PLACEMENT CHECKLIST
FOR FOSTER CAREGIVERS

1. **Placement Referral Form (SS61rb):**

   Caregivers receive this completed form at the time of placement so that they know as much about the child as the agency does at that time. You will be asked to sign this form acknowledging that you received the information.

2. **Placement Packet (ICCA) Section (CM51):**

   This form is completed and given to caregivers within one week of placement. It is also important when there are changes or the child moves to a new placement. If there are two caregivers in your home, both of you will need to sign this form acknowledging that you received the information.

3. **Clothing and Special Needs of Foster Children:**

   A. For the **first time** a child is placed in foster care you are permitted to spend up to $150.00 for clothing. Caregivers may charge the clothing and turn **original (clothing only)** receipts in to Adam Wilson, the Fiscal Supervisor. Monthly thereafter, you may purchase $50.00 of clothing as needed for ages 0-6, $62.50 for ages 7-12, and $71.00 for ages 13-18.

   When purchasing clothing, please separate so that there is only one child's clothing per receipt and turn in original receipts using Foster Child Clothing and Graduation Expenses Reimbursement Form (BO66) to Adam Wilson, TCJFS Business Office. Please paperclip receipts to the form, do not staple or tape.

   B. In addition, foster caregivers may purchase the following personal incidentals up to the annual limits listed:

   i. Over the counter medications (e.g. vitamins, cough medication, Tylenol) as recommended by a physician, $100.00/year.
   ii. Infant and Toddler supplies (e.g. diapers, wipes) up to $250.00/year.
   iii. Fees related to activities (e.g. boy/girl scouts, sports) up to $100.00/year.
   iv. Special lessons (e.g. horseback riding, piano or other instrument) up to $250.00/year.
   v. Graduation Expenses up to $1500.00.

4. **Health Care (CM07rb):**

   Caregivers should take children for the following after the first day of placement:

A. 5 day Screening-Medical Record Form for Children in Substitute Care (all ages) **(CM05rb) This is due within 5 days of placement.**
B. 30 day Health Check Annual Exam Checklist (all ages) **(CM60rb) This is due within 30 days of placement and also annually.**
C. 90 day Dental Record Form for Children in Substitute Care (ages 2 and up). **(CM60Arb) This is due within 90 days and then every 6 months thereafter.**
D. Vision Record Form for Children in Substitute Care **(CM60Brb). This is due yearly.**
E. 30 day Mental Health Screening for children age 3 and above (see **CM07rb**); if under age three a referral to Help Me Grow will be made.

The above forms should be given to you in your "red book" placement packet, and are also available on the TCJFS website: www.tcjfs.org. On the Home Page go to Adoption and Foster Care, scroll down to Forms, and then across to Forms-Foster Care Children. Complete by the date given and return to the agency.

F. Medical Record Form (not Annual Exams) for Children in Substitute Care **(CM 60Drb)** This form is also available on the TCJFS website and should be used for any medical appointment other than the Annual Exam.
G. Emergency Treatment Record Form for Children in Substitute Care **(CM60Crb). This form should be used for any emergency treatment of a foster child.**

5. **Monthly Reports:** You are expected to submit these reports by the 5th day of the month following the month of service.

A. Caregivers Monthly Report (SS68), one for each child
B. Board Statement (SS73-This how you will get paid)
C. Transportation Billing (BO11)
D. Foster Child Clothing and Graduation Expenses Reimbursement Form (BO66)

These forms are available on the TCJFS website: www.tcjfs.org. On the Home Page go to Adoption and Foster Care, scroll down to Forms, and then across to Forms-Foster Parents, or Forms-Foster Care Children.

Please complete for each child and return to the agency.

You are able to fill out and email the forms directly to the agency using this email address fosterparents@tcjfs.org.

E. Call placement Unit with any questions regarding A, B, C, & D.

6. **Day Care: (When both parents work)**

Because of liability issues, a foster parent needing child care must use a licensed day care

provider or another foster parent. Please contact Adam Wilson, Fiscal Supervisor, at 330-556-6725.

7. **Emergency Child Care:**

Another short-term option is that each foster family can have a relative or friend approved by our agency as an Emergency Foster Child Caregiver, by having the friend or relative complete paperwork requirements which include police and fingerprint checks. Ask your foster worker for more details on this option.

8. **Transportation:**

TCJFS expects caregivers to transport foster children to medical or dental appointments, counseling, psychological testing and parental visitations. (Mileage is recorded on Transportation Billing (**BO11**) and is submitted to the agency by the 5th day of the month following the month of service).

9. **Travel out of County or State (for more than 12 hours):**

SS131 Travel Authorization and Emergency Medical Treatment Form/Children in Custody (on agency letterhead) must be completed and signed by the agency director prior to a foster child's traveling outside the caregiver's county of residence. This letter can be used for identification and informational purposes.

10. **Travel Expense Report (TCJFS06a):**

This form is used to request reimbursement of **PRIOR** approved training costs, travel for training and hospital related expenses in accordance with the **Foster Caregiver Reimbursement Policy (Agency Policy 600.9.0).**

11. **Injury:**

Any fall or injury to a foster child **must immediately** be reported to the agency. If the incident occurs in the evening or on the weekend, call the Tuscarawas County Sheriff's Department at **330-339-2000** to reach the on-call worker.

12. **Lifebooks:**

You should be given a Lifebook for each child placed in your home. This is very important for each child to help them understand their family history and placement history. You will be asked to add information to the Lifebook If you have questions on how to use it please ask your case worker or foster care worker.

