 100,000 total abortions, rather than the rate of 123.1 per 100,000 abortions reported by the state's department of health.

Abortion Reporting

As of January 1998, 48 states, the city of New York* and the District of Columbia collect data on induced abortions.⁷ The two nonreporting states, California and Oklahoma, have abortion reporting statutes on the books that are not currently in effect due to legal actions taken against related abortion statutes.

Laws

While 40 states and New York City collect abortion data as required by state statute, these laws vary. In 35 states and New York City, induced termination of pregnancy reporting is required specifically by statute (see Table 1). Overall, the laws are similar; by and large, they require every hospital or facility, or attending physician, to file a report regularly on each abortion performed, usually within a few days of the procedure or on a monthly basis. These laws mandate that abortion reports be submitted to the state department of health, state registrar or state vital statistics officer, and that the agency in turn publish the statistics on a regular basis.

Jurisdiction	Type of reporting			
	Mandatory			Voluntary
	Abortion statute	Fetal death statute	Regulatory policy	
Alabama	X			
Alaska				X
Arizona			X	
Arkansas	X*			

California				
Colorado		X†		
Connecticut			X	
Delaware	X			
District of Columbia				X
Florida	X*			
Georgia	X*			
Hawaii		X		
Idaho	X*			
Illinois	X*			
Indiana	X			
Iowa	X*			
Kansas	X			
Kentucky	X			
Louisiana	X			
Maine	X			
Maryland				X
Massachusetts	X			
Michigan	X			
Minnesota	X*			
Mississippi	X*			
Missouri	X*			
Montana	X			
Nebraska	X			
Nevada	X*			
New Hampshire				X
New Jersey				X†
New Mexico	X*			
New York		X		
New York City	X			
North Carolina	X*			
North Dakota	X*			
Ohio	X*			
Oklahoma				
Oregon	X*			
Pennsylvania	X			
Rhode Island		X*		

South Carolina	X*			
South Dakota	X			
Tennessee	X			
Texas	X*			
Utah	X			
Vermont	X			
Virginia		X*		
Washington			X	
West Virginia				X‡
Wisconsin	X			
Wyoming	X			

*A regulatory policy guides abortion data collection in addition to state statute. †Abortion reporting is done in accordance with the state's death certification statute. ‡A broad health statute provides legal authority for abortion-related data collection.

Approximately half of the state laws specify that the department of health or a related agency will prescribe and provide the abortion reporting form, and several states require that the form be similar to the U.S. standard suggested by CDC. Virtually all of the statutes include a confidentiality provision—either emphasizing that the data collected are for statistical use only and may be published in aggregate only, or, at a minimum, mandating exclusion of the patient's or provider's name on the reporting form or in the published report.

Four additional states—Hawaii, New York, Rhode Island and Virginia—are legally obligated to collect abortion data under broader fetal death reporting statutes, rather than under laws specific to abortion. The Colorado vital statistics agency, meanwhile, collects abortion data in accordance with its death certification statute, which does not single out fetal death or abortion.

Regulations

Three states—Arizona, Connecticut and Washington—are obligated to collect abortion data solely by regulations issued by their state health agencies (Table 1). Regulations in all three echo the typical reporting statute. Nineteen more states have regulatory policies that accompany their abortion or fetal death reporting statutes. Such regulations typically reinforce the provisions put forth in the state statute and provide administrative guidance for the reporting system. For example, regulations might enumerate exactly what is required on the reporting form, discriminate between requirements for different types of medical facilities or elaborate on confidentiality provisions.

Voluntary Reporting

Five states and the District of Columbia collect abortion data on a voluntary basis, and their health departments provide forms and publish the data—even though no statute or regulation requires that abortions be reported (Table 1). New Jersey and West Virginia cite broad state health statutes as providing legal authority for a state health official to collect abortion-related data, while in Alaska, Maryland, New Hampshire and the District of Columbia, the health departments do not rely on legal authority.

State Data Collection

All states that collect abortion data utilize standardized forms, and most require a separate form for each procedure. The forms largely solicit the same baseline data as does the U.S. Standard Report of Induced Termination of Pregnancy: information on the facility (name or address, city and county); demographic information on the patient (her age, marital status, race, general educational level, and city, county and state of residence); medical information on the patient (date of last normal menses and number and results of previous pregnancies); information on the procedure itself (date of termination, clinical estimate of fetal gestation and method of termination[±]) and the names of the attending physician and person completing the report.[§]

However, state forms tend to deviate from the U.S. standard in two ways. Many states do not require the same level of detail as the standard form on those items that might identify the facility, patient or attending physician—only 23 states^{**} and New York City, for example, require the patient's residential zip code, and only 28 states^{††} and New York City request information identifying the attending physician. While all but three reporting areas^{‡‡} request information on the type of procedure used, only 17 states,^{§§} New York and the District of Columbia include "medical (nonsurgical)" in the list of abortion procedures.

Conversely, many states require more information than that required in the U.S. standard form. Twenty-seven states,^{*†} for example, inquire about abortion-related complications, and several ask for additional information on the fetus, such as fetal viability, abnormality, length or weight. Nine states^{*±} ask the reason for the abortion, and seven^{*§} request information on the woman's contraceptive history.

Six states and the District of Columbia do not use a separate form for each procedure. Colorado, New Jersey, Texas and West Virginia, which require the same basic information on each abortion as does the U.S. standard form, record abortions in logs that are submitted to the state agency on a regular basis. In Florida, Massachusetts and the District of Columbia, abortions are reported to health agencies in aggregate on a monthly or quarterly schedule.

National Data Collection

Annually, CDC contacts state vital statistics agencies to request certain data tabulations from the previous year. On a voluntary basis, states then submit aggregate data to CDC in the form of the requested tabulations, or as closely as possible, based on the state's available data. In 1995, the most recent year for which CDC data are available, the agency requested data on age of woman (younger than 15, 15, 16, 17, 18, 19, 20-24, 25-29, 30-34, 35-39, and 40 and older), weeks of gestation (less than or equal to 6 weeks, 7 weeks, 8 weeks, 9-10 weeks, 11-12 weeks, 13-15 weeks, 16-20 weeks, and 21 weeks or greater), type of procedure (suction curettage, all curettage, intrauterine saline instillation, prostaglandin instillation, hysterectomy or hysterotomy, other, unknown), race, Hispanic ethnicity, marital status, previous live births and abortions, and state of residence. As in previous years, CDC surveyed abortion providers in nonreporting states to estimate the number of abortions performed in those states.

Discussion

To a great degree, a national system for collecting data on induced termination of pregnancy is in place, and, by and large, states have moved to adopt federal standards that aim to make data complete and comparable across state lines. However, there remains considerable variability among state laws, policies, forms and systems, and this variability inevitably affects CDC's ability to determine accurately even the total number of abortions performed each year. While state reporting has improved over the years—and three states installed reporting systems for the first time in 1997—AGI reported 13% more abortions nationwide than did CDC in 1995,⁷ the latest year for which comparable abortion data are available.

This variability also exacts a toll on CDC's ability to answer specific questions about abortion in the

United States. As demonstrated by the review of state reporting forms, there are considerable differences among states that do require abortion reporting in terms of the information they actually collect. Furthermore, for the information reported to the states, there often are problems with data completeness. For example, in CDC's 1995 state-level surveillance report, data on specific variables are missing for a number of states. To better assess the quality of state data, especially for small or sensitive groups, more research like the Georgia study is needed.

At the same time, it is important to understand that the information available to CDC is limited to the specific pieces of data that the agency requests from the states. For example, in 1995, in keeping with past years, the agency requested aggregated tabulations on nine variables, with some limited cross-tabulations. Therefore, the agency does not have access to state-collected abortion data in a record-by-record format, and it cannot then spontaneously answer questions about individual cases or new variables.

As a result of these data limitations, much of the information recently sought by decision-makers engaged in the "partial birth" abortion debate is currently out of CDC's grasp. Detailed information on late-term abortions is unavailable because the relatively small number of abortions beyond 20 weeks are aggregated into one gestational category. Data on certain procedures—including dilation and extraction, the medical procedure that most closely approximates characterizations of "partial-birth" abortion—are also unavailable because states and CDC collect data under broader categories.

Similarly, current limitations cast doubt on the federal government's ability to responsibly award the "illegitimacy bonuses" authorized in the federal welfare reform law: Doing so would presumably require accurate, complete and consistent data that is comparable across the years—which simply do not now exist.

Finally, the existing abortion surveillance system poses challenges to public health officials in their quest to accurately trace the use of new, nonsurgical abortion techniques. Inclusion of the new techniques on a significant number of state forms demonstrates a sensitivity to the issue on the part of many state vital statistics officers. However, ensuring reporting by all new providers will undoubtedly require increased education and outreach efforts.

While some data limitations may be intrinsic to abortion—and no system is perfect—the quality of CDC's information is primarily compromised by the unevenness of reporting in the states. Policymakers need to assess the value they place on accurate abortion statistics and match information needs with resources. If accurate abortion data are as necessary to policymaking as recent debate suggests, steps need to be taken to bolster the existing systems. Doing so first requires further research into the limitations of the current systems and data, and a significant will to improve state-level data collection and management.

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7. Henshaw SK, Abortion Services in the United States, 1995-1996, *Family Planning Perspectives*, Forthcoming.

*New York City maintains its own vital statistics systems and policies, which are separate and distinct from the rest of New York State.

†In 1996 and 1997, The Alan Guttmacher Institute (AGI) compiled state abortion reporting requirements under grant no. 000057 from the Department of Health and Human Services (DHHS), as part of the department's interest in assessing the accuracy of pregnancy data in the United States. To obtain reporting information from the states, AGI sent state vital statistics officers a copy of the state reporting law from AGI files and asked the officers to verify that the law is current, and, if not, to send AGI a copy of current law. The officers were also asked to send AGI a copy of any current regulations and reporting forms. Parts of this article are based on information gained during that effort; however, this report is neither funded by nor represents the views of DHHS.

‡Suction curettage; medical (nonsurgical) abortion; dilation and evacuation; intrauterine instillation; sharp curettage; hysterotomy or hysterectomy; and any other method.

§A chart detailing which of the 25 elements from the U.S. Standard form are used by each of the 52 jurisdictions examined in this article is available from the author.

**AL, AR, CO, DE, GA, ID, IL, IN, MD, MO, NC, ND, NH, NY, NV, OH, OR, SC, SD, TN, UT, VT, VA.

††AL, AZ, CT, GA, HI, ID, IL, IA, IN, KS, LA, ME, MI, MS, MO, MT, ND, NE, NV, NY, OH, PA, RI, SD, TN, UT, VT, WA.

‡‡IL, IA, WI.

§§AK, DE, KS, KY, ME, MI, MO, NC, NE, NH, NJ, OH, SD, TX, UT, WA, WY.

*†AZ, CT, GA, HI, ID, IL, IN, LA, MA, MD, MI, MN, MS, MT, NC, ND, NE, NY, OH, OR, PA, RI, SD, UT, WA, WI, WY.

*‡AZ, FL, IL, LA, NE, NY, PA, UT, WV.

*§LA, MN, NE, NH, OH, OR, UT.

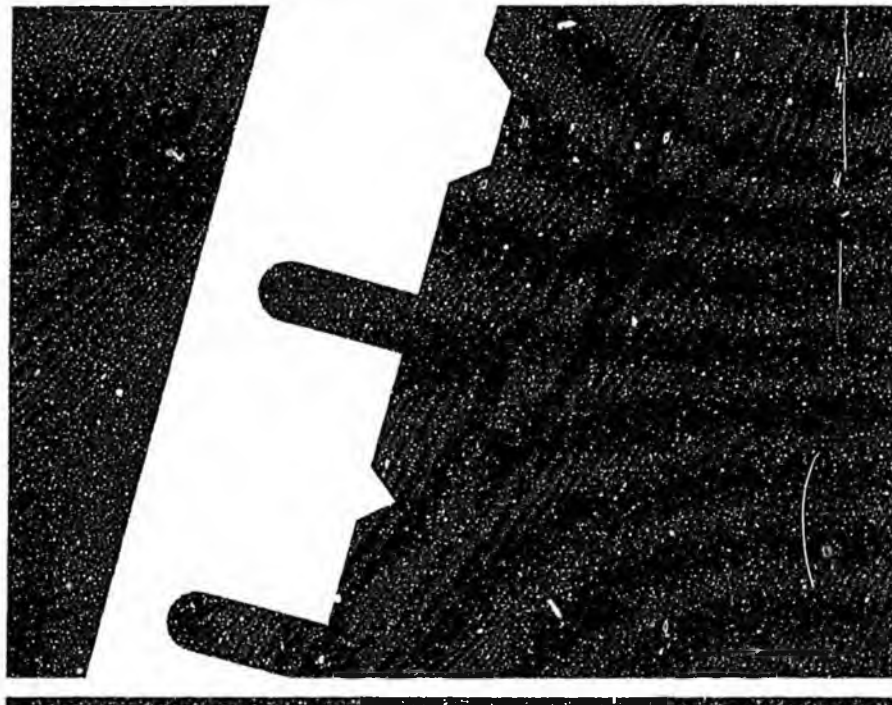
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Handbook on the Reporting of Induced Termination Of Pregnancy

Reprinted from 1988, Includes Revised Instructions
and Reporting Form, 1997



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Preface

This handbook is prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and contains instructions for persons with responsibilities for completing and filing reports of induced terminations of pregnancy (induced abortions). It pertains to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy as modified in 1996 by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion and the 1992 revision of the *Model State Vital Statistics Act and Regulations*. This handbook is intended to serve as a model for adaptation by any vital statistics registration area.

Other handbooks available as references on preparing and registering vital records are:

- *Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting*
- *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting*
- *Physicians' Handbook on Medical Certification of Death*
- *Funeral Directors' Handbook on Death Registration and Fetal Death Reporting*
- *Guidelines for Reporting Occupation and Industry on Death Certificates*
- *Handbook on Marriage Registration*
- *Handbook on Divorce Registration*

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Introduction

Purpose

This handbook is designed as an aid to acquaint hospital and clinic personnel, physicians, and others with responsibilities related to completing and filing reports of induced termination of pregnancy (induced abortion). Background information is included on the importance of these documents for statistical purposes and specific instructions for recording entries.

The purpose is to achieve improved reporting by promoting better understanding of the forms and of the uses of information entered on them.

Although State laws vary in specific requirements, generally the person in charge of the institution or facility where the induced abortion is performed has the overall responsibility for obtaining the required data, preparing the report, and filing the report with the State registrar. For abortions performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for preparing and filing the report.

Importance of induced termination of pregnancy reporting

Reports of induced termination of pregnancy are not legal records and are not maintained permanently in the files of the State office of vital statistics. However, the data they provide are very important from both a demographic and a public health viewpoint.

In January 1973, the U.S. Supreme Court ruled that the restrictive abortion laws in two States were unconstitutional and that, within the first two trimesters after conception, whether an abortion was to be performed or not was a matter between the woman and her doctor (*Roe v. Wade*, 410 U.S. 113 (1973); and *Doe v. Bolton*, 410 U.S. 179 (1973)). The net result of this ruling is that induced abortion under these criteria is legal in all States. In July 1976, the Supreme Court ruled that it is legal for States to require the reporting of certain information about induced abortions performed in that State (*Planned Parenthood of Central Missouri v. Danforth*, 96 Supreme Court 2831 (1976)). As a result of these two rulings, many States have established mandatory induced abortion reporting systems.

Data from reports of induced termination of pregnancy provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with induced abortion at various lengths of gestation and by the type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. The data also help measure the role that induced abortion plays in birth prevention as compared with contraception. Because these abortion data provide information necessary to promote and monitor health, it is important that the forms be completed carefully.

State reporting requirements

In those States requiring the reporting of information on induced abortions, various methods are used to collect the data. Some States include induced abortion reporting as a part of their fetal death reporting system by collecting additional information on induced terminations on their fetal death report. A majority of the States use a separate form, usually called Report of Induced Termination of Pregnancy, for the reporting of induced abortions. In a few States, a combination system is used whereby induced abortions above a certain gestational age are reported on the fetal death report and those below that gestational age are reported on the induced termination of pregnancy report. However, regardless of the reporting system used, all States with reporting systems require the reporting of all induced abortions regardless of length of gestation.

Because of the variations that exist from State to State, it is imperative that those persons having responsibilities in the reporting of induced abortions familiarize themselves with the procedures and forms used in their State.

Live birth

Although unlikely, the induced abortion procedure may result in a live birth. Should this occur, the report of induced termination of pregnancy is not to be completed and filed. Rather, a certificate of live birth is to be prepared for the infant. In the event the infant should later die, a death certificate would also have to be prepared and filed.

U.S. Standard Report of Induced Termination of Pregnancy

The National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services has historically provided leadership and coordination in the development of the

Standard Report of Induced Termination of Pregnancy to serve as a model for use by States. This report has been revised periodically in collaboration with State health officials, registrars, and statisticians; Federal agencies; local registrars, and medical record personnel. In these revisions, each item is evaluated thoroughly for its registration, statistical, health, and research value.

In recent years, responsibility for the collection of abortion data from the official files of the States has rested with the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. In 1996, in response to the emerging use of medical procedures to induce abortion, the Division of Reproductive Health, in consultation with a working group of experts, revised Item 15: *Type of Termination Procedure*. The instructions for completing several sections of the form were also revised at this time. This Handbook reflects those revisions.

Each State is encouraged to adopt the recommended standard report as a means of developing a uniform national induced abortion reporting and statistics system. Although many States use the recommended standard report, some States modify it to comply with State laws and regulations or to meet their own particular needs for information.

State health department

The State health department administers the induced termination of pregnancy reporting system under the laws and regulations of the State. The State health department is responsible for developing forms and procedures and for ensuring adherence to the requirements of the laws and regulations. It also publishes statistical data derived from the reports of induced termination of pregnancy it receives.

Local registrar

Generally, the Report of Induced Termination of Pregnancy is filed directly with the State registrar. In a few States, however, these reports are filed with the local registrar who then forwards them to the State registrar.

Confidentiality

The Report of Induced Termination of Pregnancy is designed to collect information for statistical and research purposes only. These reports are not maintained permanently in the official files of the State health department. The data that are gathered from these reports are presented in aggregate statistics, not individually, so that specific individuals may not be identified.

Hospitals, clinics, and physicians are assured that extensive legal and administrative measures are used to protect individuals from unauthorized disclosure of personal information contained on the reporting form.

Specific responsibilities

Hospital or clinic

The hospital, clinic, or other institution or facility where the induced abortion is performed is responsible for obtaining the necessary data, completing the form, and filing it with the State registrar within the time period specified by law. To ensure the proper performance of these responsibilities, it is preferable that one staff member be given the overall responsibility and authority to see that the reports are completed and filed on time. Specifically, the hospital, clinic, or other institution should:

- Develop efficient procedures for prompt preparation and filing of the reports.
- Collect and record the information required by the report.
- Prepare a correct and legible report, making certain that every item is completed.
- File the report with the proper official within the time specified in the vital statistics laws of the State.
- Cooperate with State or local registrars concerning queries on report entries.
- Call on the State or local office of vital statistics for advice and assistance when necessary.

Physician

For induced abortions performed in a hospital, clinic, or other institution, the physician performing the abortion is responsible for providing the medical information required by the report. When an induced abortion is performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for obtaining all of the necessary data, completing the form, and filing it with the State registrar within the time period specified by law.

Part I. General instructions for completing reports

The data necessary for preparation of the induced termination of pregnancy report are obtained from the:

- Patient
- Attending physician
- Hospital or clinic records

Reports of induced termination of pregnancy are not permanent records and are used only for statistical purposes. However, the data obtained from these reports are very important from both a demographic and a public health viewpoint. Therefore, it is essential that these reports be prepared accurately. These general rules should be followed:

- File the original report with the registrar. Reproductions or duplicates are not acceptable.
- Avoid abbreviations except those recommended in the specific item instruction.
- Spell entries correctly.
- Refer problems not covered in these instructions to the State office of vital statistics.
- Use the current form designated by the State.
- Type all entries whenever possible. Do not use worn typewriter ribbons.
- If a typewriter cannot be used, print legibly in black ink.
- Complete each item following the specific instructions for that item.
- Do not make alterations or erasures.

Part II. Completing the report of induced termination of pregnancy

These instructions pertain to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy.

1-3 PLACE OF TERMINATION

1. FACILITY NAME *(If not clinic or hospital, give address)*

Enter the full name of the hospital or clinic where the induced termination of pregnancy occurred.

If the induced termination of pregnancy occurred in a hospital or a clinic that is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital.

If the induced termination of pregnancy occurred in a freestanding clinic, a clinic that is physically and administratively separate from a hospital, enter the full name of the clinic.

If the induced termination of pregnancy occurred in a physician's office or some other place, enter the number and street name or name of the place.

2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

Enter the name of the city, town, or location where the pregnancy termination occurred.

3. COUNTY OR PREGNANCY TERMINATION

Enter the name of the county where the pregnancy termination occurred.

Item 1 provides information about the types of facilities where induced terminations are performed. Items 2 and 3 provide information that is used in the planning of health facilities and health education programs.

4. PATIENT'S IDENTIFICATION

Enter the hospital, clinic, or other patient identification number. This number must be one that would enable the facility or physician to access the medical file of this patient.

This information is used with Items 1 and 2 for querying for missing information without identifying the patient.

5. AGE LAST BIRTHDAY

Enter the age of the patient in years at her last birthday.

This information permits analysis of health risks related to length of pregnancy and type of procedure among different age groups. It is also used to study the impact of induced terminations on the fertility rates of different age groups.

6. MARRIED?

Yes No Specify: _____

Check "Yes" if the patient was legally married (including separated) at the time of conception, at the time of termination, or at any time between conception and the termination. Otherwise, check "No."

This information is used to study the health risk of induced terminations by marital status. It also helps determine the impact of induced terminations on the fertility rates of married and unmarried women and aids in planning for and evaluating the effectiveness of family planning programs.

7. DATE OF PREGNANCY TERMINATION (Month, Day, Year)

Enter the exact month, day, and year of the pregnancy termination.

The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun. *Exception:* For termination procedures performed by medical (nonsurgical) methods, the date of the termination should be recorded as the actual date the *initial* dosage of the medication was given—not the actual date of termination of pregnancy.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

This information is used to determine when the pregnancy termination occurred and to determine the length of gestation. Length of gestation is an essential element in the study of risks associated with induced terminations.

8a-e RESIDENCE OF PATIENT

The patient's residence is the place where her household is located. This is not necessarily the same as her "home State," "voting residence," "mailing address," or "legal residence." The State, county, and city should be that of the place where the patient actually lives. Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is *not* considered temporary and should be entered as the place of residence of the patient on the report.

If the patient has been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, this facility should be entered as the place of residence.

8a. RESIDENCE—STATE

Enter the name of the State where the patient lives. This may differ from the State in her mailing address. If the patient is not a resident of the United States, enter the name of the country and the name of the unit of government that is the nearest equivalent of a State.

8b. RESIDENCE—COUNTY

Enter the name of the county where the patient lives.

8c. RESIDENCE—CITY, TOWN, OR LOCATION

Enter the name of the city, town, or location where the patient lives. This may differ from the city, town, or location in her mailing address.

8d. RESIDENCE—INSIDE CITY LIMITS? (Yes or no)

Enter "Yes" if the location entered in item 8c is incorporated and the patient's residence is inside its boundaries. Otherwise, enter "No."

8e. RESIDENCE—ZIP CODE

Enter the ZIP Code of the place where the patient lives.

These items provide data for the analysis of induced termination by residence of the patient. This information is used with the city and county of termination to provide information on the amount of movement occurring within a State or between States to obtain an induced termination of pregnancy. This type of information is useful in planning the location of health care facilities.

9. OF HISPANIC ORIGIN?

(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

No Yes Specify: _____

Check "No" or "Yes." If "Yes" is checked, enter the specific Hispanic group as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, Puerto Rico, Cuba, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining Hispanic origin. A patient may report Hispanic origin based on the country

of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry. Although the prompts include the major Hispanic groups of Cuban, Mexican, and Puerto Rican, other Hispanic groups can also be identified in the space provided.

If a patient indicates that she is of multiple Hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a patient indicates that she is Mexican American or Cuban American, enter the Hispanic origin as stated.

This item is not a part of the Race item. A person of Hispanic origin may be of any race. Each question, Race and Hispanic origin, should be asked independently.

Hispanics comprise the second-largest minority in this country. This item provides data to measure differences in pregnancy outcome and variations in health care for people of Hispanic and non-Hispanic origin. Without collection of data on persons of Hispanic origin, it is impossible to obtain valid demographic and health information on this important group of Americans.

Some States may wish to obtain data on other groups or may have a very small Hispanic population. Therefore, they may opt to include a general Ancestry item on their report instead of a specific Hispanic origin item. Instructions for the general Ancestry item follow:

ANCESTRY—Mexican, Puerto Rican, Cuban, African, English, Irish-German, Hmong, etc. (Specify)

Enter the ancestry as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For purposes of this item, ancestry refers to the nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States. American Indian or Alaskan Native ancestry should be entered as such.

There is no set rule as to how many generations are to be taken into account in determining ancestry. A person may report ancestry based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry.

Some persons may not identify with the foreign birthplace of their ancestors or with a nationality and may report "American." If, after clarification of the intent of this item, the patient still feels that she is an "American," enter "American" on the record.

If a patient indicates that she is of multiple ancestry, enter the ancestry as reported (for example, English-Scottish-Irish, Mexican American).

