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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **MEDICAL FOSTER CARE ASSESSMENT TOOL** | | | | | | | | | | | |
| **I. IDENTIFYING INFORMATION** | | | | | Foster Youth | | | | Adopted/Guardianship Youth | | | |
| 1. Name of Youth | | | | 2. Date of Birth | | 3. DCN | | | | 4. Date of Completion | | |
| 5. Case Manager | | | | 6. County of Jurisdiction | | | | | | 7. County of Residence | | |
| 8. Resource Provider(s) | | | | | | | | | | 9. DVN | | |
| 10. Resource Provider(s) Address | | | | | | | | | | 11. Resource Provider(s) Phone Number | | |
| 12. Physician/Specialty | | | | | | | | | | 13. Physician’s Phone Number | | |
| 14. Physician’s Address | | | | | | | | | | | | |
| 15. Physician / Specialty | | | | | | | | | | 16. Physician’s Phone Number | | |
| 17. Physician’s Address | | | | | | | | | | | | |
| **II. Any condition checked in Section II A-E qualifies for Elevated Medical Level of Care**  **Attach all documentation relating to the medical/developmental condition.**  **Physician Certification Letter is not required for Section II** | | | | | | | | | | | | |
| 1. The following Genetic and or Medical Conditions: | | | | | | | | | | | | |
| Down Syndrome | | Cri-du-Chat Syndrome | | | | | Klinefelter's Syndrome | | | | |
| Trisomy 18 (Edward's Syndrome) | | Trisomy 13 (Patau's Syndrome) | | | | | Turner's Syndrome | | | | |
| Triple-X Syndrome | | Fragile X Syndrome | | | | | Prader-Willi Syndrome | | | | |
| Pierre Robin Syndrome | | **E**pilepsy/Seizure Disorder | | | | | Spina Bifida | | | | |
| Cystic Fibrosis | | Cerebral Palsy | | | | | Sickle Cell Disease | | | | |
| Cancer | | HIV + status | | | | | PKU (phenylketonuria) | | | | |
| Autism Spectrum Disorders | | Fetal Alcohol Syndrome | | | | | Systemic Lupus Erythamatosus | | | | |
| Visual impairment which includes the following:   1. A medical diagnosis of visual acuity 20/70 or less in the better eye with maximum correction; 2. A very limited field of vision (20 degrees at its widest point); 3. A progressive disease leading to either of the above; 4. A physician’s statement that the prognosis for useful vision is guarded or doubtful; 5. A physician’s statement that the functional loss of visual performance is comparable to the visual function of other children with a diagnosed visual impairment. | | Hearing impairments, as defined in the Medicaid eligibility, 102.08  Hearing impairments:   1. For children below 5 years of age, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or 2. For children 5 years of age and above: 3. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or 4. Speech discrimination scores at 40 percent or less in the better ear; or 5. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment. | | | | | Cyanotic Congenital Heart Disease | | | | |
| Hypoxic-Ischemic Encephalopathy (HIE) and at term (36 weeks gestation or more) | | | | |
| Diabetes Mellitus Type I, or Type II requiring daily glucose monitoring. | | | | |
| Congenital viruses/bacteria Herpes, syphilis, cytomegalovirus, toxoplasmosis, and rubella) | | | | |
| Short Gut Syndrome with Dependence on Parenteral Nutrition | | | | |
| Cranio-facial anomalies (i.e., cleft palate, etc.) | | | | |
| Hydrocephalus with Ventriculo-Peritoneal Shunt | | | | |
| 1. Qualifies for and receives First Steps of Missouri early intervention program services due to developmental delays in at least one area listed below. Check applicable condition(s). | | | | | | | | | | | | |
| Cognitive Development | | | Communication Development | | | | | Adaptive Development | | | | |
| Physical Development, including vision and hearing | | | | | | | | Social or Emotional Development | | | | |
| 1. Has immobility i.e. traction, cast, bed rest, paralysis. | | | | | | | | | | | | |
| 1. Requires wheelchair and is dependent on a mechanical support to move around. | | | | | | | | | | | | |
| 1. Has appliance for breathing, feeding or drainage i.e. catheter, colostomy, gastrostomy tube, or tracheostomy. | | | | | | | | | | | | |
| **III. Physician Certification letter, CD-144** | | | | | | | | | | | | |
| **Yes, I recommend my patient receive a medical level of care which provides elevated supervision and care to meet his/her medical needs because: (Please list specifically the diagnosis/condition requiring elevated supervision and care. Attach the CD-144 and use additional paper if necessary)**  **This is a life-long condition with no possibility of improvement:  yes  No**  **No, the medical needs of my patient do not necessitate a level of medical care to provide elevated supervision and care. I have reviewed the criteria on this form and the expectations for elevated level of medical care located on the cover letter and I conclude that my patient does not require elevated supervision and care. (Please comment. Use additional paper if necessary)** | | | | | | | | | | | | |
| **IV. SIGNATURES** | | | | | | | | | | | | |
| Case Manager | | | | | | | | | | | Date | |
| Referring Physician | | | | | | | | | | | Date | |
| Supervisor Approval | | | | | | | | | | | Date | |