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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN’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:
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| **[ ]** 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).
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| **[ ]** 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.
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| 1. **[ ]** Requires wheelchair and is dependent on a mechanical support to move around.
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| 1. **[ ]** Has appliance for breathing, feeding or drainage i.e. catheter, colostomy, gastrostomy tube, or tracheostomy.
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| **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 |