If she gives a religious group—such as, Jewish, Moslem, or Protestant—ask for the country of origin or nationality.

This item is not a part of the Race item. Both questions, Race and Ancestry, should be asked independently. This means that for certain groups—such as Japanese, Chinese, or Hawaiian—the entry will be the same in both items. The entry should be made in both items even if it is the same. However, an entry of “Black” or “White” should never be recorded in the ancestry item.

10. RACE

American Indian Black White

Other (*Specify*) _____

Check the box that describes the race of the patient. The entry in this item should reflect the response of the patient.

If the patient is not American Indian, Black, or White, check “Other” and specify the race on the line provided.

For Asian or Pacific Islanders, enter the national origin of the patient, such as Chinese, Japanese, Korean, Filipino, or Hawaiian.

If the patient is of mixed race, check “Other” and enter both races or origins.

Information on race is needed to study the impact of induced terminations on the birth, fertility, and out-of-wedlock rates of different racial groups.

11. EDUCATION (*Specify only highest grade completed*)

Elementary/Secondary (0–12) _____ College (1–4 or 5+) _____

Enter the highest number of years of regular schooling completed by the patient in either the space for elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

Count formal schooling. Do not include beauty, barber, trade, business, technical, or other special schools when determining the highest grade completed.

This item is an important indicator of socioeconomic status of the patient. This information is used for studying the effect of induced terminations on the health and fertility of various educational and socioeconomic groups. This information is also useful in planning educational programs that address family planning.

12. DATE LAST NORMAL MENSES BEGAN (*Month, Day, Year*)

Enter the exact date (month, day, and year) of the first day of the patient’s last normal menstrual period, as obtained from the hospital or clinic record or the patient herself.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the patient, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only.

Enter "Unknown" if the date cannot be determined. Do not leave this item blank.

This item is used in conjunction with the date of termination to determine the length of gestation. Gestational age is important in evaluating the effectiveness and safety of the various termination procedures.

13. CLINICAL ESTIMATE OF GESTATION (Weeks)

Enter the length of gestation as estimated by the attending physician in completed menstrual weeks. Do not compute this information from the date last normal menses began and date of termination. If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank. *Exception: For termination procedures performed by medical (nonsurgical) methods, gestational age should be recorded as the gestational age of the pregnancy on the actual date the initial dosage of medication was given.*

This item provides a check on the length of gestation as calculated from date of last normal menses. It permits the physician to report an estimate when there is doubt as to the accuracy of the length of gestation or when date of last normal menses is unavailable or misleading.

14a-d PREVIOUS PREGNANCIES (Complete each section)

14a-b LIVE BIRTHS

14a. Now living

Number _____ None

Enter the number of children born alive to this patient who are still living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are dead.

14b. Now dead

Number _____ None

Enter the number of children born alive to this patient who are no longer living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are still living.

14c-d OTHER TERMINATIONS

14c. Spontaneous

Number _____ None

Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. This should not include induced terminations. Check "None" if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

14d. Induced (*Do not include current termination*)

Number _____ None

Enter the number of previous induced terminations (induced abortions) that this patient has had. Do not include this termination. Check "None" if the patient has had no previous induced terminations.

This information provides a pregnancy history and allows for insight into the use of induced terminations to limit family size. Because this item also collects information on the number of previous induced terminations, it provides some data on characteristics of women who may need alternative methods of family planning.

15. TYPE OF TERMINATION PROCEDURE

(Definitions of certain abortion procedures can be found in Appendix C.)

- Suction Curettage
- Medical (Nonsurgical), Specify Medication(s) _____
- Dilation and Evacuation (D&E)
- Intrauterine Instillation (Saline or Prostaglandin)
- Sharp Curettage (D&C)
- Hysterotomy/Hysterectomy
- Other (Specify) _____

Check the box that describes the procedure that actually terminated this pregnancy. Check only one box. If a procedure not listed was used, check "Other" and specify on the line provided.

This item provides information on the frequency of specific procedures and the incidence of terminations involving multiple procedures. When used in conjunction with length of gestation it provides an indication of the safety, appropriateness, and health risks of the various termination procedures at different gestational ages.

16. NAME OF ATTENDING PHYSICIAN (Type/Print)

Enter the full name of the attending physician. Be sure to spell it correctly and verify correct spelling. This item is used to query for missing or additional information.

17. NAME OF PERSON COMPLETING REPORT (Type/Print)

Enter the full name of the person completing this report.

This is the primary person who is queried for missing information on the report, although the physician is contacted in some instances.

Appendixes

A.	U.S. Standard Report of Induced Termination of Pregnancy	15
B.	Definitions of live birth, fetal death, and induced termination of pregnancy	16
C.	Definitions of induced abortion procedures.	17

Appendix A

U.S. Standard Report of Induced Termination of Pregnancy

TYPE/PRINT
IN
PERMANENT
BLACK INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

U.S. STANDARD
REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR DISEASE CONTROL AND PREVENTION — NATIONAL CENTER FOR HEALTH STATISTICS — 1987 REVISION

1. FACILITY NAME (if not clinic or hospital, give address) Merrywood Clinic		2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION Louisville		3. COUNTY OF PREGNANCY TERMINATION Jefferson	
4. PATIENT'S IDENTIFICATION 25466		5. AGE LAST BIRTHDAY 23		6. MARRIED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
7. DATE OF PREGNANCY TERMINATION (Month, Day, Year) November 20, 1997		8a. RESIDENCE-STATE Ohio		8b. COUNTY Hamilton	
8c. CITY, TOWN, OR LOCATION Cincinnati		8d. INSIDE CITY LIMITS? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		8e. ZIP CODE 45202	
9. OF HISPANIC ORIGIN? (Specify No or Yes - if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Specify: Puerto Rican		10. RACE <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input checked="" type="checkbox"/> White <input type="checkbox"/> Other (Specify) _____		11. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) : 12 College (1-4 or 5+) :	
12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) September 5, 1997		13. CLINICAL ESTIMATE OF GESTATION (Weeks) 10 weeks		14. PREVIOUS PREGNANCIES (Complete each section)	
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living		14b. Now Dead	
		Number _____		Number _____	
		<input checked="" type="checkbox"/> None		<input checked="" type="checkbox"/> None	
				14c. Spontaneous	
				Number _____	
				<input checked="" type="checkbox"/> None	
				14d. Induced (Do not include this termination)	
				Number _____	
				<input checked="" type="checkbox"/> None	
15. TYPE OF TERMINATION PROCEDURE (Check only one)					
<input checked="" type="checkbox"/> Suction Curettage					
<input type="checkbox"/> Medical (Nonsurgical), Specify Medication(s) _____					
<input type="checkbox"/> Dilation and Evacuation (D&E)					
<input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin)					
<input type="checkbox"/> Sharp Curettage (D&C)					
<input type="checkbox"/> Hysterotomy/Hysterectomy					
<input type="checkbox"/> Other (Specify) _____					
16. NAME OF ATTENDING PHYSICIAN (Type/Print) Edmund Matthew Stone, M.D.			17. NAME OF PERSON COMPLETING REPORT (Type/Print) Julia Lynn Koval		

Appendix B

Definitions of live birth, fetal death, and induced termination of pregnancy

The following definitions are included in the 1992 revision of the *Model State Vital Statistics Act and Regulations*. The definitions of live birth and fetal death conform to the definitions adopted by the Assembly of the World Health Organization.

Live birth—means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Important—If an infant breathes or shows any other evidence of life after complete delivery, even though it may be only momentary, the birth must be registered as a live birth and a death certificate must also be filed.

Fetal death—means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Induced termination of pregnancy—means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following fetal death.

Appendix C

Definitions of induced abortion procedures

Suction curettage (Also known as vacuum aspiration)—In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter (dilators). When the cervix is sufficiently dilated, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then removed using an electric vacuum pump.

Medical (Nonsurgical)—This nonsurgical procedure involves the administration of a medication or medications to induce an abortion. Medications (e.g., methotrexate, mifepristone, misoprostol, etc.) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g., prostaglandin suppositories, injectable prostaglandins, etc.) may be administered during the second trimester of pregnancy to induce abortion. Medications may be administered orally, by injection, or intravaginally.

Dilation and evacuation (D&E)—This procedure, used most frequently in the second trimester of pregnancy (greater than or equal to 13 weeks gestation) involves opening the cervix (dilation) and primarily using sharp instrument techniques, but also suction and other instrumentation such as forceps for evacuation.

Intrauterine instillation (saline or prostaglandin)—This procedure involves either withdrawing a portion of the amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated salt solution (known as saline instillation, saline abortion, or saline amniotic fluid exchange) or injecting a prostaglandin—a substance with hormone-like activity—into the uterine cavity through a needle inserted through the abdominal wall (known as intrauterine prostaglandin instillation). The saline instillation process induces labor, which results in the expulsion of the fetus approximately 24 to 48 hours later. The interval between prostaglandin injection and expulsion tends to be shorter than in a saline abortion.

Sharp curettage (D&C) (Also known as dilatation and curettage, D&C, or surgical curettage)—This procedure involves the dilation of the cervix as in the suction curettage procedure, although usually to a larger diameter. The fetal and placental tissues are then removed with a sharp curette.

Hysterotomy/Hysterectomy—Hysterotomy involves surgical entry into the uterus to remove a fetus. Hysterotomy is usually performed only if other abortion procedures fail or if other abortion procedures are not appropriate. Hysterectomy is a procedure in which the uterus is removed (with the fetus inside). It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.

All definitions, except for D&E, are from *Legalized Abortion and the Public Health* (Institute of Medicine, 1975). The definition of D&E is based on NCHS consultation with the Center for Health Promotion and Education, Centers for Disease Control and Prevention.

All other procedures should be shown as "Other" and the specific procedure listed. This category includes procedures using a combination of agents, such as urea and prostaglandin, prostaglandin and oxytocin, or prostaglandin and saline.

For a list of reports published by the National Center for Health Statistics contact:

Data Dissemination Branch
National Center for Health Statistics
Centers for Disease Control and Prevention
6525 Belcrest Road, Room 1064
Hyattsville, MD 20782-2003
(301) 436-8500
Internet: www.cdc.gov/nchswww/

MEMORANDUM

March 29, 2001

SUBJECT: Use of "may not" versus "shall not" in bills

TO: Representative Fred Dyson, Chair
House HESS Committee
Attn: Randy Lorenz

FROM: Jack Chenoweth
Assistant Revisor of Statutes

Under the current Manual of Legislative Drafting, "may not" and not "shall not" expresses a prohibition on action. See Legislative Drafting Manual at page 57. The Drafting Manual is quite specific: "Do not use "must not" or "shall not."" Drafting Manual at 60.

Rmwyg HB 160 File

Please submit my testimony to the bill packet for HB 160 "Induced Pregnancy Reporting Bill" which will be heard today, March 29, in the House HESS committee. Thank you.

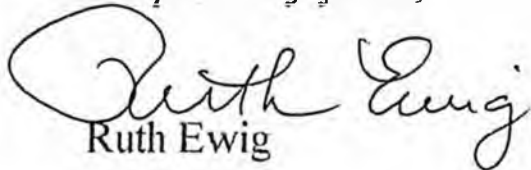
My name is Ruth Ewig and I reside at 2325-30th Avenue, Fairbanks, Alaska 99701. My phone number is (907) 452-5538. I am one of several council members in Alaska Interior Right to Life.

This bill makes abortion a vital statistic in Alaska along with births, deaths, fetal deaths, etc. The lack of information on abortions here in Alaska is the greatest in the whole country with the exception of California. These two are the only states that do not collect abortion data.

Ironically, those on all sides of the abortion issue want and need to have solid research backup and this is evident as we read about the Centers for Disease Control and the Alan Guttmacher Institute strong advocacy toward abortion reporting.

We have a right to know what is happening as we are all impacted by the results. In the book Lime 5 by Mark Crutcher one can see the disastrous and fatal results surrounding the secrecy of the abortion industry. The whole family is impacted. All physicians need to be accountable and abortionists are the only ones who are not. This needs to change for the good of all citizens in Alaska.

