



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
DIVISION OF FAMILY SERVICES  
CHILDREN'S SERVICES UNIT  
**MEDICAL FOSTER CARE ASSESSMENT**

<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> NON-ELIGIBLE
DATE	DETERMINED BY

**I. IDENTIFYING INFORMATION**

1. NAME OF CHILD \_\_\_\_\_ 2. DATE OF BIRTH \_\_\_\_\_ 3. DATE EVALUATED \_\_\_\_\_

4. DEPARTMENTAL CLIENT NUMBER (DCN) \_\_\_\_\_ 5. COUNTY OF JURISDICTION \_\_\_\_\_ 6. CASE MANAGER \_\_\_\_\_

7. COUNTY OF RESIDENCE \_\_\_\_\_ 8. SERVICE WORKER (IF DIFFERENT FROM CASE MANAGER) \_\_\_\_\_ 9. EXPECTED TIME MFC REQUIRED \_\_\_\_\_

10. PARENT'S NAME \_\_\_\_\_ 11. PARENT'S ADDRESS \_\_\_\_\_

**II. COMPLETE A BRIEF STATEMENT OF THE PRINCIPLE MEDICAL AND/OR DEVELOPMENTAL PROBLEMS WHICH NECESSITATE THE NEED FOR MEDICAL FOSTER CARE (ATTACH ALL DOCUMENTATION RELATING TO THE MEDICAL/DEVELOPMENTAL CONDITION)**

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**III. CHECKLIST INSTRUCTIONS**

A. READ THROUGH EACH LIST CHECKING IN THE BOX BESIDE EACH STATEMENT ONLY IF IT APPLIES TO THE CHILD.  
B. REVIEW THOSE STATEMENTS CHECKED AND MAKE A FURTHER RATING (1, 2 OR 3) BY PUTTING A CHECK IN THE APPROPRIATE BOX.  
LEVEL 1 — THE CHILD REQUIRES THE SAME AMOUNT OF CARE, TIME AND ENERGY AS A DEPENDENT CHILD OF THE SAME AGE WITHOUT MEDICAL OR DEVELOPMENTAL PROBLEMS.  
LEVEL 2 — THE CHILD REQUIRES PHYSICAL CARE, SOME SPECIALIZED TRAINING AND MORE EXPENDITURE OF TIME AND ENERGY THAN THAT SPENT ON A DEPENDENT CHILD OF THE SAME AGE WITHOUT MEDICAL OR DEVELOPMENTAL PROBLEMS.  
LEVEL 3 — THE CHILD REQUIRES ACUTE NURSING CARE AND EXTENSIVE SPECIALIZED KNOWLEDGE AND A GREAT DEAL MORE TIME AND ENERGY THAN THAT SPENT ON A DEPENDENT CHILD OF THE SAME AGE WITHOUT MEDICAL OR DEVELOPMENTAL PROBLEMS.

A. PERSONAL CARE	LEVELS OF CARE	C. ANCILLARY CARE	LEVELS OF CARE
	1 2 3		1 2 3
BECAUSE OF THIS CHILD'S DISABILITY (NOT AGE) HE/SHE:		BECAUSE OF THIS CHILD'S MEDICAL/DEVELOPMENTAL DISABILITY (NOT AGE) HE/SHE REQUIRES:	
1. NEEDS ASSISTANCE IN BATHING, CLOTHING, ORAL HYGIENE		1. EXCESSIVE LAUNDRY BECAUSE OF ENURESIS	
2. HAS ENCOPIRESIS OR ENURESIS (LACK OF EDWEL AND/OR BLADDER CONTROL)		2. EXCESSIVE PRECAUTIONS AND CARE OF EQUIPMENT BECAUSE CHILD IS DESTRUCTIVE TO HOUSEHOLD GOODS (I.E. SMEARING AND SOILING, HYPERACTIVITY)	
3. HAS IMMOBILITY, I.E. TRACTION, CAST, BEDREST, PARALYSIS		3. CONTINUOUS OR REQUIRED SUPERVISION BY MATURE ADULT (I.E. CANNOT BE LEFT WITH TEENAGE BABYSITTER)	
4. PHYSICAL DEVELOPMENTAL DELAY, MOTOR DEFICITY		4. CONTINUOUS OR REQUIRED SUPERVISION BY SKILLED ADULT (EG. TRAINED NURSE)	
5. REQUIRES BRACES, WHEELCHAIR, ORTHOPEDIC APPLIANCES - DEPENDENT ON A MECHANICAL SUPPORT TO MOVE AROUND		<b>D. SOCIALIZATION OR EMOTIONAL CARE</b>	
6. HAS FEEDING PROBLEMS: MUST BE FED OR NEEDS HELP, COAXING, NEEDS BURPING, FREQUENT FEEDINGS, ETC.		BECAUSE OF THIS CHILD'S MEDICAL/DEVELOPMENTAL DISABILITY (NOT AGE) HE/SHE REQUIRES:	
7. HAS APPLIANCE FOR DRAINAGE OR FEEDING; I.E., CATHETER, COLOSTOMY, LEVINE TUBE		1. NEEDS EMOTIONAL SUPPORT, ENCOURAGEMENT AND REASSURANCE DUE TO WITHDRAWAL, FEARFULNESS, DEPRESSION, DEPENDENCY, FEELINGS OF INFERIORITY, ETC.	
8. HAS CONSTIPATION, DIARRHEA, ETC. (SUCH THAT EXTRA CARE IS NEEDED ON A DAILY BASIS)		2. STRUCTURED BEHAVIOR MANAGEMENT REGIMEN	
<b>B. TREATMENT OR THERAPEUTIC INTERVENTION</b>		3. SOCIALIZATION STIMULATION I.E., TOUCH RESPONSE	
BECAUSE OF THIS CHILD'S DISABILITY (NOT AGE) HE/SHE REQUIRES:		4. FOSTER PARENTS TO SPEND TIME WITH NEIGHBORS, COMMUNITY FIGURES, SCHOOL AUTHORITIES IN WORKING OUT PLANS TO ADDRESS THE CHILD'S DISABILITY	
1. ORAL MEDICATIONS ON A REGULAR AND ONGOING BASIS		5. CALMING MEASURES ON A DAILY BASIS	
2. INJECTIBLE MEDICATIONS		6. RESTRUCTURING OF BONDING WITH BIOLOGICAL PARENTS OR ATTACHMENT TO A PERMANENT PLACEMENT	
3. SKIN IRRITATION TREATMENT, DRESSING		<b>E. BIOLOGICAL OR POTENTIAL ADOPTIVE PARENT</b>	
4. SPECIAL OR MODIFIED DIET		BECAUSE OF THIS CHILD'S DISABILITY (NOT AGE) THE PARENT NEEDS:	
5. MIST OR CROUP TENT, OXYGEN FOR RESPIRATORY DISTRESS		1. REGULAR INSTRUCTION BY FOSTER PARENT IN HOW TO ASSIST THE CHILD IN HIS/HER DEVELOPMENT	
6. PRECAUTIONS OR SEIZURE PRECAUTIONS DUE TO ALLERGIES		2. PARENTING SKILLS	
7. SPECIAL OR MODIFIED ENVIRONMENT DUE TO ALLERGIES OR OTHER MEDICAL CONDITIONS		3. EDUCATION IN MEDICAL/THERAPEUTIC SKILLS	
8. HYPERGLYCEMIA (HIGH GLUCOSE) OR HYPOLYCEMIA (LOW GLUCOSE) MONITORING		4. ASSISTANCE WITH BONDING AND/OR REATTACHMENT TO THE CHILD	
9. TRACHEOSTOMY CARE			
10. AT LEAST WEEKLY PHYSICAL OR SPEECH THERAPY DUE TO DISABILITY OR MEDICAL CONDITION			
11. VITAL SIGNS, DAILY WEIGHT, URINE TEST, ETC. ON A DAILY BASIS			
12. APNEA MONITOR			
13. FREQUENT HOSPITALIZATION			
14. FREQUENT VISITS TO DOCTOR OR ALLIED PROFESSIONALS			
<b>SCORING INSTRUCTIONS</b>	TOTAL		TOTAL

TO DETERMINE THE MEDICAL FOSTER CARE ASSESSMENT, COMPLETE THE CALCULATIONS AT RIGHT. SECTIONS A, B, C, & D (CHILD SCORE) SHOULD BE SCORED SEPARATELY FROM SECTION E (PARENT SCORE) WHICH MAY BE CONSIDERED IF PARENT INVOLVEMENT WITH THE FOSTER PARENT IS PART OF THE CASE PLAN.

1. TOTAL OF ALL LEVEL RATINGS FROM ABOVE

2. TOTAL NUMBER OF STATEMENTS CHECKED

3. DIVIDE TOTAL IN #1 BY TOTAL OF #2 = TOTAL SCORE

**IV. COMMENTS**

INDICATE ANY OTHER INFORMATION, NOT ADDRESSED IN THIS FORM OR ACCOMPANYING INFORMATION, WHICH WILL ASSIST THE REVIEWER IN DETERMINING THE ELIGIBILITY OF THE CHILD ON A SEPARATE SHEET(S).

CASE MANAGER SIGNATURE \_\_\_\_\_ MATERIALS ATTACHED  YES  NO