Health Care Program for Children in Foster Care (HCPCFC)
Foster Care Medical (Specialty) Contact Form

Submit to the Santa Cruz Family Child Services PHN within 5 business days of the examination at FAX: (831) 763-8410 ATTN: Public Health Nurse

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system.

Patient Name (Last) (First) (Initial) | **Language** | **Date of Service** Month Day Year

Birthdate Month Day Year | **Age(yr/m)** | **Sex** | **Gender** | **Patient's County of Residence** | **Telephone #** (Home or Cell) | **Alternate Phone #** (Work or Other)

Responsible Person (Name) (Street) (Apt/Space) (City) (Zip)

Ethnic Code ☐
1-White
2-Hispanic/Latino
3-Black/African American
4-American Indian/Alaska Native
5-Asian
6-Native Hawaiian/Other Pacific Islander
7-Other

Patient Eligibility: County Code | Aid Code | Identification Number

Next CHDP Exam Month Day Year

A. Medical Assessment and Referral Section

Type of Visit:

MEDICAL ☐ Well Child Exam ☐ Immunization Visit ☐ Sick Visit/Urgent Care ☐ Reproductive Health ☐ Follow Up

SPECIALTY _____ ☐ Initial Consultation ☐ Follow Up

Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health)

Height To nearest 0.1 cm	Height Percentile	**Weight** To nearest 0.1 kg	Weight Percentile	**BMI**	BMI Percentile	**Head Circumference**	Head Circ. Percentile

Blood Pressure	**Hemoglobin**	**Hematocrit**	**Vision Results** OD OS OU	**Hearing Results** R L

Labs Ordered ☐ CBC ☐ Lead ☐ Other:_____ | **Date Labs Ordered** | **Lab Results**

Any known **allergies** to medication/food/environment? ☐ Y ☐ N Please list:_____

ASSESSMENT/DIAGNOSIS:

Depression Screening: ☐ Y ☐ N **Substance Abuse Screening:** ☐ Y ☐ N **Tool Used (if any)?** _____

MEDICATIONS/TREATMENTS:
(DOSAGE/FREQUENCY)

If prescribed psychotropic medication was a
JV220 (A) completed? ☐ Y ☐ N
Was EKG completed? ☐ Y ☐ N
Were Labs completed? ☐ Y ☐ N

DEVELOPMENTAL SCREENING/ASSESSMENT: **Completed today?** ☐ Y ☐ N

Developmental tool used, if any: (Please attach a copy) ☐ ASQ-3 ☐ ASQ-SE ☐ Other (Specify):_____

Age appropriate development? ☐ Y ☐ N **if NO, Indicate:** ☐ Gross ☐ Fine ☐ Speech/Language ☐ Social/Emotional ☐ Cognitive

Physical Growth ☐ WNL ☐ Delayed

_____

REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)

IMMUNIZATIONS
☐ **Copy of IZ Records Attached?**
Please check (☑) which immunizations have been given TODAY:

IPV	1☐	2☐	3☐	4☐	
DTaP	1☐	2☐	3☐	4☐	5☐
Td	☐				
Tdap/Booster	☐				
Hib	1☐	2☐	3☐	4☐	
MMR	1☐	2☐			
Hep B	1☐	2☐	3☐		
Hep A	1☐	2☐			
VZV	1☐	2☐			
PCV	1☐	2☐	3☐	4☐	5☐
PCV13	☐				
MenACWY	☐				
HPV	1☐	2☐	3☐		
Influenza	1☐	2☐			
Rotavirus	1☐	2☐	3☐		

Other:_____
☐ **Up to date** ☐ **Not up to date**

☐ **PPD** ☐ **TB Risk Assessment**
Date Given:_____
Date Read:_____
Results: ☐ **Negative** ☐ **Positive**
☐ **Return for PPD Read**
☐ **Lab ordered for QFT/IGRA**

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis
Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis
Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain
Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

☐ **Dental home referral** **Referred To and Contact Number:** _____

C. Provider Information

Service Location: Office Name, Address, Telephone/Fax Number

NPI Number

Provider Name (Print Name)

Provider Signature | **Date**

Follow up appointments needed? ☐ Y ☐ N **Date/Time**_____

Revised 09/2017

Foster Care Medical (Specialty) Form: Completion Instructions

Health Care Providers:

- Submit a copy of the form, an EHR patient summary, or an equivalent via eFax to the Local HCPCFC Program when providing care to children and youth in the foster care system
- Give a copy of the form or a printout of your EHR patient summary or an equivalent to the responsible person indicated on the form.