Respectfully yours,


Ruth Ewig

3/29/01

FISCAL NOTE

**STATE OF ALASKA
2001 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: HB 160
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: An Act requiring the reporting of induced terminations of pregnancies BRU: State Health Services
 Component: Bureau of Vital Statistics
 Sponsor: Rep. Coghill
 Requester: House (HES) Component Number: 961

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	56.7	57.8	59.0	60.2	61.4	62.6
Travel	3.0	1.5	1.5	1.5	1.5	1.5
Contractual	34.0	3.0	3.0	3.0	3.0	3.0
Supplies	0.5	0.5	0.5	0.5	0.5	0.5
Equipment	8.5				4.5	
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	102.7	62.8	64.0	65.2	70.9	67.6

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	102.7	62.8	64.0	65.2	70.9	67.6
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	102.7	62.8	64.0	65.2	70.9	67.6

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The Department anticipates 2000 - 2500 reports per year.
Personal Svs: 1 full time Public Health Specialist I to establish, maintain and oversee the statewide program
Travel: first year - travel to each provider to establish procedures, install programs and train staff, succeeding yrs travel to oversee system function and train replacement staff due to turnover
Contractual: first year (a) 30k Build an Induced termination of pregnancy subsystem in the new vital statistics information system (b) 4k lay-out and print reporting form succeeding yrs Print forms
Supplies: Standard office supplies - (Yearly cost)
Equipment: first year Computer and furniture for new program manager succeeding yrs - replace computer

Prepared by: Karen E. Pearson, MS Phone 465 3092
 Division: Public Health Date/Time _____
 Approved by: Elmer A. Lindstrom, Special Assistant Date 3/28/01 3:48 PM
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

Subject: Committee Staff Meeting

Date: Tue, 27 Mar 2001 17:15:48 -0900

From: Tom Wright <Tom_Wright@legis.state.ak.us>

Organization: Alaska State Legislature

To: lhsctww+committeestaff@legis.state.ak.us

Please be advised that a committee staff meeting is tentatively scheduled for Friday, March 30, at 10AM, in the Speaker's Chambers. Session timelines and other pertinent info will be discussed. Please call me at 3721 if you have any questions.

Thanks

Tom

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE COGHILL

TO: HB 160

- 1 Page 3, line 8, following "AS 47.07":
- 2 Insert "or the general relief assistance program established under AS 47.25.120 -
- 3 47.25.300"

Alaska State Legislature

Interim:

119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907) 456-5081 - Phone
(907) 456-8245 - Fax



Session:

State Capitol, Room 102
Juneau, AK 99801
(907) 465-3719 - Phone
(907) 465-3258 - Fax

Representative John Coghill

SPONSOR STATEMENT

HB 160

Currently, the State of Alaska does not monitor or collect any abortion data. This hampers efforts on a state and national level in publishing and evaluating accurate abortion data in relation to important maternal health information.

House Bill 160 would implement a reporting system for abortions in Alaska by requiring physicians to submit an induced termination of pregnancy report within three days after the procedure to the Bureau of Vital Statistics, who would publish the aggregated data in an annual report.

Abortion data in the United States is collected and evaluated by the Centers for Disease Control and the Alan Guttmacher Institute. Data from abortion surveillance is used in conjunction with birth data and fetal death computations to estimate pregnancy rates and other maternal health rates. Abortion data is also used in defining characteristics of women who are at high risk for unintended pregnancy. Moreover, ongoing annual surveillance is used to monitor trends in the number, ratio, and rate of abortions in the United States and provide data for assessing changes in clinical practice patterns related to abortion.

This information is collected by the states, and it is compiled and published at the national level by the Centers for Disease Control and Prevention. However, some states, including Alaska, have no abortion reporting system. The Alan Guttmacher Institute periodically conducts surveys of abortion providers and uses the results together with the CDC data to estimate the number of abortions and the abortion rate.

The Centers for Disease Control and the National Center for Health Statistics advocate the collection of detailed abortion data since it is vital to accurate evaluations of abortion related topics and essential for both health and public policy issues.

The information that House Bill 160 would require to be reported is modeled after the federal guidelines for induced termination of pregnancy reports, established by the National Center for Health Statistics.

22-LS0457F
Lauterbach
4/2/01

CS FOR HOUSE BILL NO. 160()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Dyson, James, Kott, Wilson, Meyer

A BILL

FOR AN ACT ENTITLED

1 **"An Act requiring the reporting of induced terminations of pregnancies."**

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 *** Section 1. AS 18.50 is amended by adding a new section to read:**

4 **Sec. 18.50.245. Report of induced termination of pregnancy. (a) A**
5 **hospital, clinic, or other institution where an induced termination of pregnancy is**
6 **performed in the state shall submit a report directly to the state registrar within 30 days**
7 **after the induced termination is completed. The report may not contain the name of**
8 **the patient whose pregnancy was terminated but must contain the information required**
9 **by the state registrar in regulations adopted under this section.**

10 **(b) When an induced termination of pregnancy is performed by a physician**
11 **outside of a hospital, clinic, or other institution, the physician shall submit the report**
12 **required under this section within 30 days after the induced termination of pregnancy**
13 **is completed.**

14 **(c) For purposes of this section,**

15 **(1) an induced termination of pregnancy is considered to be performed**

1 where the act interrupting the pregnancy is performed even if the resultant expulsion
2 of the product of conception occurs elsewhere;

3 (2) prescription of a medicine by a physician who knows that the
4 medicine will be taken with the intention of inducing termination of a pregnancy is
5 considered to be the act that interrupts the pregnancy even if the medicine is taken
6 outside of the physician's presence; and

7 (3) an induced termination of pregnancy is considered to be completed
8 when the product of conception is extracted or expelled.

9 (d) The state registrar shall annually prepare a statistical report based on the
10 reports received under this section. The report must include the types of information
11 required under (e) of this section. The data gathered from the reports received under
12 this section may only be presented in aggregate statistics, not individually, so that
13 specific individuals may not be identified. After preparation of the annual report, the
14 state registrar shall destroy the reports received under this section.

15 (e) The state registrar shall adopt regulations to implement this section. The
16 regulations that establish the information that will be required in a report of an induced
17 termination of pregnancy must require information substantially similar to the
18 information required under the United States Standard Report of Induced Termination
19 of Pregnancy, as published by the National Center for Health Statistics, Centers for
20 Disease Control and Prevention, United States Department of Health and Human
21 Services, in April 1998, as part of DHHS Publication No. (PHS) 98-1117.

22 * Sec. 2. AS 18.50.310(b) is amended to read:

23 (b) The bureau may permit the use of data contained in vital statistics records,
24 other than reports of induced terminations of pregnancy, for research purposes.

25 * Sec. 3. AS 18.50.310(e) is amended to read:

26 (e) The department may by regulation provide for the release of information,
27 other than information in reports of induced terminations of pregnancy, to
28 authorized representatives of organizations or foundations that counsel the next of kin
29 of victims of sudden infant death syndrome.

30 * Sec. 4. AS 18.50.350 is amended to read:

31 **Sec. 18.50.350. Duty to furnish information.** A person having knowledge of

1 the facts shall furnish the information the person possesses regarding a birth, death,
2 fetal death, induced termination of pregnancy, marriage, or divorce, upon demand
3 of the state registrar.

4 * Sec. 5. AS 18.50.950(8) is amended to read:

5 (8) "fetal death" means death before the complete expulsion or
6 extraction from its mother of a product of human conception, irrespective of the
7 duration of pregnancy, where

8 (A) [AND] the death is indicated by the fact that, after
9 expulsion or extraction, the fetus does not breathe or show evidence of life
10 such as beating of the heart, pulsation of the umbilical cord, or definite
11 movement of voluntary muscles; and

12 (B) the expulsion or extraction is not caused by an induced
13 termination of pregnancy;

14 * Sec. 6. AS 18.50.950(18) is amended to read:

15 (18) "vital statistics" means records of birth, death, fetal death,
16 induced termination of pregnancy, marriage, divorce, adoption, and related data.

17 * Sec. 7. AS 18.50.950 is amended by adding a new paragraph to read:

18 (19) "induced termination of pregnancy" means the purposeful
19 interruption of an intrauterine pregnancy with the intention other than to produce a
20 live-born infant, and that does not result in a live birth, except that "induced
21 termination of pregnancy" does not include management of prolonged retention of
22 products of conception following fetal death;

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: _____
 (H) Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: An Act requiring the reporting of induced BRU: State Health Service
 terminations of pregnancies Component: Bureau of Vital Statistics
 Sponsor: Rep. Coghill
 Requester: House HESS Component Number: _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Randall C. Lorenz Phone 465-3759
 House HESS Committee Aide

Approved by: _____ Date 4/2/01
 Agency _____

Sec. 18.50.300. Reproduction of records. To preserve original documents the state registrar may prepare typewritten, photographic, or other reproductions of original records and files in the state registrar's office. When certified by the state registrar, the reproduction shall be accepted as the original record. (§ 26 ch 118 SLA 1960)

Sec. 18.50.310. Disclosure of records. (a) To protect the integrity of vital statistics records, to ensure their proper use, and to ensure the efficient and proper administration of the vital statistics system, it is unlawful for a person to permit inspection of, or to disclose information contained in vital statistics records, or to copy or issue a copy of all or part of a record, except as provided by this section or as authorized by regulations issued under this chapter.

(b) The bureau may permit the use of data contained in vital statistics records for research purposes.

(c) Information in vital statistics records indicating that a birth occurred out of wedlock may not be disclosed except upon order of a superior court or as provided by regulations.

(d) Appeals from decisions of the custodians of local records refusing disclosure under (a) and (b) of this section shall be made to the state registrar, whose decision is binding upon the custodian of local records.

(e) The department may by regulation provide for the release of information to authorized representatives of organizations or foundations that counsel the next of kin of victims of sudden infant death syndrome.

(f) Notwithstanding the provisions of AS 40.25.120, when 100 years have elapsed after the date of a birth, or 50 years have elapsed after the date of a death, marriage, divorce, dissolution of marriage, or annulment, the records of these events in the custody of the state registrar become public records subject to inspection and copying as provided in AS 40.25.110 — 40.25.140.

(g) The principal health officer of a municipality, or a municipal health officer designated by the principal health officer, may inspect vital statistics records pertinent to the functions of the principal health officer. The state registrar may enter into an agreement with a municipality governing the conditions and purposes of those inspections.

(h) Marriage license applications shall be open for public inspection or examination during normal business hours. The bureau may, in response to a request under AS 25.27.300, disclose to the child support enforcement agency whether the bureau has a record indicating that a person has remarried after the date specified by the agency.

(i) In this section, "principal health officer" means the municipal official who is exercising health powers and who is primarily responsible for public health in the municipality. (§ 27 ch 118 SLA 1960; am § 1 ch 132 SLA 1978; §§ 1, 2 ch 25 SLA 1984; am § 11 ch 200 SLA 1990; am § 1 ch 79 SLA 1997; am § 10 ch 132 SLA 1998)

Revisor's notes. — Subsection (h) was enacted as (i). Relettered in 1997, at which time former subsection (h) was relettered as (i).

In 2000, in subsection (f), "AS 40.205.120" was substituted for "AS 09.25.120" and "AS 40.25.110 — 40.25.140" was substituted for "AS 09.25.110 — 09.25.140" to reflect the 2000 renumbering of AS 09.25.110 — 09.25.140.

Cross references. — For inspection and copying of public records other than vital statistics records maintained under this chapter, see AS 40.25. For purpose, findings, and nonseverability provisions related to the 1998 amendment to subsection (h), see §§ 1 and 56, ch. 132, SLA 1998 in the 1998 Temporary and Special Acts.

Effect of amendments. — The 1997 amendment, effective September 11, 1997, added subsection (h).

The 1998 amendment, effective June 26, 1998, added the second sentence in subsection (h).

Opinions of attorney general. — The Bureau of Vital Statistics is authorized under its regulation, 7 AAC 05.925, to comply with requests for copies of documents made by the Longevity Bonus Program when necessary to perform its statutory duty of determining an individual's eligibility to receive the longevity bonus, unless otherwise prohibited by federal law. February 4, 1981, Op. Att'y Gen.



Planned Parenthood®
of Alaska

3401 East 42nd Ave., Suite 200, Anchorage, Alaska 99508
(907) 565-7526 Fax (907) 565-7529

DATE: March 29, 2001

TO: House HESS Committee
Reps. Fred Dyson (Chair), Peggy Wilson, John Coghill, Vic Cohring,
Gary Stevens, Sharon Cissna, Reggie Joule.

FROM: Anna Franks, Executive Director

RE: Written/Verbal Testimony for HB 160, "Reporting of induced terminations of pregnancies"

Ladies and Gentlemen:

I am the Executive Director of Planned Parenthood of Alaska and today I speak on behalf of our statewide agency.

It may surprise you to know that Planned Parenthood of Alaska is in support of requiring certain statistics to be required of physicians performing abortions. Indeed, knowing how many abortions are performed, the age of people who receive abortions, and whether or not they already have children or have had other terminations is information we can use to assess whether or not our efforts to REDUCE abortion and provide family planning services are working. Alaska is, I believe, the only state that does not currently have a reporting requirement.

Sadly, however, we must oppose HB 160 as it is currently drafted. The bill is truly unprecedented and very burdensome. No other state requires such specific information. While it reads that the information to be required is "substantially similar" to the information required under the US Standard Report of Induced Termination of Pregnancy, as published by the Centers for Disease Control and Prevention, we see nothing similar about the requirements.

