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| Child’s Name: | DOB: |
| Male  Female | SSN: |
| Date of initial entry into OOHC: |  |
| Date of most recent placement or proposed placement: | TWIST #: |
| Home county: | County of placement: |

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| **Placement Information**  (if child is medically complex, complete page 3) | | |
| Is the child being placed in a DCBS Resource Home?  Yes  No | Basic  Advanced  Care Plus | Medically Complex  (Basic, Advanced  Degreed (RN/MD))  Emergency Shelter |
| Is the child being placed in a Private Child Caring or Private Child Placing Agency?  Yes  No | Private Foster Care  Residential | |
| Placement name:  Address:  Telephone number: | Relative  Independent Living  (ILP)  Supports for  Community Living  (SCL) | Psychiatric Hospital  Out of State  Placement  Other |

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| **Physical and Behavioral Health Care** | | | | | | |
| **Type of Provider** | **Provider/ Specialist Name** | **Diagnosis/ Condition** | | **Telephone Number** | **Date of Last Exam** | **Date of Next Visit** |
| Primary Care Physician |  |  | |  |  |  |
| Optometrist |  |  | |  |  |  |
| Dentist |  |  | |  |  |  |
| Therapist |  |  | |  |  |  |
| Other |  |  | |  |  |  |
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| **Does the child currently receive any of the following?** If yes, document the provider’s name and telephone number. | | | | | | |
| Speech Therapy:  Yes  No  N/A | | |  | | | |
| Occupational Therapy:  Yes  No  N/A | | |  | | | |
| Physical Therapy:  Yes  No  N/A | | |  | | | |
| Developmental Interventionist:  Yes  No  N/A | | |  | | | |
| Home Health:  Yes  No  N/A | | |  | | | |
| First Steps:  Yes  No  N/A | | |  | | | |
| Durable Medical Equipment:  Yes  No  N/A | | | Describe: | | | |
| List all known allergies: | | | | | | |
| Pharmacy name and telephone number: | | | | | | |

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| Is child currently hospitalized?  Yes  No | If yes, explain circumstances of hospitalization and anticipated discharge date: |
| Name of hospital: | Hospital contact name and telephone number: |
| List any prior hospitalizations. Explain circumstances of hospitalization, length of stay, date of discharge, name of hospital and treating physician: |  |

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| **Current Medication Information** | | | |
| **Medication Name** | **Dosage** | **Frequency** | **Refill Date** |
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| Are immunizations up to date?  Yes  No | Name/telephone number who provided immunizations: |

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| Please list any physical or behavioral health history not already listed above. Include pertinent birth information here. Please document reason for medically complex request in this section. |
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| Name of Managed Care Organization (MCO): |  |
| Regional MCO Liaison/Telephone Number: |  |
| Initial Entry Date: | Re-entry Date: |
| Does child have private or supplemental insurance? If yes, list provider. | Yes No |
| Does the child receive SSI? | Yes No |
| Person providing information signature: |  |

DCBS staff printed name Signature

Phone # Email Address Date

DCBS Address

MCO printed name Signature

Stop here UNLESS requesting a medically complex designation

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| This section to be completed ONLY if requesting a medically complex designation | |
| DCBS medically complex placement name, address and phone number: | Basic Medically Complex  Advanced Medically Complex  Degreed Medically Complex (RN/MD)  Specialized Advanced Medically Complex (per medical support section)  Specialized Degreed Medically Complex (per medical support section) |
| Private child placing (PCP) agency and foster parent name, address and phone number:  Does the agency have a medically complex license?  Yes  No  If no, contact the Medical Support Section in Central Office for consultation.  \*Agency must hold a medically complex license: | Private child caring (PCC) agency name, address and phone number:  \*Detailed plan by agency required describing how they will meet the medical needs of the child/youth. |
| Other name, address and phone number:  \*Detailed plan required describing how they will meet the medical needs of the child/youth. | Relative  Independent Living (ILP)  Supports for Community Living (SCL)  Psychiatric Hospital  Out of State Placement |
| Has the foster parent completed all medically complex training requirements?  Yes  No | Does the foster parent have current certification in first aid and CPR for infants, children and adults?  Yes  No |
| **If requesting a medically complex designation, please ensure that this entire document is sent to the appropriate regional Medically Complex Liaison.**  **Please include**   1. **Any medical records available** 2. **Copy of the court’s custody order** 3. **M001-CCSHCN Verbal Release of Information**   **CCSHCN Referral**  Upon receipt of this referral, the child/youth will be enrolled in the Commission for Children with Special Health Care Needs Medically Complex 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.  SRA/Designee Sign and print Date  FSOS Sign and print Phone # Date  SSW Sign and print Phone # Date  Medically Complex Liaison Sign and print Date  CCSHCN Nurse Consultant Sign and print Date  I have been consulted concerning this child/youth for possible consideration for medically complex designation. | |