FOR: Fee-For-Service Medi-Cal or Gateway
Medi-Cal Patients ONLY
Child Health and Disability Prevention Program
(Ages: 0 up to 21st Birthday)
Care Coordination / Follow-up Request Form

Patient Label [optional]
Patient name, birthdate, age and gender, if present on the label, do not need to be re-entered on the form.

Do not complete this form if child is in the foster care system. Health Care providers are required to submit a Foster Care Medical / Dental Examination form when providing care to children and youth in the foster care system for all types of appointments.

Submit to the Sacramento County CHDP Program **within 5 business days** of examination **– Secure Fax: (916) 875-9773**
9616 Micron Ave. Suite 670, Sacramento, CA 95827 Phone: (916) 875-7151

Patient Name (Last) (First) (Initial)	**Language**	**Date of Service** Month Day Year

Birthdate Month Day Year	**Age**	**Sex** ☐M ☐F	**Gender**	**Patient's County of Residence**	**Telephone #** ( )	**Alternate Phone #** ( )

Responsible Person (Name) (Street) (Apt/Space #) (City) (Zip)

Ethnic Code: 1-White, 2-Hispanic/Latino, 3-Black/African American, 4-American Indian/Alaska Native, 5-Asian, 6-Native Hawaiian/Other Pacific Islander, 7-Other

Patient Eligibility	County	Aid	Medi-Cal Identification Number

A. Medical Assessment and Referral Section

☐ **No Medical Problem Suspected (SKIP TO SECTION B)**

Significant Medical History or Special Conditions?
☐ Yes, specify:

Physical Exam	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled
	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or ☐Return Visit Scheduled
Developmental Assessment	☐Speech Delay ☐Social/Emotional ☐Cognitive ☐Fine Motor Delay ☐Gross Motor Delay ☐ Other	Referred To & Contact # Or ☐Return Visit Scheduled
Vision Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other	Referred To & Contact # Or ☐Return Visit Scheduled
Hearing Screening	☐Problem Suspected ☐Not screened – rescheduling ☐Other	Referred To & Contact # Or ☐Return Visit Scheduled
Comments:		Blood Lead test ordered: ☐Yes ☐No BMI: _____ BMI percentile: _____

B. Dental Assessment and Referral Section

☐ **Has a Dental Home**
☐ **No Dental Home / No Dental Visit in last 6 months - Please help connect family to dental clinic**

Referred To: _____

Contact Number: _____

☐ **Class I: No Visible Problems** Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months) **ROUTINE DENTAL REFERRAL**	☐ **Class II: Visible decay,** small carious lesion or localized gingivitis. Needs non-urgent dental care.	☐ **Class III: Urgent – pain, abscess, large** carious lesions that may involve nerve or extensive gingivitis. Immediate treatment for urgent dental condition; can progress rapidly. May need urgent dental treatment within 24 hours.	☐ **Class IV: Emergent – acute injury,** oral infection or other pain. Needs immediate dental treatment within 24 hours **PLEASE CALL! (And Fax Form- See top of form)**

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted ☐ Other reason for not applying:

C. Referring Provider Information

Service Location or Clinic Stamp: Office Name, Address, Telephone Number	**Provider Name** (Print Name)
	Provider Signature
	Date

CHDP Fee-For-Service Care Coordination/Follow-up Form: Completion Instructions

CHDP Providers:

- Submit a copy of the form via Fax (916) 875-9773 to the Local CHDP program for a **(0 up to 21 year birthday)** child with **Fee-For-Service Medi-Cal if the child has been referred for the following:**

  Medical diagnosis, Medical treatment, Dental home, Dental treatment or Scheduled for a return visit.

- Give a copy of the form to the parent/guardian indicated on the form. Keep a copy in patient's medical record.

Explanation of Form Items

Patient Information (Demographics section):

Patient Name. Enter the patient's last name, first name and middle initial, exactly as it appears on the Benefits Identification Card (BIC), including blank spaces. If the patient's name differs in any way from the name on the BIC or is incorrect, enter the name that the patient is Also Known As (AKA) in the *Comments* area.

Language. Enter the patient's primary language spoken at home. Documentation of the language is essential in providing in appropriate and expedited care coordination.

Date of Service. Enter the date the CHDP service was rendered. Insert forward slash marks for all dates.

Birthdate. Enter the month, day and year of the patient's birth exactly as it appears on the Medi-Cal eligibility verification system.

Age. Enter the patient's age with one of the following indicators: "y" for years, "m" for months, "w" for weeks, or "d" for days (for example, 5y represents 5 years of age).

Sex. Enter an "F" if the patient is female. Enter an "M" if the patient is male.

Gender. Enter the gender patient identifies with even if the gender is not female or male. If information is not available leave blank.

Patient's County of Residence. Enter the name of the county where the patient lives (not county where assessment is performed).

Telephone#. Enter the best contact number, including area code where the responsible person can be reached during the day. This number is critical to enable local CHDP program staff to assist families in linking to care.

Alternate Phone#. Enter alternate number if available.

Responsible Person. Enter the name, street address (including apartment or space number), city, and ZIP code of the parent or legal guardian with whom the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY Enter the patient's two-digit county code (obtained when eligibility verification is performed).
- AID Enter the patient's two-digit aid code (obtained when eligibility verification is performed).
- MEDI-CAL IDENTIFICATION NUMBER. Enter the patient's ID# from the plastic Benefits Identification Card (BIC) or *Immediate Need Eligibility* – (Gateway) document

Ethnic Code. Enter the appropriate ethnic code (select one only). If the patient's ethnicity is not included in the code list, or if ethnicity is unknown, enter code 7 (Other).

A. Medical Assessment:

No Medical Problems Suspected. Enter check mark (X) in this box **& Skip to Section B - Dental Assessment and Referral.**

Significant Medical History or Special Conditions. Check mark (X) this box & and enter medical problems or special conditions.

If a problem is suspected for any exam, assessment or screening areas (Physical, Nutritional, Developmental, Vision, and Hearing) and a referral is indicated, enter the following:

1. Name and telephone number of the provider or agency you referred the patient.
2. Problem Suspected – and follow-up contact numbers.
3. Any additional information may be placed in the Comments area.
4. For return visit for any of the above areas, check box and enter date of return visit.
5. Check mark (X) in box: Y or N for blood lead test ordered.
6. Enter BMI and BMI percentile.

Comments. Use this space for remarks that clarify the results of the health assessment and to communicate issues to the local CHDP program.

B. Dental Assessment and Referral Section:

Dental home referral. Enter a check mark (X) in either box for: "Has a Dental Home" or "No Dental Home/No Dental Visit in last 6 months".

Note: An annual referral for a routine dental visit still needs to be made if the patient has no dental problems (Class I) and is 1 year of age or older and has erupted teeth. Be sure to check (X) Class I box. CA SB75 [P. 32 of Ch.18. SEC. 22.124040.(6)(D)] (Scroll to Ch.18. Page 32)

Referred To and Contact Number. Enter the name & telephone number of the dental provider or agency to which you referred. Enter a check box in one of the Classification boxes: Class I Class II Class III Class IV

Fluoride Varnish Applied. Enter a check mark (X) on the Yes box if the patient had fluoride varnish applied during visit on date of service listed above. Enter a check mark (X) on appropriate box if child did not get fluoride varnish and state reason why not.

C. Referring Provider Information:

Service Location. Enter business name, street address, telephone # w/area code of clinic/office. **A provider stamp is acceptable.**

Rendering Provider Name. Print legibly or type the provider's name that renders the services.

Provider Signature. Provider or a designated representative must sign.

Date. Enter the date of signature.