If I could call your attention to Section 1 (e) 2, clearly, the requirements are beyond what the state has a compelling interest to know. Why a woman needs or chooses to have an abortion is none of the state's interest. Whether or not the termination is paid through Medicaid is redundant. Because a physician already files a claim to Medicaid for this



Anchorage Center
3401 E. 42nd Avenue, #201
Anchorage, Alaska 99508
(907) 563-2229 Fax: 563-7419

Sitka Center
P.O. Box 515
Sitka, Alaska 99835
(907) 747-3883 Fax: 747-8282

Soldotna Center
44109 Sterling Hwy., #D
Soldotna, Alaska 99669
(907) 262-2622 Fax: 262-8564

For clinic nearest you 1-800-230-PLAN

procedure if it is therapeutic, the state already has this information readily available and should not be required to track it more than once.

Furthermore, under Section 1 (b), the requirement of the physician to submit the information within three days is, again, burdensome, unprecedented, and in many instances, the physician would be unable to comply. This is because if a physician were providing a medical abortion, known to be safer and done earlier than a surgical abortion, it is likely that the abortion would not be complete within the specified three-day period. What is typical of other states is to require information on an annual or semi-annual basis.

We believe this bill, as written, is in violation of Alaska's Constitution. We would support a redrafted bill that would require information on an annual or semi-annual basis that actually IS similar to the CDC requirements. Those requirements, and I believe you have a sample reporting form in front of you, include a patient ID, age, marriage status, date of termination, residence information, race, education, date of last menstrual period, estimated gestation, previous pregnancies and live births, other terminations, the type of termination procedure, the name of the attending physician, and the name of the person completing the report.

Again, Planned Parenthood of Alaska is pleased that we may be able to know, by aggregate statistics, information associated with induced abortion, information on the characteristics of the women who choose or need an abortion, and information on the role that abortion plays in prevention of unintended births as compared with contraception. The data obtained are very important from both a demographic and a public health viewpoint.

Thank you for your time, and thank you for considering to amend the bill as written to protect women's privacy and keep the state's interest to that which simply protects and promotes women's health.

Appendix A

U.S. Standard Report of Induced Termination of Pregnancy

TYPEPRINT
OR
FORMER
BLACK INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

U.S. STANDARD
REPORT OF INDUCED TERMINATION OF PREGNANCY

Form PHS 5020-101

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES - CENTERS FOR DISEASE CONTROL AND PREVENTION - NATIONAL CENTER FOR HEALTH STATISTICS - BIRTH DIVISION

1. FACILITY NAME (If not clinic or hospital, give address) Merrywood Clinic		E. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION Louisville		3. COUNTY OF PREGNANCY TERMINATION Jefferson	
4. PATIENT'S IDENTIFICATION 25466		8. AGE LAST BIRTHDAY 23		7. DATE OF PREGNANCY TERMINATION (Month, Day, Year) November 20, 1997	
6a. RESIDENCE-STATE Ohio		6b. COUNTY Hamilton		6c. CITY, TOWN, OR LOCATION Cincinnati	
6d. INSIDE CITY LIMITS? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		6e. ZIP CODE 45202			
9. OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Specify: Puerto Rican		10. RACE <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input checked="" type="checkbox"/> White <input type="checkbox"/> Other (Specify) _____		11. EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) : 12 College (1-4 or 5+) :	
12. DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year) September 5, 1997		13. CLINICAL ESTIMATE OF GESTATION (Weeks) 10 weeks		14. PREVIOUS PREGNANCIES (Complete each section)	
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now (Living)		14b. Stillborn (Do not include this termination)	
		14c. Now Dead		14d. Spontaneous (Do not include this termination)	
		Number _____ <input checked="" type="checkbox"/> None		Number _____ <input checked="" type="checkbox"/> None	
		Number _____ <input checked="" type="checkbox"/> None		Number _____ <input checked="" type="checkbox"/> None	
15. TYPE OF TERMINATION PROCEDURE (Check only one)					
<input checked="" type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical (Nonsurgical), Specify Medication(s) _____ <input type="checkbox"/> Dilatation and Evacuation (D&E) <input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin) <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (Specify) _____					
16. NAME OF ATTENDING PHYSICIAN (Type/print) Edmund Matthew Stone, M.D.			17. NAME OF PERSON COMPLETING REPORT (Type/print) Julia Lynn Koval		

3/29/01.

Testimony to the House HESS Committee on HB 160

I am astounded that Alaska is currently the only state that does not require mandatory reporting of abortions. These statistics are essential. The National Center for Health Statistics, Centers for Disease Control and US Dept. of Health and Human services have developed a Standard Report of induced termination of pregnancy designed to be a model for use by the states. If each state adopts this standard report, there will be a uniform system of reporting nationwide which can yield very useful and important information to be used in policy making and assessment of current programs. I urge you to adopt this reporting tool for use in Alaska.

Unfortunately, HB 160 requires the mandatory reporting of a different set of statistics, and does not make use of the standard created by the CDC. Many of the statistics required by HB 160 are frankly inappropriate and/or irrelevant. The time table of required reporting is also very short and difficult to comply with.

I urge you to oppose HB 160, and instead draft a bill which would require reporting based on the model provided by the CDC.

Thank you for your attention.

Sharon Smith MD

FISCAL NOTE

**STATE OF ALASKA
2001 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: HB 160
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: An Act requiring the reporting of induced terminations of pregnancies BRU: State Health Services
 Component: Bureau of Vital Statistics
 Sponsor: Rep. Coghill
 Requester: House (HES) Component Number: 961

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	56.7	57.8	59.0	60.2	61.4	62.6
Travel	3.0	1.5	1.5	1.5	1.5	1.5
Contractual	34.0	3.0	3.0	3.0	3.0	3.0
Supplies	0.5	0.5	0.5	0.5	0.5	0.5
Equipment	8.5				4.5	
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	102.7	62.8	64.0	65.2	70.9	67.6

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	102.7	62.8	64.0	65.2	70.9	67.6
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	102.7	62.8	64.0	65.2	70.9	67.6

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

The Department anticipates 2000 - 2500 reports per year.

Personal Svs: 1 full time Public Health Specialist I to establish, maintain and oversee the statewide program

Travel: first year - travel to each provider to establish procedures, install programs and train staff, succeeding yrs travel to oversee system function and train replacement staff due to turnover

Contractual: first year (a) 30k Build an Induced termination of pregnancy subsystem in the new vital statistics information system (b) 4k lay-out and print reporting form succeeding yrs Print forms

Supplies: Standard office supplies - (Yearly cost)

Equipment: first year Computer and furniture for new program manager succeeding yrs - replace computer

Prepared by: Karen E. Pearson, MS Phone 465 3092
 Division: Public Health Date/Time: _____
 Approved by: Elmer A. Lindstrom, Special Assistant Date 3/28/01 3:48 PM
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: HB 160
 (H) Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health and Social Service
 Title: An Act requiring the reporting of induced BRU: State Health Services
terminations of pregnancies Component: Bureau of Vital Statistics
 Sponsor: Rep. Coghill
 Requester: _____ Component Number: 160

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0					
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0				
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

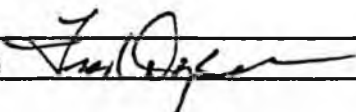
1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by: Representative Fred Dyson 
 Chair, HESS

Phone 465-2199

Date March 29, 2001

HB

164



Alaska State Legislature

Please enter into the record my testimony to the H. HESS
 committee name
 committee on HB 164, dated April 3, 2001
 bill/subject

5 PAGES

Including Cover Sheet

Signed: Shazik Lee Shields
 Testifier
Grandparents Rights Organization Committee
 Representing (Optional)
He 02 Box 7347 Palmer, AK 99645
 Address
(907) 745-3106
 Phone No.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

April 5, 2001

Dear Sir or Madam:

My name is Kris S. Johnston, and I am a parent with a child with a disability and IEP (Individualize Education Plan), living in Cordova, Alaska. I would like to address your Bill #SB133 Version R, concerning the Exit Exam.

I would like to give my support for the Green portion of Bill 133. I also believe the additional language in the revision of this bill for individuals with an IEP to show "mastery" of the performance standards that will be decided by the IEP team and a board will set unreasonable expectations on these students.

My son, Kristofer, has worked really hard to get as far as he has that other children attain with just coasting through school. If he needs to show "mastery" of the performance standard that other children also need to do then he is not given any consideration for the distance that he has come with so much work. I believe he deserves that diploma, even if it was not with an endorsement of meeting the standards. He would then get credit for all that he worked for and as far as he had gone.

This is one of the reasons that I support the Green portion of the SB133 bill, and would like to understand the reason that your committee feels this would water down the diploma. I do not feel that an endorsement process would do this. I believe all children that work really hard to learn deserves a diploma. Just as an individual that work really hard deserves a paycheck. We do not need to shortchange our most vulnerable.

Thank you,

Kris Johnston

HB 164

Dixie Armstrong
PO Box 870186
Wasilla, Ak 99687-0186
ana@mtaonline.net
907-357-3790

HES Committee

March 28, 2001

I support House Bill NO. 164. Our grandson is seven years old. He is an important part of our life. Family is important. When the court becomes involved in the life of a child(children), the Court, State departments, and their employees should have the responsibility of doing everything possible to insure that the child(without good cause)has the opportunity to enjoy the parents and grandparents. Divorce or any involvement with DFYS can tear a family apart. The child suffers the greatest loss. During Court interruptions (with divorce or DFYS), the social growth and development suffers delay or stops. Grandparents can help bridge these gaps and build good foundations.

Sincerely,

Dixie Armstrong
Dixie Armstrong

Grandparent Rights member

Faxed 3/29/01
3:50 PM
JP

HB 164



Alaska State Legislature

Please enter into the record my testimony to the House Health Educ/Soc/Ser
committee name
committee on HB 164, dated 3-29-01
bill/subject

HB or SB	Bill number	and check one:	<input checked="" type="checkbox"/>	Support	OR enter a general Subject (LIO staff may modify):
HB	164		<input type="checkbox"/>	Oppose	
			<input type="checkbox"/>	Amend	

Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

Grandparents	are	assuming	more	responsibility	5
and	custody	of	grandchildren.	Please	10
allow	their	role	in	childrens'	15
lives	to	not	be	pushed	20
aside	when	DFYS	enters	the	25
picture	HB 164	needs	to	be	30
passed	to	protect	a	child's	35
right	to	include	grandparents	in	40
the	event	their	lives	fall	45
into	the	system.	Thank	you.	50

Signed: Mari Schmelt
Testifier

Representing (Optional)
2040 Wasilla Fishhook Road, Wasilla AK 99654
Address
376-0188 / 357-3618
Phone No.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CSHB 164 (HES)
 (H) Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: An act prescribing the rights of grandparents BRU: Health & Social Services
 related to CINA hearings Component: _____
 Sponsor: Rep. Dyson Component Number: _____
 Requester: House HSS _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Randall C. Lorenz

Phone 465-3759

REPRESENTATIVE FRED DYSON
 Chairman

Date 4/3/01

Subject: House Bill #133

Date: Wed, 04 Apr 2001 09:37:56 -0800

From: Kathie Elmore <kelmore@gci.net>

Organization: THE ELMORE CLAN

To: Representative_Fred_Dyson@legis.state.ak.us

Dear Representative Dyson;

I am writing you to encourage you to vote in favor of house bill #133. Our children with Special needs need to know that their hard work and efforts count for something other than a Certificate of Attendance. Please make sure our kids with IEP's and 504's in our Special Education School System know that we value their hard work and efforts count. please vote in favor of this bill.

Thank you
Kathie Elmore
1313 Gilmore Trail
Fairbanks, AK 99712
907-457-1035

THE ELMORE CLAN <KELMORE@GCI.NET>

CS FOR HOUSE BILL NO. 164(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVE DYSON

A BILL

FOR AN ACT ENTITLED

1 "An Act prescribing the rights of grandparents related to child-in-need-of-aid hearings;
2 and amending Rules 3, 7, 10, 15, 17, and 19, Alaska Child in Need of Aid Rules of
3 Procedure."

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 * **Section 1.** AS 47.10.030(b) is amended to read:

6 (b) In all cases under this chapter, the child, each parent, the tribe, foster
7 parent or other out-of-home care provider, guardian, and guardian ad litem of the child
8 and, subject to (d) of this section, each grandparent of the child shall be given
9 notice adequate to give actual notice of the proceedings and the possibility of
10 termination of parental rights and responsibilities, taking into account education and
11 language differences that are known or reasonably ascertainable by the petitioner or
12 the department. The notice of the hearing must contain all names by which the child
13 has been identified. Notice shall be given in the manner appropriate under rules of
14 civil procedure for the service of process in a civil action under Alaska law or in any

1 manner the court by order directs. Proof of the giving of the notice shall be filed with
2 the court before the petition is heard. The court may also subpoena the parent of the
3 child, or any other person whose testimony may be necessary at the hearing. A
4 subpoena or other process may be served by a person authorized by law to make the
5 service, and, where personal service cannot be made, the court may direct that service
6 of process be in a manner appropriate under rules of civil procedure for the service of
7 process in a civil action under Alaska law or in any manner the court directs.