13. **Agency After Hours:**

To get in touch with the agency after hours regarding need for emergency medical treatment or any other emergency, please call the Tuscarawas County Sheriff Department at **330-339-2000**, and ask for the on-call worker for the Tuscarawas County Job and Family Services.

14. **Training Hours:**

A foster parent needs **20 hours** of training **per each year**. (This is to go from the date your license starts and must be completed by the year-end according to your license).

15. **Reminder:**

Caregivers are not allowed to get haircuts for foster children without birth parents' permission. Prior to getting a child's hair cut, please discuss with child's caseworker.

Updated 04/22/2019

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
PLACEMENT REFERRAL FORM

The following information is being provided to the foster care worker and foster caregiver(s) to facilitate the best placement for the child and to provide all known information about the child **on day of placement only**.

CHILD'S NAME:	GENDER: ☐ M ☐ F	HEIGHT:	WEIGHT:	DOB:	TODAY'S DATE:
SCHOOL DISTRICT:	CHILD'S RACE:	IQ:		WORKER PROVIDING INFORMATION:	
SCHOOL GRADE:	IEP: ☐ Yes ☐ No	COMMENTS:			
CHILD'S CURRENT LIVING ARRANGEMENT:					
REASON FOR PLACEMENT: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Dependency ☐ Unruly/Delinquency ☐ Neglect					
CURRENTLY IN COUNSELING: ☐ Yes ☐ No	NAME OF COUNSELOR: ☐ Unknown				
IF INFANT, TYPE OF FORMULA:				DIAPER SIZE:	

A. Trauma/Loss Exposure History

TRAUMA TYPE (DEFINITIONS ATTACHED)	AGES (CHECK EACH BOX AS APPROPRIATE)									SUMMARY
1. Sexual Abuse or Assault/Rape	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2. Physical Abuse or Assault	☐	☐	☐	☐	☐	☐	☐	☐	☐	
3. Emotional Abuse/Psychological Maltreatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	
4. Neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	
5. Serious Accident or Illness/medical Procedure	☐	☐	☐	☐	☐	☐	☐	☐	☐	
6. Witness to Domestic Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	
7. Victim/Witness to Community Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	
8. Victim/Witness to School Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	
9. Natural or Manmade Disasters	☐	☐	☐	☐	☐	☐	☐	☐	☐	
10. Forced Displacement (DH, DYS, Refugee)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
11. War/Terrorism/Political Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	
12. Victim/Witness to Extreme Personal/Interpersonal Violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	

A. Trauma/Loss Exposure History

TRAUMA TYPE (DEFINITIONS ATTACHED)	AGES (CHECK EACH BOX AS APPROPRIATE)									SUMMARY
Suicide, Homicide	☐	☐	☐	☐	☐	☐	☐	☐	☐	
13. Traumatic Grief/Separation (does not include placement in foster care)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
14. Systems-Induced Trauma (secondary) – placed in foster care, court testimony, kinship placements, separation of siblings	☐	☐	☐	☐	☐	☐	☐	☐	☐	

CHARACTERISTICS SUBCATEGORIES										
1. BEHAVIORS:										
a. Lying	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Stealing	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Runaway	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. ☐ Soiling ☐ Bedwetting	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
e. Defiant/Aggressive	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Cruelty to Other Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Cruelty to Animals	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. Unruly/Delinquent Specify Charge:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
i. Fire-setter	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Temper Tantrums	☐	☐	☐	☐	☐	☐	☐	☐	☐	
2. SCHOOL ISSUES:										
a. Truant From School	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Poor Academically	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Developmentally Delayed	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Learning Disabled/Special Education Classes	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Mild Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐	
3. PHYSICAL ISSUES:										

CHARACTERISTICS SUBCATEGORIES										
a. Lice	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Scabies	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Physically Handicapped	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Seizure Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
e. Hearing Impairment	☐	☐	☐	☐	☐	☐	☐	☐	☐	
f. Birth Defect Specify:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
g. Allergies (food, medication, soap)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
h. ☐ Emotional Problems ☐ Mental Illness Diagnosis:	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
i. Attachment Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
j. Attention Deficit Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	
k. Fetal Alcohol Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	
4. SEXUAL ISSUES:										
a. Sexually Acting Out (self-masturbation)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Sexually Acting Out With Others	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Sexually Active Teenager	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. STD (sexually transmitted disease) Specify:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

B. Behaviors Requiring Immediate Stabilization					
	Yes	Historical	No	N/K	Provide Summary, if applicable
1. Suicidal Intent	☐	☐	☐	☐	
a. Intent to Harm Self	☐	☐	☐	☐	
b. Intent to Harm Others	☐	☐	☐	☐	
2. Active Substance Abuse	☐	☐	☐	☐	
a. Alcohol Use/Abuse	☐	☐	☐	☐	
b. Drug Use/Abuse	☐	☐	☐	☐	
c. Cigarette/Cigar Smoking	☐	☐	☐	☐	
3. Eating Disorder	☐	☐	☐	☐	
4. Serious Sleep Disturbance	☐	☐	☐	☐	

Please provide additional details regarding any of the above which would be critical to the child's care and placement:

Positive Attributes of Child:

List any medications/dosages child is currently taking:

Do the child's parents indicate any restrictions on the child participating in religious activities: ☐ YES ☐ NO

If so, what are the restrictions:

I understand that this form only provides the information known about the child on the day of placement. I understand that the information is to be kept confidential and is only to be shared for the care and protection of the child. I was given a copy of this form the date of signing.

Foster Caregiver _____ Date _____

Agency Worker _____ Date _____

☐ Copy to Foster Care Worker ☐ Copy to Foster Caregiver ☐ Signed Original for Child's Record

INSTRUCTIONS:

- Placing worker completes prior to placement; makes two copies
- One copy to foster care worker when request for placement is made.
- One copy to foster caregiver at time of placement.
- Original signed and dated at time of placement and filed in child's case record.

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
PLACEMENT PACKET – Individual Child Care Agreement Section A

TITLE IV-E AGENCY Tuscarawas County Department of Job & Family Services	
AGENCY ADDRESS **389 16th Street, SW** **New Philadelphia, Ohio 44663**	AGENCY PHONE NUMBERS **330-339-7791 or 1-800-431-2347** **Emergency: 330-339-2000 (after hours)** **Fax: 330-339-6388**

I. INDIVIDUAL CHILD CARE AGREEMENT (ICCA)

The ICCA must be completed and signed by all parties with a copy provided to the substitute caregiver(s) prior to placement. For documented emergency placements, a copy must be provided to the substitute caregiver(s) within 7 days.

By execution of this agreement on this day of , 20 , agree(s) to provide substitute care services for **Tuscarawas County Job & Family Services**, on behalf of , born on , for whom the agency has custody or is facilitating a placement in substitute care.

The agency representative placing the child is: _____

The worker responsible for the child is: _____

The worker can be reached at: _____

The child's medical billing number is: _____
☐ Copy of printout is located in the placement folder.

This foster child ☐ MAY OR ☐ MAY NOT be left unattended per OAC 5101:2-7-08.
He/She (if permitted) may be unattended for the following time period: _____
(e.g., from 3-4 p.m. after school)

***NOTE**: "Substitute caregiver" refers to any of the following, as appropriate to the substitute care setting referenced in this specific ICCA: relative or kinship caregiver, agency foster parent, network foster parent/agency, group home caregiver, residential facility caregiver, or psychiatric hospital caregiver.
"Substitute care setting" refers to any of the following, as appropriate to the placement setting referenced in this specific ICCA: relative/kinship home, agency foster home, network foster home, group home, residential facility, or psychiatric hospital.

** By signing this ICCA, the substitute caregiver expressly understands and agrees that no contractual or other legally enforceable relationship has been established.

A. **Provider's Information**

PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBERS	PROVIDER'S ADDRESS
PROVIDER'S FAX NUMBER		
PROVIDER'S EMERGENCY NUMBER	NETWORK REPRESENTATIVE	

B. **Estimated Length of Stay (please check one)**

☐ Up to 3 months ☐ 3 to 6 months ☐ 6 to 12 months
☐ 12 to 18 months ☐ 18 to 24 months ☐ over 24 months

C. **Goal of Plan (please check one)**

☐ Reunification ☐ Independent Living ☐ Adoption
☐ Planned Permanent Living Arrangement (excluding adoption)

D. **Family Visits**

1. Persons who will visit the child: (check all that apply):

☐ Father ☐ Mother ☐ Sister
☐ Brother ☐ Grandparents ☐ Other: _____

2. How often shall child visit (please check **one**):

☐ Once a week ☐ Bi-weekly ☐ Monthly
☐ Other: _____

3. Location of visit:

4. Clarification as to family and other visits:
   Child will be allowed to stay overnight with foster caregiver's approval. Refer to Agency Policy 500.24.0.

E. **Non-Emergency Medical**: The provider is responsible for child receiving routine medical care, including transportation to medical, dental, and optical care, and administering prescription medicine to child. Refer to Agency Policy 500.4.0.

F. **Emergency**: The provider will transport child to child's physician, or, if unavailable, to the hospital emergency room and notify the agency as soon as possible. Refer to Agency Policy 500.4.0. At the time of treatment, please present child's medical (Medicaid) card. If there is no medical card, please have the practitioner bill: Tuscarawas County Job & Family Services, 389 16th Street, SW, New Philadelphia, Ohio 44663-6401.

G. **Transportation**: The primary source of transportation for children in custody is the child's caregiver and/or network provider. Refer to Agency Policy 100.13.0.

H. **Child Care**:

1. Employment-related child care costs for substitute caregivers licensed by TCJFS may be authorized when a licensed foster home or certified child care provider provides the service in accordance with OAC 5101:2-47-17.

2. Network foster homes should refer to their contract with TCJFS for any questions related to child care costs.
3. Foster caregivers may use qualified emergency child caregivers for absences of 24 hours or more. Refer to Policy 600.4.0.

I. **Discipline**: Provider agrees to provide humane, instructive discipline appropriate to the child's age and functioning level and consistent with agency's policy. Provider shall not use as discipline: verbal abuse, derogatory remarks about the child, his/her family, race, or religion. There shall be no threat or use of physical punishment or the denial of parental visits or communications as punishment. Use of physical restraints shall be done in accordance with agency policy, and each instance shall be promptly reported to the agency by the provider. The use of prone restraints is prohibited. Discipline shall comply with OAC 5101:2-7-09 or OAC 5101:2-9-21.

J. **Reporting Requirements**: The provider assures that all applicable data to enable the agency to report to ODJFS all information required by Section 479 of the Social Security Act (42 USC Section 679 1994 108 stat 4459), CFR Parts 1355, 1356, and 1357 for the Adoption and Foster Care Analysis and Reporting System (AFCARS) will be provided to the agency having custody of the child.

K. **Rights and Responsibilities of the PCSA, the Agency Providing Services to the Child, and the Substitute Caregivers**: Rights and responsibilities of the agency and provider agency (if applicable) are set forth in a contract between parties.

L. **Amendments**: This writing constitutes the entire agreement between the parties with respect to all matters herein. This agreement may be amended only by a written agreement signed by all parties; however, it is agreed by the parties that any amendments to laws or regulations cited herein will result in the correlative modification of this agreement, without the necessity for executing written amendments. The impact of any applicable law, statute, or regulation not cited herein and enacted after the date of execution of the agreement will be incorporated into this agreement by written amendment by both parties and effective as the date of enactment to the law, statute, or regulation. Any other written amendment to this agreement is prospective in nature.

M. **Construction**: This agreement shall be governed, construed, and enforced in accordance with the laws of the State of Ohio. Should any portion of this agreement be found to be unenforceable by operation of statute or by administrative or judicial decision, the operation of the balance of this agreement is not affected thereby; provided, however, the absence of the illegal provision does not render the performance of the remainder of the agreement impossible.

N. **Distribution**: Provider agency agrees to provide a copy of this document to the substitute caregiver.

O. **Child Information**:

History and background information known about the child:

SPECIAL NEEDS OF THE CHILD (medical, dietary, psychological, therapy, tutoring, LD, or other needs requiring assistance from substitute caregiver):

IMMEDIATE HEALTH NEEDS AND CURRENT MEDICATIONS:

PSYCHIATRIC AND/OR PSYCHOLOGICAL DIAGNOSIS AND TREATMENT:

DEVELOPMENT (physical, intellectual, social…):

POSITIVE ATTRIBUTES, CHARACTERISTICS, STRENGTHS, SUCH AS CHILD'S FRIENDLINESS, TALENTS, INTERESTS, AND EDUCATIONAL ACHIEVEMENTS:

HISTORY OF ABUSE/NEGLECT:

ATTACHMENT AND BONDING OF THE CHILD TO PREVIOUS CAREGIVES AND FAMILY MEMBERS:

** Tuscarawas County Department of Job & Family Services (a Title IV-E Agency) believes that parent/child and sibling relationships for children in substitute care have intrinsic value. It is the Agency's policy to require ongoing parental visits when children are placed out-of-home and to encourage sibling visits when siblings are placed in separate substitute care settings. Visits should occur as outlined in this agreement or as communicated to Provider by an authorized representative of the Agency. It is the responsibility of both the assigned social services worker and the substitute caregiver(s) to work together to assure that child, sibling, and parent visits take place.

UNRULY/DELINQUENT ADJUDICATIONS, OFFENSE, DISPOSITION/KNOWN VIOLENT ACTS COMMITTED BY THE CHILD:

☐ A formal request for a written report was sent to Tuscarawas County Juvenile Court on:
_____ (date)

☐ The written report was received by Tuscarawas County Job & Family Services from the Court on:
_____ (date)

☐ The written report was provided to the substitute caregiver on:
_____ (date) Receipt is in the case file.

INFORMATION REGARDING THE CHILD'S NEED FOR PLACEMENT:

☐ Failure of previous placement
☐ Physical abuse
☐ Sexual abuse (familial/non-familial) (circle)
☐ Emotional maltreatment
☐ Move to a more/less restrictive setting (circle)
☐ Delinquent behavior
☐ Neglect
☐ Dependency
☐ Permanent surrender
☐ Parent/Child Conflict
☐ Unruly behavior
☐ Other (specify):

What is the relationship between the perpetrator and the child?

Indicate any placement restrictions (i.e., boys or girls only, no other children, location, etc.):

Is this child of American Indian or Native Alaskan heritage? ☐ Yes ☐ No

If so, what tribe? _____

Worker obtained this information on _____ (dates) from the following family members: _____

Worker completed form letter CM 701 on _____ (dates)

This letter was sent to: ☐ BIA and/or ☐ identified tribal leader per Policy 500.23.0

VISIT DUE DATES

7-Day _____ 4-Week _____

SIGNATURES

PROVIDER (print name)	SIGNATURE	DATE
PROVIDER (print name)	SIGNATURE	DATE
CASE MANAGER (print name)	SIGNATURE	DATE
SUPERVISOR (print name)	SIGNATURE	DATE

PLEASE CHECK THE PARTIES TO WHOM THIS REPORT WAS COPIED AND THE DATE THE COPY WAS PROVIDED:

☐ _____ Case Plan/Family File

☐ _____ Substitute Caregiver

☐ _____ Med/Ed Clerk

☐ _____ School district, orally and in writing no later than 5 days after placement, in which the child is placed if the child is school aged *(for initial placement/placement changes only)*

☐ _____ PCSA, orally and in writing no later than 5 days after placement, of the county in which the substitute caregiver is located *(for initial placement/placement changes only)*

☐ _____ Juvenile Court, orally and in writing no later than 5 days after placement, of the county in which the substitute caregiver is located if the child has been found to be unruly or delinquent *(for initial placement/placement changes only)*

REMINDER TO CASEWORKER: Complete a SACWIS activity log to document that this completed form was provided to the parties above.

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
FOSTER CHILD CLOTHING AND GRADUATION EXPENSES REIMBURSEMENT FORM

PLEASE ATTACH RECEIPTS; ADD ADDITIONAL PAGES IF NECESSARY

NAME OF CHILD:	AGE:	DOB:

CASEWORKER'S NAME

REIMBURSE	
Foster Parent's Name:	
Foster Parent's Address:	

OK TO PAY: _____

ACCOUNT: _____

Return to:	Tuscarawas County Job & Family Services Business Office, 389 16th Street, SW, New Philadelphia, Ohio 44663

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
HEALTH CARE AND EDUCATION MANDATES FOR CHILDREN IN CUSTODY

CHILD'S NAME	FOSTER PARENT
PLACEMENT DATE	CASE MANAGER

PLACEMENT SCREENING EXAM DUE BY: (DUE WITHIN 5 WORKING DAYS OF PLACEMENT) **DATE OF PLACEMENT SCREENING EXAM:**	Child must be checked by a licensed physician, registered nurse, licensed practical nurse, or physician's assistant in order to prevent possible transmission of common childhood communicable diseases and identify any symptoms of illness, injury or maltreatment. If the 60-day HEALTHCHEK EXAM is completed within 5 days, no placement screening is required.
HEALTHCHEK EXAM DUE BY: (DUE WITHIN 60 WORKING DAYS OF PLACEMENT – includes vision and hearing screening) **DATE OF HEALTHCHEK EXAM:**	Only a Healthchek Exam will count for the 60-day exam. **<u>It must be completed by a licensed physician.</u>** Clearly state you need an appointment for a "Healthchek Exam" when you call the provider. *(Healthchek exams for children placed in the Attention Center at time of custody must be completed within 60 days of custody.)*
TUBERCULIN TEST DUE BY: (DUE WITHIN 30 WORKING DAYS OF PLACEMENT) **DATE OF TUBERCULIN EXAM:**	*(Tuberculin tests for children placed in the Attention Center at time of custody must be completed within 60 days of custody.)*
VISION EXAM DUE BY: **DATE OF VISION EXAM:**	The agency shall secure an annual vision exam no later than 30 days after the anniversary date of the child's last vision exam or upon recommendation from the initial physical exam.
DENTAL EXAM DUE BY: (DUE WITHIN 6 MONTHS OF PLACEMENT) **DATE OF DENTAL EXAM:**	Each child over three years of age must be examined by a licensed dentist.

MENTAL HEALTH SCREENING DUE BY: (DUE WITHIN 60 DAYS OF PLACEMENT)
DATE OF MENTAL HEALTH SCREENING:

- Caregiver for child placed in **regular** or **therapeutic** foster care or **group home** care should contact their preferred mental health provider.
- Child placed in **residential treatment** must have a mental health screening completed by that facility within 60 days of placement. This screening must be forwarded to the Agency within 45 days of completion.
- Psychological completed within 60 days prior to placement can be used in place of this screening.
- Child under the age of three should be referred to Help Me Grow in place of this screening.

AS SOON AS THESE EXAMINATIONS ARE SCHEDULED, PLEASE NOTIFY:

SCHOOL ENROLLMENT

EARLY CHILDHOOD EDUCATION PROGRAM (AGE 3-5) HEAD START APPLICATION IS DUE BY: (DUE WITHIN 60 DAYS OF PLACEMENT)
DATE OF HEAD START APPLICATION:

- Application available under Foster Care forms for children on www.tcjfs.org.
- Caregiver should attend all school meetings and home visits as requested by the early childhood education program and notify the caseworker of all scheduled meetings.

GRADES KINDERGARTEN-12TH SCHOOL ENROLLMENT IS DUE BY: (DUE AS SOON AS POSSIBLE AFTER CHILD'S PLACEMENT)
DATE OF SCHOOL ENROLLMENT:

- Caregiver should obtain all enrollment paperwork needed by their local school district and work with the district and caseworker to get the enrollment paperwork completed according to the district's guidelines; i.e., caseworker present, director's signature, etc.

cc: Foster Caregiver
Medical Records Clerk

TUSCARAWAS COUNTY JOB & FAMILY SERVICES

NOTICE

5-DAY INITIAL SCREENING

1. This medical screening is required within **5 working days** of child=s removal from his/her home.

2. Please have the attached Medical Record Form completed and signed by a physician or nurse within **5 working days.**

3. Return the completed Medical Record Form to our agency in the envelope provided.

NOTE: If the 60-day Healthchek Examination is completed within the first 5 working days of placement, it may be counted as both the 5-day initial screening and the 60-day Healthchek Examination.

CM 63rb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES

NOTICE

5-DAY INITIAL SCREENING

1. This medical screening is required within **5 working days** of child=s removal from his/her home.

2. Please have the attached Medical Record Form completed and signed by a physician or nurse within **5 working days.**

3. Return the completed Medical Record Form to our agency in the envelope provided.

NOTE: If the 60-day Healthchek Examination is completed within the first 5 working days of placement, it may be counted as both the 5-day initial screening and the 60-day Healthchek Examination.

CM 63rb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
MEDICAL RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE

Child's Name: _____ Date of Birth: _____ Date of Exam: _____

This is to certify that I have examined the above-named child.
This child is free from apparent communicable disease ☐ YES ☐ NO

Please note any special concerns or problems relative to this child:

Name of Medical Practitioner: _____ Telephone Number: _____

Street Address: _____ City, State, & Zip Code: _____

Medical Practitioner's Signature: _____ Date: _____

RETURN TO: Tuscarawas County Job & Family Services OR FAX: 330-308-7790
389 16th Street, SW
New Philadelphia, Ohio 44663-6401

CM 05rb (02/13)

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
MEDICAL RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE

Child's Name: _____ Date of Birth: _____ Date of Exam: _____

This is to certify that I have examined the above-named child.
This child is free from apparent communicable disease ☐ YES ☐ NO

Please note any special concerns or problems relative to this child:

Name of Medical Practitioner: _____ Telephone Number: _____

Street Address: _____ City, State, & Zip Code: _____

Medical Practitioner's Signature: _____ Date: _____

RETURN TO: Tuscarawas County Job & Family Services OR FAX: 330-308-7790
389 16th Street, SW
New Philadelphia, Ohio 44663-6401

CM 05rb (02/13)

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
HEALTHCHEK (EPSDT) EXAM CHECKLIST

NAME _____ DOB _____ DATE _____

1. **HEALTHCHEK (EPSDT) EXAM** Components (A) through (I) must be performed as part of every initial or periodic HEALTHCHEK (EPSDT) examination. Laboratory services (J) must be completed if medically indicated.

A. **Comprehensive Health and Development History**

- ☐ Allergies _____
- ☐ Chief Complaint, Current Complaints/Concerns _____
- ☐ Medical History _____
- ☐ Family History of Illnesses, Diseases, Allergies _____
- ☐ Current Medications & Adverse Effects to Medication _____
- ☐ Notation of sexual activity and contraceptive methods of adolescents _____

B. **Comprehensive Unclothed Physical**

- ☐ HEIGHT _____ PERCENTILE _____ WEIGHT _____ PERCENTILE _____
- ☐ Head circumference (as age appropriate) _____
- ☐ General appearance _____
- ☐ Blood Pressure (as age appropriate) _____
- ☐ Examination of respiratory and cardiovascular system: Respirations: _____ Pulse: _____
  Cardiovascular, Gastrointestinal, Reproductive, Eyes: _____ Ears: _____
  Musculoskeletal, Neurological Nose: _____ Throat: _____
- ☐ Pelvic examination, if medically indicated _____
- ☐ Testicular exam, if medically indicated, & instruction in self-examination _____
- ☐ Breast Inspection & Palpation, and instruction in breast self-examination _____

C. **Developmental Assessment**,

Age Appropriate	Developmentally Delayed	
☐	☐	Gross and fine motor development _____
☐	☐	Communication skills _____
☐	☐	Self-help skills _____
☐	☐	Social-emotional development _____
☐	☐	Cognitive skills _____

D. **Nutritional Assessment**

- ☐ Dietary History _____

E. **Vision Assessment**

- ☐ Internal opthalmoscopy (children ages birth–3 years) and external (gross) observation _____
- ☐ External observation, internal opthalmoscopy, visual acuity testing, and complete ocular muscle balance test (children ages 3-20 years administered at distance and near) _____
- ☐ Stereopsis test _____

F. **Hearing Assessment**

- ☐ Manually-administered individual pure-tone air conduction screenings (age 3 and above), if available _____
- ☐ Observation by gross exam children ages birth – 3 years and 3 years – 20 years (if pure-tone available) _____
- ☐ Other: _____

--over--

G. **Dental Assessment**

- ☐ Growth and Development assessment of dento-facial structure (birth-2) _____
- ☐ Oral inspection for dental caries (birth-2) _____
- ☐ Referral of children with suspected problems to a dentist _____
- ☐ Parent instructed to make dental appointment (recommended for children over 2 years of age, required for those 3 years of age and older) _____

H. **Immunization Assessment**

☐ IPV @ 2 mo	_____	☐ DTaP @ 2 mo	_____	☐ Hep B @ Birth	_____
☐ IPV @ 4 mo	_____	☐ DTaP @ 4 mo	_____	☐ Hep B @ 1-2 mo	_____
☐ IPV @ 6-18 mo	_____	☐ DTaP @ 6 mo	_____	☐ Hep B @ 6-18 mo	_____
☐ IPV @ 4-6 yr	_____	☐ DTaP @ 15-18 mo	_____	☐ PCV 13 @ 2 mo	_____
☐ MMR @ 12-15 mo	_____	☐ DTaP @ 4-6 yr	_____	☐ PCV 13 @ 4 mo	_____
☐ MMR @ 4-6 yr	_____	☐ Tdap @ 11-12 yr	_____	☐ PCV 13 @ 6 mo	_____
☐ Meningococcal	_____	☐ Varicella @ 12-15 mo	_____	☐ PCV 13 @ 12-15 mo	_____
☐ Rotavirus @ 2 mo	_____	☐ Varicella @ 4-6 yr	_____	☐ HPV2/HPV4 @ 11-12 yr	_____
☐ Rotavirus @ 4 mo	_____	☐ Hep A @ 12-23 mo	_____	☐ Influenza @ 6-23 mo, 2 doses	_____
☐ Rotavirus @ 6 mo	_____			☐ Influenza @ 2-18 yr, annual	_____

Haemophilus Influenza B (HIB) Recommended by the American Academy of Pediatrics (AAP) (11/90)

- ☐ Hib-Conjugate @ 2 mo _____ ☐ Hib-conjugate @ 4 mo _____
- ☐ Hib-Conjugate @ 6 mo _____ ☐ Hib-Conjugate @ 12-15 mo _____

I. **Health Education**

- ☐ Patient education such as child's development, accident and disease prevention, and benefits of healthy lifestyles, breast exam, immunizations, weight management, smoking cessation, alcohol/drug dependency _____
- ☐ Discuss results of HEALTHCHEK exam _____
- ☐ Counsel about baby bottle tooth decay, if applicable, and fluoride treatment _____

J. **Laboratory Services**

1. Lead toxicity screening must be done at any age, if indicated, and required annually between the first birthday and the day before the fourth birthday:
   ☐ 1 year ☐ 2 years ☐ 3 years ☐ Other
   Every child receiving an initial HEALTHCHEK (EPSDT) exam between the fourth birthday and the day before the sixth birthday must be tested.
2. Hemoglobin and/or Hematocrit: Recommended on all low birth weight babies during first six (6) months of life, children one (1) year of age and once during adolescence:
   ☐ Hgb ☐ HCT
3. Sickle cell test and other hemoglobinopathies:
   ☐ Was child born in Ohio (after March 1, 1990)?
   If no, please test and/or list results _____
4. ☐ Pap Smears for age-appropriate females Results: _____
   ☐ Tests for sexually-transmitted diseases if medically indicated for age-appropriate females/males Results: _____
5. Tuberculin test:
   ☐ Tuberculin Test Results: _____
6. ☐ Other: _____

K. **Follow-up or Referable Condition**

Diagnosis: _____

Referred to: _____ Date of Appointment: _____

PHYSICIAN'S SIGNATURE:
PLEASE PRINT NAME, ADDRESS, PHONE NUMBER:

RETURN TO TCJFS
389 – 16th Street, SW
New Philadelphia, Ohio 44663
or FAX TO:
330-308-7790

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
DENTAL RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE

PLEASE PRINT

CHILD'S NAME	DATE OF BIRTH
DENTIST	DATE OF EXAM
ADDRESS	

TYPE OF EXAMINATION

- ☐ INITIAL EXAM
- ☐ SIX MONTH CHECKUP
- ☐ OTHER

DENTIST'S PROCEDURES

SIGNIFICANT DENTAL PROBLEMS

- ☐ YES
- ☐ NO

DESCRIPTION OF PROBLEMS

SPECIAL INSTRUCTIONS

DATE OF NEXT EXAM	SIGNATURE OF DENTIST

RETURN TO: TUSCARAWAS COUNTY JOB & FAMILY SERVICES
389 16TH STREET, SW
NEW PHILADELPHIA, OHIO 44663-6401

CM 60Arb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
VISION RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE

PLEASE PRINT

CHILD'S NAME	DATE OF BIRTH
DOCTOR'S NAME	DATE OF EXAM
ADDRESS	

TYPE OF EXAMINATION

☐ INITIAL EXAM
☐ ANNUAL CHECKUP
☐ OTHER: _____

SIGNIFICANT VISION PROBLEMS ☐ YES ☐ NO
Diagnosis:

TYPE OF EXAM RECEIVED BY CHILD

TREATMENT AND RECOMMENDATIONS

DATE OF NEXT EXAMINATION _____

_____ _____
DOCTOR'S SIGNATURE **DATE**

Please Return:	**Mail to:**	**or**	**Fax to:**
	Tuscarawas County Job & Family Services 389 16th Street, SW New Philadelphia, Ohio 44663		330-308-7790

CM 60Brb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
MEDICAL RECORD FORM (not Annual Exams)
FOR CHILDREN IN SUBSTITUTE CARE

PLEASE PRINT

CHILD'S NAME	DATE OF BIRTH
NAME OF PHYSICIAN / MEDICAL PROVIDER	DATE OF EXAM
ADDRESS	

SIGNIFICANT MEDICAL PROBLEMS

☐ YES
☐ NO

DESCRIPTION OF PROBLEMS

OUTCOME OF APPOINTMENT

FOLLOW-UP INSTRUCTIONS (if any)

SIGNATURE OF MEDICAL PROVIDER

RETURN TO: TUSCARAWAS COUNTY JOB & FAMILY SERVICES
389 16TH STREET, SW
NEW PHILADELPHIA, OHIO 44663-6401

CM 60Drb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
EMERGENCY CARE/TREATMENT AND/OR HOSPITALIZATION RECORD FORM FOR CHILDREN IN SUBSTITUTE CARE

PLEASE PRINT

CHILD'S NAME	DATE OF BIRTH
HOSPITAL NAME	DATE(S) OF TREATMENT AND/OR HOSPITALIZATION
HOSPITAL ADDRESS	
ATTENDING PHYSICIAN'S NAME (PLEASE PRINT) AND SIGNATURE	

PRESENTING CONCERNS AND DIAGNOSIS
TREATMENT PROVIDED
MEDICATION PRESCRIBED
DISCHARGE INSTRUCTIONS

Please Return:	**Mail to:**	**or**	**Fax to:**
	Tuscarawas County Job & Family Services 389 16th Street, SW New Philadelphia, Ohio 44663		330-308-7790

Copy to Parent: ☐ YES

Date _____

CM 60Crb

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
CAREGIVER MONTHLY REPORT

Child: _____ **Month/Year:** _____

Caregiver: _____ **Case Manager:** _____

CHILD'S ADJUSTMENT (interaction with caregivers interaction with other family members, friends, peers):

CURRENT MEDICATIONS (include dosage, frequency, and time given, e.g., Abilify, 100 mg. daily, a.m.):

BEHAVIOR:

Positive Behaviors:

Rewards Used:

Negative Behaviors:

Discipline (note if discipline used is effective or ineffective in changing negative behaviors):

SCHOOL PROGRESS (attach grade report each grading period, note progress, school conferences):

VISITATIONS (include dates, child's behavior if visits occur in your home, include times and observations):

COUNSELING (include dates, name of counselor, foster parent consultations):

INTERESTS/HOBBIES (how does child spend leisure time?):

OBSERVATIONS ON CHILD'S FUNCTIONING?

Developmental Status:

Emotional Status:

Mental Ability:

☐ **Child Health Record Attached**

ARE YOU COMFORTABLE WITH THIS PLACEMENT? ☐ Yes ☐ No

Describe:

SPECIAL PROBLEMS, COMMENTS, SUGGESTIONS?

EXCEPTIONS TO TRANSPORTATION POLICY:	
Name of Driver: _____	**Name of Driver:** _____
Date of Event: _____	**Date of Event:** _____
Event: _____	**Event:** _____

OVER-NIGHT STAYS with friends or extended Foster Family members:
Name & Address of Household: _____
Relationship to Child/Foster Family: _____
Date of Over-night Stay: _____
Name & Address of Household: _____
Relationship to Child/Foster Family: _____
Date of Over-night Stay: _____

REVIEWED BY:		
Supervisor:	Foster Care Worker:	Case Manager:

STATEMENT

TO: Tuscarawas County Job & Family Services
389 16th Street, SW
New Philadelphia, Ohio 44663

DATE COMPLETED _____

FOR: FOSTER CARE OF THE FOLLOWING CHILDREN

CHILD'S NAME	FROM	TO	TOTAL DAYS	CHILD'S AGE	FOR AGENCY USE ONLY RATE	TOTAL

APPROVED BY _____

SS 73

FOSTER PARENT SIGNATURE AND ADDRESS

STATEMENT

TO: Tuscarawas County Job & Family Services
389 16th Street, SW
New Philadelphia, Ohio 44663

DATE COMPLETED _____

FOR: FOSTER CARE OF THE FOLLOWING CHILDREN

CHILD'S NAME	FROM	TO	TOTAL DAYS	CHILD'S AGE	FOR AGENCY USE ONLY RATE	TOTAL

APPROVED BY _____

SS 73

FOSTER PARENT SIGNATURE AND ADDRESS

TRANSPORTATION BILLING

Tuscarawas County
Job & Family Services

389 16th Street, SW
New Philadelphia, Ohio 44663
(330) 339-7791 or 1-800-431-2347

CASE NAME
NAME(S) OF FOSTER CHILD(REN)
CASE MANAGER

DATE	DEPARTURE POINT	DESTINATION POINT	CHILD	PURPOSE	MILES

SUB TOTAL FROM THIS PAGE	
SUB TOTAL FROM PAGE 2	
GRAND TOTAL	

I/we hereby certify that I/we have provided these services, in accordance with written agreement with the Tuscarawas County Job & Family Services, for the number of units shown.

1st PROVIDER'S SIGNATURE	2nd PROVIDER'S SIGNATURE
1st PROVIDER'S PRINTED NAME	2nd PROVIDER'S PRINTED NAME
DATE	DATE
PROVIDER'S STREET ADDRESS OR PO BOX	
PROVIDER'S CITY	PROVIDER'S ZIP CODE
HOME PHONE	CELL PHONE
CASE MANAGER'S SIGNATURE	DATE
SUPERVISOR'S APPROVAL	DATE

DATE	DEPARTURE POINT	DESTINATION POINT	CHILD	[illegible]	[illegible]
			(report this amount on page 1)	**SUB TOTAL**	

TUSCARAWAS COUNTY
Job & Family SERVICES
David W. Haverfield, J.D., Director

389 16th Street SW
New Philadelphia, Ohio 44663
Phone: 330-339-7791 or 800-431-2347
Fax: 330-339-6388 TTY/TTD: 1-800-750-0750
www.tcjfs.org

TRAVEL AUTHORIZATION AND EMERGENCY MEDICAL TREATMENT INFORMATION FOR CHILDREN IN CUSTODY

Tuscarawas County Job & Family Services holds custody of the following child:

_____, _____.
(child's name) (d.o.b.)

TRAVEL

_____ has/have authorization to travel
(foster caregiver's(s') name(s)

with the above-named child to _____
(location of travel)

over the period of _____
(dates)

MEDICAL

For authorization of emergency medical treatment determined necessary by a licensed physician or dentist for this child:

- ✓ During **working hours**, 8:00 a.m. to 4:30 p.m., Monday through Friday, contact the agency at **330-339-7791** or **1-800-431-2347**.
- ✓ During **non-working hours**, contact our on-call worker through the County Sheriff's Department at **330-339-2000**.

_____ _____
Director Date

TRAVEL EXPENSE REPORT

NAME	TITLE	TUSCARAWAS COUNTY JOB & FAMILY SERVICES (Employing Agency)
HOME ADDRESS (Number, Street)	CITY, STATE	ZIP

DATE 20	DEPART Time	TRAVEL POINTS Point of Departure	ARRIVAL Time	a. Miles	b. Parking	LIVING EXPENSES (Itemize on back) c. Meals	d. Lodging	e. Other
Attach required receipts and properly signed certificates of attendance when applicable.			COLUMN TOTALS	a.	b.	c.	d.	e.

TRAVELER'S CERTIFICATE

I certify that the statements made hereon are true, that the mileage listed was actually driven on County business, and that the expenses incurred were in accordance with State and County regulations. I also certify that I have liability insurance as required by ORC 4509.51.

Signature of Traveler	Date	I. **TOTAL** mileage (a) _____ @ _____¢ / mile $ _____
Supervisor's Approval Signature	Date	II. **TOTAL** other expenses (b, c, d, e) $ _____
Report Approved by Director/Designee	Date	III. **TOTAL** (I, II) $ _____

TCJFS 06a

REMARKS Purpose of travel if out-of-town and any other pertinent facts relative to travel. List announced beginning and ending time of workshop, meeting, etc.	ITEMIZATION Meals (breakfast, lunch, dinner) Lodging, Incidentals, Parking, Other Expenses DATE	ITEMIZATION/EXPLANATION	AMOUNT	MONTH/DATE	NAMES OF OTHERS TRAVELING IN SAME AUTO

TAPE RECEIPTS IN THIS SPACE, IF POSSIBLE:

TCJFS 06a

Child Information for Respite Care

Child's First Name: _____ Child's Last Name: _____

Date of Birth: _____

Any Allergies, Illnesses or Concerns:

Medical Card (Copy or Billing Number): _____

Case Worker Number: _____

Visit Dates:	Visit Times:
_____	_____
_____	_____
_____	_____

Any Other Appointments Scheduled: