YELLOW JACKET CHECKLIST

Child's Name:_____ **DOB:**_____ **SSN:**_____

Document	In File	Needed	N/A	Comments
Temporary Custody Letter				
Copy of Birth Certificate / SS#				
Shelter Order (Court Documents)				
Medication(s) / Allergies				
Shot Record				
Physical				
Medicaid Card / Number				
School Information				
Picture of Child				
Child Information / History				
Inventory of Child's Belongings				
Special Diets				
Case Plan				
Medical Information: Medical Referral Form Residential Health Form Child Medical Diagram (3 pages)				
Judicial Review				

Investigator/Case Manager:_____ Unit:_____ Date:_____

Phone (Office and Cell):_____

Foster Parent:_____ Date Received:_____

Counselor:_____

CHILD INFORMATION FACE SHEET

Please complete the information below including the attached health checklist:

CAREGIVER'S NAME:_____ PHONE:_____

_____ _____

_____ _____

COUNSELOR'S NAME:_____ PHONE:_____

_____ _____

CHILD'S NAME:_____ DOB:_____

SCHOOL/DAYCARE ATTENDED:_____

ANY SIBLINGS AND THEIR AGES:_____

_____

_____

_____

_____

_____

WHY CHILD WAS REMOVED FROM THE HOME:_____

_____

_____

_____

_____

PAST HISTORY: Include known accidents, illnesses, hospitalizations, immunizations, and medications. Also, attach any available medical records such as emergency room evaluations.

_____

_____

_____

_____

_____

CURRENT MEDICATIONS: Please list all prescribed medications. Also include any over-the-counter medicines/supplements being taken such as aspirin, Tylenol, cough medicine, and vitamins. Please list by brand name if known. Does child wear glasses or require special equipment?

_____

_____

_____

_____

_____

_____

_____

Counselor's Signature

EMERGENCY INTAKE

Date and Time: _____ County: _____

Child's Name: _____ Date of Birth: _____

Child's Physician Contact Information:

Physician's Name	Physician's Phone Number
Physician's Address	

Are siblings also in foster care? ☐ Yes ☐ No

If yes, siblings' names and ages: _____

Parents'/Caregivers' Names: _____

Reasons for Removal:

☐ Suspected Physical Abuse ☐ Suspected Neglect ☐ Father Incarcerated ☐ Mother Incarcerated

☐ Suspected Sexual Abuse ☐ Other (specify): _____

Any known allergies: ☐ Yes ☐ No

If yes, list allergies: _____

Any known physical or emotional problems: ☐ Yes ☐ No If yes, list problems:

Any special dietary needs/formulas: ☐ Yes ☐ No If yes, list needs:

I (print name of parent or legal guardian), _____, certify that my child (print child's full name), _____, is currently prescribed and taking the listed medications and by my signature I am giving authorization to the Department of Children and Families to continue to provide the listed medications and continue any listed behavioral health services.

Signature of Parent:_____ **Date:**_____

Medications	Reason for taking medication	Dosage	Length of Time on Medication	Giving to Shelter/ Foster Parent
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Medical Equipment/Information Accompanying Child: ☐ Eyeglasses ☐ Medication ☐ Medical Equipment

☐ Immunization Records ☐ Newborn Discharge Summary

Where is the child being taken: ☐ Temporary shelter ☐ Relative of family ☐ Temporary foster home

☐ Friend of family ☐ Other (specify): _____

Contact Name: _____ Phone Number: _____

Address: _____

Notes:

Name/Title of
person completing form: _____ Phone #: _____

Rick Scott
Governor

David E. Wilkins
Secretary

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Dear Shelter Home Parent:

As a shelter home parent entrusted with the care of children referred by the Department of Children and Families, we wish to advise you that we are now responsible for the care of these children. We need your assistance in this. As such, it is important that you become familiar with the following information.

Any child that is brought to you is immediately eligible for Medicaid coverage. You will find in this folder a letter of assurance for your use if you use a private doctor. This will assure the provider that Medicaid will be responsible for eligible Medicaid costs incurred by Medicaid provider. Within a few days you will receive a temporary Medicaid card.

After a child is placed with you, a Child Protective Investigator or Case Manager may contact you by telephone to make an appointment to bring the child to a clinic serving your area. The Department of Children and Families will make a priority appointment within 72 hours for an initial health assessment (shelter physical). Please complete the enclosed Health Checklist before the child goes to the clinic. This is important in helping to ensure the best medical care for the child.

Should a child become ill before the scheduled appointment, call your Case Manager or Child Protective Investigator for instructions. After hours or weekends call the telephone number listed in the Child Resume Record.

When you or the Child Protective Investigator or Case Manager brings a baby or small child to the clinic, be sure to bring the items listed on the sheet contained in this folder.

We are happy to offer our services to the children in our care. Do not hesitate to contact your Case Manager or Child Protective Investigator should you have any questions.

Thank you for your cooperation.

Rick Scott
Governor

David E. Wilkins
Secretary

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Date:_____

Child's Name:_____

DOB:_____

SS#:_____

To Whom It May Concern:

This correspondence is in reference to the temporary placement of the above named child. The child was taken into custody on _____. The child has been placed in the temporary custody of the Department of Children and Families Foster Care System.

The child is currently residing with _____. The official court document has not been provided to the foster parents at this time. Please accept this correspondence as a temporary document to allow _____ to receive WIC, public assistance, and/or Medicaid and medical treatment for the above named child.

If you have any questions, please contact _____, the undersigned counselor at _____ or _____.

Thank you in advance for your attention in this matter.

Sincerely,

_____
Child Protective Investigator
Circuit 10: Polk, Highlands, and Hardee Counties

Lakeland Office: 863-413-3564
Bartow Office: 863-519-8262
Lake Wales Office: 863-589-0424
Sebring Office: 863-402-7716

ITEMS TO BE BROUGHT TO THE CLINIC OR PRIVATE MEDICAID PROVIDER AS APPROPRIATE FOR CHILD:

1. Diapers
2. Bottles / Formula
3. Food / Snack
4. Blanket or Sweater
5. Medical Information including immunizations if available
6. Referral form for shelter children
7. BRING ALL MEDICATIONS

Rick Scott
Governor

David E. Wilkins
Secretary

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Date:_____

Dear Health Care Provider:

The Department of Children and Families is committed to providing children in the care and control of the Department with all necessary health care. Part of this commitment includes our assurance to health care providers that these services will be reimbursed either directly by the Department or agencies contracted or through Medicaid if the child is determined to be eligible.

An authorized representative of the Department whose responsibility is to secure medical care for the child identified below has given you this letter. You will be contacted by the Case Manager or Economic Self-Sufficiency worker regarding the Medicaid Identification number for the child so you will be notified of an alternative method to receive reimbursement for your services. If after seven days you have not received this information, please contact either of the individuals below at the phone numbers indicated.

Thank you for caring for our children.

Patient Name:_____

Date of Birth:_____

Case Manager:_____

Phone Number:_____

ESS Worker:_____

Phone Number:_____

DEPARTMENT OF CHILDREN AND FAMILIES – CIRCUIT 10
SHELTER PARENT MEDICAL REFERRAL FORM FOR SHELTER CHILDREN

When a child is placed in shelter care it is not always possible for the shelter parent to accompany the child for medical care.

Please fill out the information below including the attached health checklist to help the medical team provide good medical care for the child. Do not forget to have the items listed to the clinic with the child.

Shelter / Foster Parent's Name:_____ Phone:_____

Worker's Name:_____ Phone:_____

Child's Name:_____ DOB:_____

Past History: (Significant accidents, illnesses, hospitalizations, immunizations, medications, and usual source of health care. Also attach any available medical records such as emergency evaluations.)

Reasons for Referral to Doctor of Clinic: (If child is ill, give as much information as possible including presence of fever, feeding problems-including name of formula, vomiting, diarrhea, etc. List any of symptoms, e.g. upper respiratory (ear, nose, throat), rashes, etc.

Current medications including aspirin, Tylenol, vitamins, cough medications, etc.

_____

Worker / Shelter Parent's Signature

Results of Medical Consultation:

Diagnosis:_____ Date:_____

Recommendations:_____

_____

Return Appointment Date:_____ Time:_____

Name of Doctor (Please Print):_____ Phone:_____

Signature:_____

MEDICAID / HMO INFORMATION

Child's Name:_____ **DOB:**_____.

Social Security Number:_____.

MEDICAID NUMBER	HMO
_____.	Name:_____. Address:_____. _____. Phone:_____.

THIRD PARTY INFORMATION

Name of Insurer:_____. **Policy Number:**_____.

Use the Third Party Insurance First if the child has 3rd party coverage.

MEDICAID *will not pay* until after the 3rd party coverage pays.

***ALL HMO's are assigned by the Zip Code of the Shelter or Foster Home address.

***You *must* contact the DCF Investigator or Case Manager regarding changes or problems.

Rick Scott
Governor

David E. Wilkins
Secretary

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

HEALTH CHECKLIST FORM

Name:_____ Placement:_____
Age:_____ Date of Placement:_____
Date of Release:_____

Health / Medical

1. General Health Conditions: (Identify existing medical / health conditions)

_____
_____
_____
_____

2. Medication: YES_____ NO_____
Name of medication / Dosage:_____
_____
_____

3. Allergies: If so, name_____

4. Follow-up Doctor's appointment, Date and Time:_____

5. Special diet or formula:_____
_____

6. Recent exposure to communicable diseases (please check):

Measles_____	Staph_____	Hepatitis_____
Mumps_____	Lice_____	Encephalitis_____
Chicken Pox_____	TB_____	VD_____
Meningitis_____	Other_____	

Emotional / Behavioral

1. Appears retarded_____ Mild_____ Severe_____

2. Emotional Problems_____ Describe (i.e., physically aggressive, depression, suicidal)

_____
_____

3. Behavioral Problems_____ Describe (i.e., wanders, defiant, steals, abnormal, sexual behavior)

_____
_____