8 * Sec. 2. AS 47.10.030 is amended by adding a new subsection to read:

9 (d) The department shall give advance written notice of all court hearings in a
10 child's case to a grandparent of the child if

11 (1) the grandparent has contacted the department, provided evidence
12 acceptable to the department of being the child's grandparent, requested notice about
13 the hearings in the child's case, and provided the department with a current mailing
14 address; or

15 (2) the department is aware that the child has a grandparent and the
16 grandparent's mailing address is on file with the department.

17 * Sec. 3. AS 47.10.070(a) is amended to read:

18 (a) The court may conduct the hearing on the petition in an informal manner.
19 The court shall give notice of the hearing to the department, and it may send a
20 representative to the hearing. The court shall also transmit a copy of the petition to the
21 department. The department shall send notice of the hearing to the persons for whom
22 notice is required under AS 47.10.030(b) and to each grandparent of the child
23 entitled to notice under AS 47.10.030(d). The department and the persons to whom
24 the department must send notice of the hearing are entitled to be heard at the hearing.
25 However, the court may limit the presence of the foster parent or other out-of-home
26 care provider and of any grandparent of the child to the time during which the
27 person's testimony is being given if it is (1) in the best interest of the child; or (2)
28 necessary to protect the privacy interests of the parties and will not be detrimental to
29 the child. The public shall be excluded from the hearing, but the court, in its
30 discretion, may permit individuals to attend a hearing if their attendance is compatible
31 with the best interests of the child.

1 * Sec. 4. AS 47.10.080(f) is amended to read:

2 (f) A child found to be a child in need of aid is a ward of the state while
3 committed to the department or the department has the power to supervise the child's
4 actions. For an order made under (c)(1) of this section, the court shall hold a
5 permanency hearing as required by (l) of this section and at least annually thereafter
6 during the continuation of foster care to determine if continued placement, as it is
7 being provided, is in the best interest of the child. The department, the child, and the
8 child's parents, guardian, and guardian ad litem are entitled, when good cause is
9 shown, to a permanency hearing on application. If the application is granted, the court
10 shall afford these persons and their counsel reasonable advance notice and hold a
11 permanency hearing where these persons and their counsel shall be afforded an
12 opportunity to be heard. The persons entitled to notice under AS 47.10.030(b) and
13 the grandparents entitled to notice under AS 47.10.030(d) are entitled to notice of a
14 permanency hearing under this subsection and are also entitled to be heard at the
15 hearing. The child shall be afforded the opportunity to be present and to be heard at
16 the permanency hearing. After the permanency hearing, the court shall make the
17 written findings that are required under (l) of this section. The court shall review an
18 order made under (c)(2) of this section at least annually to determine if continued
19 supervision, as it is being provided, is in the best interest of the child; this review is
20 not considered to be a permanency hearing and is not governed by the provisions of
21 this subsection that relate to permanency hearings.

22 * Sec. 5. The uncodified law of the State of Alaska is amended by adding a new section to
23 read:

24 DIRECT COURT RULE AMENDMENT. Rule 17(b), Alaska Child in Need of Aid
25 Rules of Procedure is amended to read:

26 (b) **Statements.** The parties may offer evidence in aid of disposition at the
27 hearing. The court shall also afford the parties, a grandparent of the child who is in
28 attendance at the hearing, and any foster parents or other out-of-home care providers
29 an opportunity to be heard.

30 * Sec. 6. The uncodified law of the State of Alaska is amended by adding a new section to
31 read:

1 COURT RULE CHANGES. (a) Section 5 of this Act, AS 47.10.030, as amended by
2 secs. 1 and 2 of this Act, AS 47.10.070(a), as amended by sec. 3 of this Act, and
3 AS 47.10.080(f), as amended by sec. 4 of this Act, have the effect of amending Rules 3, 7, 10,
4 15, 17, and 19, Alaska Child in Need of Aid Rules of Procedure, by requiring that
5 grandparents be given notice of and an opportunity to be heard at certain child-in-need-of-aid
6 proceedings.

7 (b) Sections 1 - 5 of this Act take effect only if this section receives the two-thirds
8 majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.



Alaska State Legislature

- Interim (May-Dec.) -
10928 Eagle River Rd., Suite 140
Eagle River, Alaska 99577
☎ (907) 694-6683
FAX (907) 694-1015

- Session (Jan.-May) -
Alaska State Capitol
Juneau, Alaska 99801-1182
☎ (907) 465-2199
FAX (907) 465-4587

Toll free (800) 342-2199

REPRESENTATIVE FRED DYSON

HB 164 Sponsor Statement

"An Act relating to Grandparents

Updated: March 30, 2001

Contact: Representative Fred Dyson's office at (907) 465-2199

Grandparents are often the most stable and healthy influence in the life of a child from a troubled family. HB 164 assures that grandparents will have an opportunity to be heard at; Child in Need of Aid (CINA) hearings and custody hearings when the hearings involve their grandchildren.

Over the past couple of sessions the legislature has focused considerable effort on making our child protection and custody procedures more open, responsive and responsible. We have given foster parents more input and the right to be heard in treatment and in placement decisions and have encouraged more efficient placement procedures.

HB 164 will result in more informed decisions about the treatment and placement of Alaska's abused and neglected children. We also believe this measure will increase the likelihood of children being placed with relatives who may not have otherwise been located, heard, or considered.

The bill specifies that, unless the court specifically finds otherwise, the testimony of parents will be given more weight than a grandparents. This approach protects the primary parental interest while specifically allowing a court to defer to a grandparent for good cause.

Because we recognize that there will be cases where a grandparent is not a suitable option for child placement, HB 164 does not mandate that end. Instead, it requires notification of grandparents who care enough to make themselves known, so they can be part of the process if they will. The intended result is to encourage the department and parents to consider grandparents more frequently as a preferred placement option for children in need.

- E-mail -
Representative_Fred_Dyson
@Legis.state.ak.us

- Internet -
<http://www.akrepublicans.org>

Sponsor Statement

HB 164 Sectional Analysis

Revised: April 2, 2001 LS0693\C

Section 1: Inserts "Grandparents" into the list of those who must receive notice of court proceedings that could result in termination of parental rights and responsibilities in Child in Need of Aid (CINA) cases. "Grandparents" are included with; parent, tribe, foster parent or other out-of-home care provider, guardian, and guardian ad litem.

Section 2: Defines the parameters defining when the department must give notice to grandparents.

- The department must first be aware that a child has a grandparent. The department is not required to search for grandparents, the grandparent must contact the department.
- Grandparent must make the department aware of their current mailing address.

Section 3: Requires grandparent notification for informal hearings related to a custody petition and gives them the right to be heard. The court may limit the testimony and presence of a foster parent or a grandparent if it is in the best interest of the CINA.

Section 4: Requires grandparent notification of a permanency hearing for a CINA child. "Grandparents" are included with; parent, tribe, foster parent or other out-of-home care provider, guardian, and guardian ad litem.

Section 5: Amends court Rule 17(b) that allows grandparents to be heard at disposition hearings. This rule is a section of HB 164 because there is no statute that specifically addresses disposition hearings, therefore it could be argued that the bill doesn't warrant mention in Section 6.

Section 6: Itemizes the court rules changes that result from this bill: Rules 3, 7, 10, 15, 17 and 19 are changed consistent with the changes made by this act and spells out that a 2/3 majority vote is required.

FISCAL NOTE

**STATE OF ALASKA
2001 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: HB 164
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: Grandparents' rights regarding CINA. BRU: Family and Youth Services Mngmt
 Component: FYS Management
 Sponsor: Rep. Dyson
 Requester: House (HES) Component Number: 2306

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time	0					
Part-time	0					
Temporary	0					

ANALYSIS: (Attach a separate page if necessary)

In its present form, this bill will have no fiscal impact on the Department if enacted.

Prepared by: Theresa Tanoury, Director Phcne 465-3191
 Division: Family & Youth Services Date/Time: _____
 Approved by: Elmer A. Lindstrom, Special Assistant Date 3/26/01 11:44 AM
 Agency: Department of Health & Social Services

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Alaska State Legislature

Please enter into the record my testimony to the H. HESS
 committee name
 committee on HB 164, dated April 3, 2001
 bill/subject

5 PAGES

Including Cover Sheet

Signed: Sharon Lee Shields
 Testifier
Grandparents Rights Organization Committee
 Representing (Optional)
HC 02 Box 7347 Palmer, AK 99645
 Address
(907) 745-3106
 Phone No.

Public Opinion Message

Mat-Su Legislative Information Office (LIO)
600 East Railroad Ave • Wasilla, AK 99654 • Phone: 376-3704 Fax: 376-6180

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From: Please PRINT the information below. This form must be signed by the sender.

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Residence (street) address if different from mailing address				Zip code
Daytime telephone number	Group affiliation (if applicable)		Signature	Date

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			<input type="checkbox"/>	Amend	

Message: Your PRINTED message cannot exceed 50 words or contain any vulgar language.

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Sharon Lee Shields
HC 02 Box 7347
Palmer, Alaska 99645
(907) 745-3606
E-mail: Bigcrow_ak@hotmail.com

April 3, 2001

STATE OF ALASKA
Legislative Affairs Agency

Reference: HB 164 "An Act prescribing the rights of grandparents related to child-in-need-of-aid hearings and amending Rules 3, 7, 10, 15, and 19 Alaska Child in Need of Aid Rules."

My name is Sharon Lee Shields, and my granddaughter is "a-child-in-need." The mother to my granddaughter is my younger child. My daughter was put on a pedestal all her life, loved and supported as a child, young adult, and now grown adult. I supported so much that I'm satisfied that there was nothing more that I could've given her or done to make her life happy, and provided her with a direction for great opportunity in her life.

Then in 1993 my daughter became pregnant and had my first granddaughter in January 1994. My daughter was and still is a single mother, and the father of my granddaughter was [is] military. The father was transferred out of Alaska when my granddaughter was just over a year old, and has recently been transferred back to Alaska last August 2000 after being absent for almost six years.

In the beginning of my granddaughter's life, my daughter and the military-father moved in together and for a short time stumbled through making an effort at being parents, they depended on that I supported them along with my granddaughter physically, financially, and emotionally.

Up to that point, my daughter had only babysat one time in her entire life before having my granddaughter. In her teenage years and as a young adult she didn't have time for children and was impatient around them. So, I knew what her child would be up against: a mother with a days training and self-absorbed. Currently, my granddaughter has lived through six live-in boyfriend relationships of my daughters.

I had no plans of raising another child, but as time went on I knew she was a "child-in-need." So I just assumed the position of the absent parents, and became a psychological, emotional, physical and financial parent to my granddaughter, and had my granddaughter 80% of her life up to November 5, 2000. That time is well documented, as I am a writer. The documentation started out as a diary of fun days and events with my granddaughter, and then last May 2000 the diary turned into documentation of horrible physical and mental abuses reported to me by my granddaughter.

My granddaughter reported: May 23, 2000 my daughter slapped her across the face so hard it knocked her off her feet. And because she cried too loud, my daughter ordered her to go to the bathroom until she could quit crying. My granddaughter reported: there, she lay on the bathroom rug until it quit hurting so badly, and she could quit crying. The next morning when my daughter dropped her off to me again, the big red mark (handprint) on her face was still visible; the next

reported incident was that my granddaughter was slugged in the back, on her kidneys by my daughter's sixth live-in boyfriend and the red mark across her kidneys was still on her back the next day after school when she came to my home; food has been withheld from my granddaughter and warm clothing not sent to school when the weather was cold.

During the past seven years, my heart has ached each time my granddaughter, as a small child, was dropped off to my home after she had spent time with her mother, because she acted out so dramatically: yelling and screaming at other children, it took a few days for her to calm down, again. The stress and sadness in my granddaughter's eyes told me of the results of her stay with mommy.

My daughter has a history of impatience, and violence when she doesn't get her way, and I had suspicions that she wasn't capable of proving my granddaughter with a loving, nurturing environment. But I always kept hope.

So there I was: I was a brand new grandmother already with "a-child-in-need." I don't know where the years have gone, but during that time, my granddaughter was provided a normal life because of my elder daughter and her family, and me. As the years passed, it just became natural that my granddaughter was apart of my elder daughter's family and my life and included in our plans: plans for the day, the week, the month, and then the years. Time has slipped away, and out of love and caring, the end result of time was that we have given my granddaughter a normal happy life.

At the time my granddaughter started reporting the abuses, I tried addressing those issues with my daughter because I had knowledge of the way the DFYS system operated and I didn't want my granddaughter dumped into an already non-functioning system. And of course, my daughter threatened me with the system I feared, telling me that I better be careful because I have no rights. And from that time on, when I addressed the abuse issues with my daughter she threatened withholding my granddaughter from me, and she threatened my granddaughter to keep secret what went on within her home, or she wouldn't be able to see grandma again. My granddaughter became confused, because I had always been the person whom she could confide in and depend on, now I was getting her in trouble.

Then when my granddaughter was dropped off on Monday mornings for the week, she would scold me, in her own young-words telling me how disappointed she was by me getting her in trouble with her mommy, and that she couldn't talk to me anymore because I got her into trouble. Perhaps only an hour would lapse, and she'd tell me what was going on because it hurt her and she had to have someone to confide in.

So there I was, my granddaughter's guardian angel, handcuffed by the system. I had all the responsibility of my granddaughter for seven years, but no authority. And a daughter very well versed in the fact that I had no rights.

Last year, I took my granddaughter to school almost everyday and volunteered in the classroom at least three times a week. I even got a volunteer award. My elder daughter and I baked cookies for every child who graduated in all the kindergarten classes at Tanaina Elementary School. My granddaughter was one of the top students in her classroom, and she looked forward to and depended on me participating in her learning and her life.

On November 5, 2000, the reports of abuse from my granddaughter got so bad, and the father would do nothing after many pleas for his help from many outside people. He didn't want to get involved, he said. So, I was forced to address this issue with my daughter, knowing how risky it was and the consequences, but I couldn't ignore my granddaughter's pleas for help, seeing her desperation, and knowing helplessness.

On November 5, 2000, I tried to do an intervention with my daughter. After many repeated attempts to sit down and talk with her to no avail, I finally demanded that she meet with me. But the intervention blew-up in my face. She brought the father, and a friend of hers from the Social Services Department on a Sunday, an elaborate scheme to squelch any of my efforts to resolve this with my daughter, or to protect my granddaughter. I was threatened by the Social Service worker, and the father; and told to keep my mouth shut. I recorded the intervention and had it transcribed by a court reporter because it proved negligence by both parents, and the Social Services worker.

The consequences of my efforts were that my granddaughter was taken out of my life. Immediately, the parents went to the school and revoked all my volunteer privileges, and access to any of the classrooms, and have not been allowed access to volunteering since that date. I have not allowed me to see or talk to my granddaughter since December 3, 2000, when I was allowed to see her for 6 hours. My granddaughter was frantic then, I can't imagine how she is doing now.

Back when my granddaughter started talking, and my daughter would come to take her for the weekend or a day, my granddaughter always asked me and made sure by asking me when she was coming back to my house. Now, I can't talk to her on the phone; she can't come to my home; she can't spend the night with me; I can't volunteer in her classroom; I'm allowed no contact with her at all because I tried to protect her. That's not even the beginning: my granddaughter cannot see anyone whom she depended on and loves, her aunt, uncle, or new cousin. We, her family, have not been allowed by the parents to have a Thanksgiving, Christmas, celebrated her birthday, or Valentines Day with my granddaughter.

This is not a normal life for my granddaughter. My granddaughter's life has been turned upside down by the parents and they could care less for my granddaughter's welfare or feelings as long as they have control over the family.

My daughter works for the system and lives in the Valley. Palmer/Wasilla is a small community, and my daughter has many friends within the social services departments in the Valley and she has been given confidential information about my contacts with the DFYS in the Valley. That fact alone has been the most damaging factor in my efforts to see and protect my granddaughter.

As so many grandparents have discussed in our Grandparents Rights Organization. The most hopeless and helpless feeling we have in the world, after loving, caring and nurturing our grandchildren, is when we are forced by our abusive children to go to the system for help and the response is **ALWAYS**: if the child is not in immediate danger right at that very moment, they say the child is safe. Meaning that the child is not in an emergency room with internal damages or broken limbs, or in a morgue waiting to be identified at the time of reporting the abuse, because, "the child is not in immediate danger."

As I stand before you today, I still struggle with the system, and the parents to see my granddaughter whom I have not seen in 5 months, now. I can't even think about what she's gone and going through. But, according to law, I have no rights to know that.

HB 164 is the beginning effort that should be made in securing rights for Grandparents who have been active in raising their grandchildren, or would like to have the opportunity to know what is happening to their grandchildren. Since when did the family unit not include Grandparents? We are sick of being looked upon as the reason our children, the parents, are the way they are, because that is just not the truth. The majority of Grandparents in our group are educated, loving people, and caring people who have loved their children and now their grandchildren. What we see as the beginning problem was that we were there too much for our children, and supported them too much. We have given our children too much, and we haven't expected any thing in return for our efforts, time and love for them. We are horrified and bewildered that our children could do this to us and to their own children.

At the least, Grandparents should have the right to raise, or **continue** to raise their grandchildren, and should have knowledge that our grandchildren are "children-in-need-of-aid" and not have them put into foster homes. To me, that would only be common sense, but to the system it is not.

I understand that morals, scruples, and common sense can't be legislated, but it's time that we start using them as laws about "our grandchildren" are being legislated. Remember these grandchildren could be one of yours in another state or another town, and the truth about their welfare withheld from you. I don't know one of you here today who wouldn't want to know that your grandchild was being placed in a foster home by DFYS just so they could get its quota of "child numbers" for state and federal funds.

Go home tonight and look at your grandchildren, or call them on the phone, and when you hear their small voices know that they could be placed in a foster home by DFYS, without your knowledge, or notifying you that your grandchildren are even in the system. When DFYS placed little Steven Murray in a foster home, he didn't have a voice, and now he's dead.

Officials from agency level people, Timothy Spangler, all the way to Commissioner Karen Purdue know exactly what is going on with my granddaughter, and do nothing because she's only a "Priority 3 case." Well I'm here to tell everyone here today that my granddaughter is and always has been a "Priority 1 case" to me.

It's time to move DYFS, its rules, and its budge out of the way, gather our morals, scruples, and common sense and put grandparents back into the family picture. Would we have so many children in the system? Would we have so much violence in schools? Would we have the school shoots if our children and grandchildren had real families to go home to? Who knows?

Thank you for your time, and I pray for all our children and grandchildren that we begin to move to the family unit back, and HB 164 will be a step in that direction. And be in the best interest of our grandchildren.

Sincerely,


Sharon Lee Shields

According to the Article in "Parade" of the ADN, 3.9 million children in the US were living in homes maintained by their grandparents. But those grandparents get paid less than 50% (if anything) of what a foster parent receives, thus saving the state over 50% on every grandchild that is with a grandparent. Some grandparents would need help, but most just want their grandchildren.

HB 164 is a great step to further protect our children in need of aid. Children whom are taken from their parents are traumatized; then to be torn apart from siblings, then thrust in the middle of strangers is emotional and mental abuse. Placing these children with a grandparent or relative eases their minds; this is their family, someone who understands them, loves them and who wants what is best for them.

DFYS utterly ignores grandparents, telling them "they have no rights", "they will never see their grandchildren again", "they are no better than a stranger". **THIS HAS GOT TO STOP!** Most grandparents are perfectly willing to take the grandchildren, so why should the state spend the money to put these children in foster care. Use that money for those who do not have grandparents or relatives that can take them. It is suppose to only take 48 hours for DFYS to investigate someone.

Other than most parents, who has the greatest concern for our children - none other than a grandparent. A grandparent is an ongoing part of a grandchild's life. It is not in the grandchild's best interest to have their lives disrupted, their grandparents and relatives taken from them and be placed with strangers.

Also in communicating with the grandparents it could help speed up investigations with their input and past knowledge of the situations, and provide a safe and familiar haven for the children while the investigation is taking place. This also saves DFYS money. I think any parent would rather have their children with their parents rather than a strangers home.

This bill allows grandparents to have the opportunity to be involved in the hearings held by the state in cases involving our grandchildren. This is a very important procedure for the Courts & DFYS to be able to properly establish what is in the "Best Interest of the Child" as described in AS 25.24.150(c)(1-9). So please vote for approval of this House Bill 164.

Betty Short, President
Grandparents Rights Organization

Although I am president of the Grandparents Rights Organization, I had a personal endeavor with DFYS which I hope will show you the need for Grandparent Intervention and DFYS to pay closer attention to Grandparents.

My granddaughter went to her teacher about 5 years ago saying she thought her mother was abusing her brother (who was then in the 8th grade). DFYS was called in and this was our chance to intervene as we had our suspicions, but in talking with our daughter, of course, she denied everything, saying he was a liar, etc. etc. DFYS opened a file, calling her on the phone and asked how she disciplined her children. She said she gave them time out, of course she's not going to admit to anything of abuse.

I gave the caseworker, Ada Gleason, names and phone #'s of adult people whom had seen this abuse. She not only did not call them, but never returned any of their calls. A few months later she closed the case sending my daughter a letter saying "charges were unfounded". Course the charges were unfounded because she never talked to anyone who could tell her any different.

It continued and my husband and myself hired an attorney and went to court, where the minor was assigned an Atty at litem, who did do some checking into the situation and made her report to the courts. We were awarded custody by Master Dugan.

Raising a teenager again was a challenge, but he excelled in high school, was very active in sports, and turned out to be a very nice young man. Now if DFYS had of intervened and checked on things like they should of, the situation would of been taken care of immediately, not have cost us money and maybe the family could of been united without the hardship and animosity that a court battle caused between the mother and us.

I hope this story shows you the need for DFYS to work more closely with the grandparents, showing things can be worked out. Had we not been able to hire an attorney I strongly feel this child would of ended up on the street in some gang, because of his home life. No child wants to put up with abuse. You teach your children to trust the system, but what do you tell them when the system fails them?

Please vote for HB 164 and give these Children a chance to stay with the family that they have left in familiar surrounds, with familiar and loving people, not STRANGERS! This allows the children also to maintain their heritage, gene history and medical backgrounds - Who they are! Years down the road this is a very important matter to them. Remember these are the children that will rule after we retire!! We are now a solid rock to these grandchildren, we want them to be a solid rock in our future.

Betty Short,
Caring & Concerned Grandparent

**Ed Stroman
3224 Linden D..
Anchorage, AK 99502**

I am vice president of the Grandparents Rights Organization of Alaska. Although I personally have had no problems with DFYS, I do see quite a few people in our group that has had problems.

I found it personally appalling that the DFYS is allowed to get away with the way they operate their agency. An organization that was formed to maintain the welfare of our families and our youth needs to rethink what they stand for, and remember what their real job is.

In their own bylaws, the DFYS is supposed to try to place the children that are taken out of a dysfunctional family with a direct family member as soon as possible, 48 hours is the rule. That being the case, why then does it take weeks and even months to get the DFYS to even consider investigating family members for appropriate placement. Placing children into foster care is a very traumatic thing for a young child who does not understand what is happening to them.

First they are taken out of the only home they know and placed in a home where they don't know anyone. Next, the grandparents that are not involved with the removal of these children are denied any visitation with these children. Who, at this time, need all the support that they can get.

The children of dysfunctional families need all the support that is available to them, and getting them into a familiar setting as soon as possible should be utmost on the minds of all lawmakers in this country. Not all children can be placed with family members, but all children deserve the right to have that opportunity.

I ask that you try to pass this bill quickly through legislation to save our children's future.

I HAVE NOT PERSONALLY HAD ANY DEALING WITH DFYS BUT DUE TO A PERSONAL DISPUTE WITH ONE OF OUR 12 CHILDREN; WE HAVE NOT BEEN ALLOWED TO SEE 2 OF OUR GRANDCHILDREN FOR OVER 3 ½ YEARS.

THE OLDEST CHILD HAS BEEN VERBALLY & EMOTIONALLY ABUSED SINCE HE WAS A SMALL CHILD. HE HAD BEEN KICKED OUT OF SCHOOL & NO-ONE SEEMED TO BE ABLE TO CONTROL HIM. ANOTHER DAUGHTER EVEN TOOK HIM FOR 3 ½ MONTHS AND THEY WORKED ON DISCIPLINE & MEDICATION CONTROL. BUT SINCE BACK HOME, HE KEEPS RUNNING AWAY FROM SCHOOL & ACCUSING HIS MOTHER OF ABUSE. ALL PROVED FALSE--- BUT HE GOT THEIR ATTENTION!!!!

WE GOT A CALL FROM THE SECOND DAUGHTER TELLING US THAT THE MOTHER WAS TRYING TO PUT THE CHILD IN FOSTER CARE. WE WROTE & THEN CALLED & FINALLY GOT A TEMPORARY GUARDIANSHIP HE IS NOW IN RABBIT CREEK SCHOOL, AND THO NOT A GREAT STUDENT-- IS DOING OKEY. HE IS STAYING IN THE CLASSROOM & USING THE RESOURCE ROOM FOR MATH & HIS PROBLEMS.

OUR POINT --- JUST A LITTLE LOVE & AFFECTION HAS MADE A WORLD OF DIFFERENCE IN THIS CHILD'S LIFE. HE SMILES & IS A HAPPY CHILD AGAIN; HE WAS IN A WORLD OF DISRUPTION & SELF-DESTRUCTION BEFORE WE COULD RESCUE HIM.

WHAT A DIFFERENCE FAMILY CAN MAKE; GRANDPARENTS CAN GIVE A CHILD NATURAL -- GOD GIVEN -- LOVE. THEY ARE OUR FLESH & BLOOD !! OUR GRANDPARENTS RIGHTS ORGANIZATION HEARS SOME HORROR STORIES OF THE FOSTER CARE & DFYS TREATMENT GIVEN TO CHILDREN. PLEASE LET US HELP THESE POOR ABUSED (IN ONE WAY OR ANOTHER) CHILDREN THAT WE LOVE NATURALLY. WE ASK YOU TO ENDORSE THIS BILL BEFORE YOU FOR THE GUARENTEE THAT GRANDPARENTS & THEIR GRANDCHILDREN' MAY FORM A LIFE-LONG BOND.

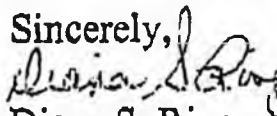
SINCERELY,
LEILA NELSON, 13926 LAKE OTIS, ANCHORAGE, AK 99516
PHONE 907-345-2578

To Whom it may concern:

In 1991, when my grandson was 6 months old there was an incidence of abuse reported to DFYS. At that time he was placed in our home with his teenage mother. My son and the mother were not married. Since that time my son has died, the mother has married and has a whole new family. My grandson has been adopted by his step father. They do not include us in their lives.

My concern for my grandsons safety remains an issue and if their were to be another incidence of abuse reported, I am not sure DFYS would include us in the case or consider us for placement. I am not sure the parents would tell a caseworker we exist. Since he has been adopted and has a new last name, I do not know if DFYS could/would pull up the previous incident for information regarding grandparents.

I see this bill as an improvement to include grandparents in the lives of children placed under DFYS jurisdiction, but I am concerned that it does not go far enough. Maybe there needs to be some kind of registry within the system to allow grandparents to register with all their grandchildren's names that can be accessed when a child enters the system.

Sincerely,

Diana S. Ring

Being in the system and having battled with DFYS for over 3 years I can very much relate to what HB164 would mean to a grandparent. DFYS just plain does not care about unity, only money a child can bring them by being placed in foster care or adopted out.

They have taken my grandchildren out of my home with some phony allegations, placed them in various foster care homes. They split them up, 2 of them ending up in a good home in Craig, Ak. The other tried to jump out of a car at a red light (she wanted to go to her grandmothers house), so they put her in Charter North, where she was drug across a floor (injuring her) by a nurse.

She was then sent to a group home being fed 3-4 drugs a day and she shakes & quivers and sometimes is very withdrawn, very pale and thin. We can't even share the holidays with her. Gifts have to be dropped off prior to a holiday. They eat or throw away the candy. They hold gifts as a behavior tool. It is devastating for a grandparent to see their once bubbly, loving grandchild like this. She is traumatized and emotionally and mentally beat down.

Just recently visitation was reinstated with 1 hour per week with her. We have not seen the other children since February '00.

I filed a grievance, which was a mistake because the retaliation from DFYS only harmed me and my grandchildren.

I ask you as the peoples representatives to vote for HB 164 to help these children that can be helped, so they may grow with the learning of their family and become good solid adults.

Marcia Whitcomb

To whom it may concern:

My experience with DFYS is minor compared to some of the other stories that I have heard and seen.

But like all the rest, the response from DFYS was the same. Being told that the grandparents are not a 'Party involved' is a great mistake. Grandparents are the "special" people that is needed and wanted by the children. If DFYS is so concerned about the "will being" of the children, they should be bringing the grandparents into the picture of what should be done. The next best thing for a child is the grandparents. Grandparents have nothing but the 'best interest' of the children. They give them 'unconditional' love that is so much needed in a child's growth.

So far, I have only seen DFYS cause hatred and anger in such little minds which is as much an abuse as what they are suppose to be protecting the children from. This hatred and anger stays with the children for a long time if not forever. How can they learn respect and kindness? Will they become another Timothy McVey? Will they become one of these children that will bring a gun to school?

When my grandson ran away from his mother when the situation began, he ran to my place for safety. It was the hardest thing to have to call his mother and let her know where he was. And before she and the police got there, I told him if there is a problem he should talk to the police or teacher or the counselor he was SUPPOSE to be seeing. What was the first thing the police did???? He yelled at the boy (only nine years old). If you could have just

seen the tears in his eyes and how he was trying so hard to hold them back, so of course, he turned it into anger. And was that ever worse!!!! His mother was not concern about about the child. Her only concern was making an issue so she can get custody in a divorce. And DFYS did not even investigate the accusations. Even, after evidence was given to them, they just ignored them.

And of course, trying to get a meeting with them to try and protect the children, it was totally IMPOSSIBLE. I was not a 'party involved'... why did the child run to safety at my house? And I could not give them that safety. I had to turn him back to his mother.

Grandparents are a part of the 'link' in the chain of life. A life of a child that needs love and understanding and spiritual growth in order to succeed and become a member of the society. Don't let them become angry at the system, at the law, and at themselves. Lets listen to these children that want to turn to their grandparents. Don't let them be taken away from the grandparents like in some instances they have, when the grandparent was already giving them the care and love they needed.

If we have to go to having a law in order to protect these children and helping them complete their circle of life, than this law should be seriously look at and make it so.

Arlene Remer

I have seen many families torn apart by a system that is not functioning in the Best Interest of the Child. The DFYS is an agency that needs to be monitored for inadequacies in their operation. Too many times our grandchildren are falling through the cracks in the system.

HOUSE BILL 164 is designed to aid our grandchildren by giving the grandparents a chance to save the children from a life lived in foster care. These grandkids need a family that they know so that they can grow up learning how to be good citizens. Living in foster care is a good temporary solution, but living with immediate family, whenever possible, is still the best solution.

Give the grandparents a chance to love their grandkids while they can, vote for HB 164.

Bill Slayton

House bill 164 is a step towards giving the grandparents of Alaska and the grandchildren of Alaska, the rights that they have always deserved.

Over the past couple years, I have seen first hand what a problem D.F.Y.S. has with placing children with immediate family whenever possible.

As a member of the Grandparents Rights Organization of Alaska, I have talked to several people that have had nothing but grief from D.F.Y.S.

Grandparents being told that they don't count because they are "only grandparents and don't have any rights".

Being denied visitation by caseworkers simply because the workers don't like the way they dress.

Not all grandparents are rich. At least not monetarily rich.

They are rich in the fact that they love their grandchildren very much. Enough to want the children to live with them when it is necessary.

But D.F.Y.S. has put up roadblocks all along the way.

There is no reason, in most cases, why the grandparents can't keep the grandchildren in their homes.

It costs a lot of money to maintain a child in a foster home, and it also damages the children's minds when they are denied visitation with a beloved grandparent just because a caseworker says no visits.

Our grandchildren are the future of this country, and need to be shown that if their parents can not be around to raise them, then their grandparents can.

Give this bill your utmost attention, because it can effect all of us. We can all be grandparents some day.

Mary Lou Foster

GRANDPARENTS HAVE A VERY SPECIAL RELATIONSHIP WITH THEIR GRANDCHILDREN. WHEN THEY ARE WHISKED AWAY AND TOLD THEY CAN NOT SEE THEIR PARENTS, MUCHLESS THEIR GRANDPARENTS OR OTHER RELATIVES, THIS IS DEVASTATING TO THEM. THEY DO NOT UNDERSTAND WHY!!

GRANDPARENTS WHO WANT TO BE INVOLVED AND PARTICIPATE IN THEIR GRANDCHILDRENS LIVES SHOULD NOT BE JUDGED THE SAME AS THOSE WHOM ONLY WANT TO SEE THEM ONCE OR TWICE A YEAR.

REP FRED DYSON INTRODUCED HB 164 WHICH ALLOWS GRANDPARENTS TO PARTICIPATE IN DFYS INVESTIGATIONS AND ENTITLES GRANDPARENTS TO BE HEARD IN COURT. THIS IS AN IMPORTANT STEP IN PROTECTING AND PROMOTING THE CHILDS MENTAL AND EMOTIONAL WELL BEING. THEY WILL KNOW THAT A FAMILIAR IDENTITY IS OUT THERE FIGHTING FOR THEM.

THERE ARE LAWS TO GRANT VISITATION TO GRANDPARENTS AS THERE IS FOR PARENTS. THERE ARE EVEN PENALTIES IF THIS IS NOT ADHERED TO.

A.S. 25.20.065 (THE GRANDPARENTS' RIGHTS LAW) RECOGNIZES A GRANDPARENTS RIGHTS TO SEE HIS OR HER GRANDCHILDREN.

A.S. 47.14.100(e)(1) PROVIDES THAT THE STATE DEPARTMENT CANNOT PLACE A CHILD IN FOSTER CARE IF A BLOOD RELATIVE REQUESTS PLACEMENT, UNLESS THE DEPARTMENT DETERMINES THAT THE PLACEMENT WITH A RELATIVE WILL RESULT IN PHYSICAL OR MENTAL INJURY TO THE CHILD, ETC. ETC.

A.S. 47.10.080(p) PROVIDES THAT THE DEPARTMENT MAY DENY VISITATION TO PARENTS, GUARDIANS OR FAMILY MEMBERS ONLY IF THERE IS CLEAR AND CONVINCING EVIDENCE THAT IT IS NOT IN THE BEST INTEREST OF THE CHILD, ETC. ETC.

DFYS DOES NOT ADHERE TO THE ABOVE. THEY ARE INTIMIDATING AND DENY THEY KNOW ANY OF THE ABOVE. THEY BELITTLE GRANDPARENTS AND TELL THEM THEY HAVE NO RIGHTS.

I ASK THAT YOU STRONGLY APPROVE HB 164 FOR ADDED STRENGTH FOR THE GRANDPARENTS TO FURTHER PROTECT THEIR GRANDCHILDRENS HERITAGE AND RIGHTS.

THANK YOU,

ROSS FOSTER

THE FOLLOWING COPIES OF LETTERS TO THE EDITOR OF OUR ADN TELLS A LOT. I HOPE THE LEGISLATION PAYS CLOSE ATTENTION TO THESE.

I THINK IT WILL BE A LONG TIME BEFORE ANYONE WILL FORGET THE STEVEN MURRAY STORY. I REMEMBER HIS MOTHER AND GRANDMOTHER COMING TO THE GRANDPARENTS RIGHTS ORG MEETINGS, PLEADING FOR ANYONE THAT COULD HELP THEM. CHILDREN NEED TO BE PROTECTED AND IF OUR CURRENT AGENCY CANNOT DO IT, THEN WE NEED TO REVAMP AND DO WHAT HAS TO BE DONE!!!

THE 2/1/01 FROM WENDY ISBELL WAS SHORT, BUT DIRECTLY TO THE POINT, BUT VERY TRUTHFUL.

EVEN THE TEEN SHELTER ONE SHOWS THE INEFFICIENCIES OF DFYS. THAT ONE SOUNDED LIKE A COVER UP TO ME. WHY WEREN'T THE FACTS CONFIRMED BEFORE A STORY LIKE THIS WAS EVEN PRINTED. BECAUSE DFYS THROWS OUT A LINE, USUALLY TO GET THE HEAT OFF OF THEMSELVES. IF THEY DO THIS WITH OUR CHILDREN OF ALASKA, WE ARE IN DEEP TROUBLE.

PLEASE VOTE FOR HB 164 AND GIVE THE GRANDPARENTS A RIGHT TO FIGHT FOR THEIR GRANDCHILDREN!! YOU ALL WILL PROBABLY BE GRANDPARENTS SOMEDAY, IF YOU AREN'T ALREADY. I'M SURE YOU DON'T WANT TO READ LETTERS TO THE EDITORS AS SUCH ABOUT YOUR GRANDCHILDREN.

BOB M. STRAUSS

12-9-00

DFYS not held accountable

I have just read yet another story about the ineffectiveness of our state's version of Hitler's Brownshirts, the Division of Family and Youth Services. Joey Wolfe, age 2, was allegedly killed at the hands of his mother's boyfriend while she was working at a strip club ("Boyfriend faces charges in death," Dec. 5). Joey had been in and out of state care for more than a year before being released to his mother, a stripper with a few convictions for disorderly conduct and forgery. Her boyfriend (whom she is "sticking by") had a history of flashing. Not exactly savory material.

It seems that every year right before our lawmakers return to Juneau, we read lots of stories describing how children have been abused while in custody of DFYS.

What was DFYS doing that was so important that they weren't keeping an eye on this little boy and his brother, Dallas? How did their mother, whose lifestyle was high risk, get her sons back after she lost custody? Did her son's father ever hear about his children being abused? Before there was a death? The article was mum on this.

When are people going to care that our Legislature is throwing money at DFYS without demanding accountability? If they had a strict procedure that they followed, a lot less people would fall through the cracks (or innocently land in it when they shouldn't) and we'd have fewer deaths. Do we need to fund a memorial site dedicated to children abused while in the state's custody before our Legislature holds DFYS accountable?

— Kellie Coulson Davis
Wasilla