**TO:** DPP Medical Support Section

**THROUGH:**      , SRA (or designee),       Service Region

 Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_\_

**THROUGH:**      , Regional Medically Fragile Liaison

 Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_\_

**FROM:**      , SSW -       County

 Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_\_

      , FSOS

Initials: \_\_\_\_\_\_ Date: \_\_\_\_\_\_

**DATE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CHILD’S NAME:  TWIST #:

Birthdate:       SSN:       [ ] Male [ ] Female

SSW:       SSW County:       SSW Phone:

Date of Placement or Proposed Placement:

Foster Parent Name(s):

Placement Address:

Placement County:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Placement Certifications**

Is Placement Approved Medically Fragile? [ ] Yes [ ] No

Is Foster Parent Licensed Practical Nurse? [ ] Yes [ ] No

Is Foster Parent Health Care Professional? [ ] Yes [ ] No

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**Type of Placement Contract**

[ ] DCBS Foster Home

[ ] Private Child Placing Agency (PCP) Foster Home

* Provide agency name:
* Case manager name (if known):
* Case manager phone:

[ ] Private Child Caring Agency (PCC) (Residential)

[ ] Relative Placement

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Summary of Child’s Medical Condition**

* History (include number of placements, family involvement, school placement, health history, developmental age, and current behaviors):
* Medical problems & care needs (attach professional evaluations, and indicate primary providers):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CCSHCN Referral**

Upon receipt of this referral, the child/youth will be enrolled in the Commission for Children with Special Health Care Needs Medically Fragile Foster Care Program. Submission of this referral form constitutes acknowledgement of CCSHCN’s Notice of Privacy Practices, posted on the CHFS Intranet at <http://chfsnet.ky.gov/ccshcn/FosterCare.htm>; and consent for services. If it is determined that this child/youth would benefit from the specialty clinic services available through the traditional CCSHCN program, a formal CCSHCN application for services should be completed.

[ ]  Child is ineligible for CCSHCN home visit services due to out of state placement

[ ]  Child should be exempt from referral for CCSHCN home visit services because (explain below): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Support Section Use Only**

Date Determined Medically Fragile:

Medical Rating:

Rate: [ ] Basic [ ] Advanced [ ]  Specialized Advanced [ ] Degreed

 [ ] PCP [ ] PCC

TWIST Entry: