|  |  |
| --- | --- |
|  | **County of Los Angeles****Department of Children and Family Services****425 Shatto Place, Los Angeles, CA 90020****(213) 351-5602** |
| PHILIP L. BROWNING Director |

|  |
| --- |
| Date:       |
|  | Please address reply to: |
|       |  |       |
|

MEDICAL CARE ASSESSMENT COVER LETTER

|  |  |
| --- | --- |
| **RE: Child’s Name:** |       |
|  **State Number:** |       |
|  **Date of Birth** |       |
|  **Caregiver:** |       |

|  |  |  |
| --- | --- | --- |
| Dear Dr. |       | , |

We understand that you recently examined the above named child who is in foster placement with the Los Angeles County Department of Children and Family Services.

Before we can authorize a specialized foster care rate of reimbursement to the care required because of the child’s diagnosed condition(s), it is necessary for us to obtain additional information.

Please complete either the attached “Medical Care Assessment” form or send a copy of your medical records or a dictated report that contains the requested information. Please send this information to the child’s social worker (CSW) named on the attached form. Your prompt attention to this matter will enable us to quickly and responsibly compensate the caregiver for their much needed services.

|  |  |
| --- | --- |
| If you require additional information, please call me at: |       |
|  |
| My return fax number is: |       | . |

 Very truly yours,

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|       |

 Children’s Social Worker

**MEDICAL CARE ASSESSMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **TO:** |   | File # |   |
|  |  |  |  |  |
|  |   |  |  |  |
|  |  |  |  |
| **RE:** |   |  |   |
|  | (Child’s Name) |  | Social Worker’s Phone |
|  |  |  |  |
| Medical Record # |       |  |   |
|  |  |  | Social Worker’s Fax # |
|  |  |  |  |
| Birth Date: |   |  |  |
| I examined the above mentioned child on |  | . The following information summarizes |
| the child’s diagnosis, treatment required, and special care activities I have prescribed for the child. |
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| **CHILD’S DIAGNOSIS:** |  | **DATE OF DX:** |  |
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|  |  |  |  |
| **CHILD’S PROGNOSIS:** |  |
|  |
| **MEDICATION/TREATMENT REQUIRED** |  | **FREQUENCY** |  | **EXPECTED DURATION** |
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| **How often is medical follow up needed?** |  |
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| **Please list all specific activities Foster Parent must perform to implement your care plan:** |
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|  |  |  |  |
| **Physician’s Signature** |  | **Physician Name (Please Print)** |  |
|  |  |  |
| Specialty: |  | Address: |  |  |
|  |  |  |  |  |
| Date Signed: |  |  |  |  |
|  |  |  |  |  |
|  |  | Phone #: |  |  |
|  |  |  |  |  |
|  |  | Fax #: |  |  |