Explanation of Form Items:

Patient Information (Demographics section)

Patient Name. Enter the patient's last name, first name and middle initial, exactly as it appears on the Benefits Identification Card (BIC), including blank spaces. If the patient's name differs in any way from the name on the BIC or is incorrect, enter the name that the patient is Also Known As (AKA).

Language. Enter the patient's primary language spoken at home. The language is critical to enable local CHDP program staff to assist families in removing barriers to diagnosis and/or treatment.

Date of Service. Enter the date the CHDP service was rendered. Use a leading zero (0) when entering dates with only one digit (for example, March 1, 2017 is entered as 03 01 17).

Birthdate. Enter the month, day and year of the patient's birth exactly as it appears on the Medi-Cal eligibility verification system. Use zeros (0) when entering dates of only one digit (for example, January 1, 2017 is entered as 01 01 17).

Age. Enter the patient's age with one of the following indicators: "yr" for years, "m" for months, "w" for weeks, or "d" for days (for example, 15yr represents 15 years of age).

Sex. Enter an "F" if the patient is female. Enter an "M" if the patient is male. This must be entered exactly as it appears on the Medi-Cal eligibility verification system.

Gender. Enter the gender the patient identifies with even if the gender is not female or male. If information is not available, leave blank.

Patient's County of Residence. Enter either the name of the county where patient lives (not county where assessment is performed) or the two-digit city code if the individual lives in Berkeley, Long Beach or Pasadena.

Telephone #. Enter residence or cellular telephone number, including area code where the responsible person can be reached during the day.

Alternate Phone #. Enter business or message telephone number, including area code where the responsible person can be reached during the day.

Responsible Person. When the patient is younger than 18 years of age and not an emancipated minor, enter the name, street address (including apartment or space number), city, and ZIP code of the legal guardian with whom the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY. Enter patient's two-digit county code (obtained when eligibility verification is performed).
- AID. Enter patient's two-digit aid code (obtained when eligibility verification is performed)
- IDENTIFICATION NUMBER. Enter patient's identification number from the plastic Benefits Identification Card (BIC) or
  - *Immediate Need Eligibility Document* – Gateway

Next CHDP Exam Date. Enter the month, day and year the next complete health assessment is due.

Ethnic Code. Enter the appropriate ethnic code (select one only). If the patient's ethnicity is not included in the code list, or if ethnicity is unknown, enter code 7 (Other).

A. Medical Assessment and Referral Section:

Type of Visit. Enter a check mark (✓) on the correct type of medical visit. For specialty exams, indicate type of specialty (i.e. Optometry, Neurology) and enter a check mark (✓) if specialty exam is an initial consultation or follow-up appointment.

Height. Enter patient height to the nearest 0.1cm and height percentile.

Weight. Enter patient weight to the nearest 0.1kg and weight percentile.

BMI. Enter patient BMI and BMI percentile.

Head Circumference. Enter patient head circumference and head circumference percentile.

Blood Pressure. Enter patient blood pressure.

Hemoglobin. Enter patient hemoglobin level.

Hematocrit. Enter patient hematocrit level.

Vision Results. Enter patient vision results for left, right and both eyes. If not completed, indicate reason (i.e. N/A, unable).

Hearing Results. Enter patient hearing results indicating passed, within normal limits (WNL) or failed. If not completed, indicate reason (i.e. N/A, unable).

Labs Ordered. Enter a check mark (✓) if CBC, Lead or other labs ordered. For other labs ordered, enter type of lab (i.e. TSH).

- *Date Labs Ordered.* Enter the date labs ordered.
- *Lab Results.* Enter lab results and attach a copy of results if available.

Allergies. Enter a check mark (✓) if patient has any known allergies to medication, food or environment. If yes, enter all allergies.

Assessment/Diagnosis. Enter assessment findings including any known or suspected diagnoses.

Depression Screening. Enter a check mark (✓) in the appropriate box indicating if a screen was completed or not. If so, indicate tool used, if any.

Substance Abuse Screening. Enter a check mark (✓) in the appropriate box indicating if a screen was completed or not. If so, indicate tool used, if any.

Medications/Treatments. If patient was prescribed any medication(s), enter the name, dosage and frequency of the medication(s). Enter any treatments rendered during the visit or future treatment(s) needed.

- *Psychotropic medication.* If patient is prescribed a psychotropic medication, enter a check mark (✓) indicating if the following were completed or not:
  - A JV220 (A)
  - An EKG
  - Labs

Developmental Screening/Assessment. Enter a check mark (✓) indicating if a developmental screen/assessment was completed at time of visit or not. If yes, indicate the type of tool used. If other than an Ages and Stages Questionnaire (ASQ), enter a check mark (✓) in *Other* and specify tool used. Attach any completed developmental screen/assessment.

- *Age Appropriate Development.* Enter a check mark (✓) in the appropriate box. If no, enter a check mark (✓) where development is not appropriate. Mark all that apply.
- *Physical Growth.* Enter a check mark (✓) in the appropriate box. If physical growth is not WNL, enter a check mark (✓) in *Delayed* and enter an explanation.

Referrals. Enter referrals made at time of visit or pending referrals to any provider or agency. Indicate the name(s) and telephone number(s) of the provider(s) the patient was referred to.

Immunizations. Enter a check mark (✓) if immunization records are attached.

- Enter a check mark (✓) for all immunizations given at time of visit.
- Enter a check mark (✓) indicating whether or not patient is up-to-date with immunizations.
- Enter a check mark (✓) if a TB risk assessment was completed.
- Enter a check mark (✓) if a PPD was given/read at time of visit.
  - If PPD given, enter date and a check mark (✓) on Return for PPD Read.
  - If PPD read, enter date and indicate result.
- Enter a check mark (✓) if QuantiFERON (QFT)/ Interferon-Gamma Release Assays (IGRA) labs ordered.

B. Dental Assessment and Referral Section

Class I. Enter a check mark (✓) on the *Class I: No Visible Problems* box if the patient has no visible problems and by checking this box you are indicating the patient is being referred for the *mandated annual routine dental referral*.

Class II. Enter a check mark (✓) on the *Class II: Visible decay box* if the patient has visible decay, small carious lesions or gingivitis and by checking this box you are indicating the patient is being referred for a *nonurgent dental care* referral.

Class III. Enter a check mark (✓) on the *Class III: Urgent* box if the patient has pain, abscess, large carious lesions or extensive gingivitis and by checking this box you are indicating the patient is being referred for *immediate treatment due to an urgent dental condition*.

Class IV. Enter a check mark (✓) on the *Class IV: Emergent acute injury* box if the patient has an acute injury, oral infection or other pain and by checking this box you are indicating the patient is being referred for *immediate dental treatment to be seen within 24 hours*.

Fluoride Varnish Applied. Enter a check mark (✓) on the *Yes* box if the patient had fluoride varnish applied during visit on date of service listed above.

- Enter a check mark (✓) on either of the No boxes if parent refused or teeth have not erupted if fluoride varnish was not applied.
- Enter a check mark (✓) on the Other reason box and state reason for not applying fluoride varnish in the space provided.

Dental home referral. Enter a check mark (✓) on the *Dental home referral* box if the patient has no dental home.

Note: A referral for a routine dental visit still needs to be made if the patient has no dental problems (Class I) and is 1 year of age or younger and has erupted teeth. Be sure to check (✓) Class I box.

Referred To and Contact Number. Enter the name and telephone number of the dental provider or agency you referred the patient or enter the patient's dental home provider information.

- If the patient does not have a dental home, be sure to enter a check mark (✓) on the *Dental home referral* box and enter the name and telephone number of the dental provider or agency you referred the patient.

C. Provider Information

Service Location. Enter the following information on the appropriate line:

- Line 1: Business Name
- Line 2: Street address
- Line 3: City, State and nine-digit ZIP code
- Line 4: Telephone number, including area code

A provider stamp is acceptable.

Follow up appointments. Enter a check mark (✓) if a follow up appointment is needed. If so, enter date/time of next appointment, if scheduled. If not scheduled, indicate when the patient should follow-up (i.e. 3 months).

NPI Number. Enter the provider National Provider Identifier (NPI) number in the appropriate line. **Provider Name.** Print legibly or type the provider's name that rendered the services.

Provider Signature. Provider or a designated representative must sign.

Date. Enter the date of signature.