**DMCPS Consent Request**

This document is to assist DMCPS’ Contracted Case Management Agencies when DMCPS has been granted Emergency, Temporary, Limited or Full Guardianship of a child and consents require signature. This form will provide the DMCPS designee with the necessary information to make pertinent and informed decisions about the child.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Request | | | | | DMCPS Response Needed by | | | | |
| **Child/Family Information** | | | | | | | | | |
| Child’s Name | | | | | | | | | Child’s Date of Birth |
| Pre-adoptive child  WRAP involved (Please include updated Plan of Care) | | | | | eWiSACWIS Case # (*Where consents should be uploaded)* | | | | |
| Case Manager | | | | | | | | | |
| Supervisor | | | | | | | | | |
| Program Manager | | | | | | | | | |
| Reviewed/Approved at Agency by | | | | | | | | | |
| Child’s Current Placement | | | | | | | | | |
| Unlicensed Placement  Inpatient MH  Foster Home/Kinship | | RCC  TFC  Group Home  Other: | | | | | | | |
| **Type of Guardianship** | | | | | | | | | |
| Emergency Guardianship  Date Granted:       Date Expires:  Rationale for why Guardianship was granted: | | | | | | | | | |
| Temporary Guardianship  Date Granted:       Date Expires: | | | | | | | | | |
| Limited Guardianship  Date Granted:       Date Expires:  Rationale for why Guardianship was granted: | | | | | | | | | |
| Full Guardianship  Date Granted: | | | | | | | | | |
| TPR Granted  Date Issued: | | | | | | | | | |
| **Type of Consent** | | | | | | | | | |
| Non-Medical Consents  DMCPS has approved this type of request in the past:  Yes  No  Unknown  Date of previous approval/or why unknown:  Explain the reason for the consent: | | | | | | | | | |
| Medical Consents (Agency Based Health Care Provider Reviewer:  DMCPS has approved this type of request in the past:  Yes  No  Unknown  Date of previous approval/or why unknown: | | | | | | | | | |
| **Care 4 Kids Information** | | | | | | | | | |
| Care 4 Kids Coordinator Name | | | | | | | | Date of last Care Plan | |
| Updated Care 4 Kids Care Plan attached(click if the updated care plan is attached that includes all medication, previous medical appointments, and upcoming medical appointments.)  *\*If the medical consent forms do not explain the medical procedure, please provide a narrative about the medical procedure. Include the date of the procedure, and name of the Medical Provider recommending and completing the procedure.* | | | | | | | | | |
| Medication Consents(Agency Based Health Care Provider Reviewer:      )  *\*This section must be filled out with ALL psychotropic, non-psychotropic, and regular OTC (ex. Seasonal allergy medications, Melatonin, etc.) medications the child is currently prescribed/taking. If available, please include the most recent visit notes from the prescribing physician.* | | | | | | | | | |
| a. | Medication and Prescribing Doctor | | | | | Status of Medication  Current Medication  New Medication  Change to Current Medication. Explain the medication change and include the previous dose: | | | |
|  | Prescribing Dosage | | | | |
|  | Diagnosis/target symptoms | | | | |
| b. | Medication and Prescribing Doctor | | | | | Status of Medication  Current Medication  New Medication  Change to Current Medication. Explain the medication change and include the previous dose: | | | |
|  | Prescribing Dosage | | | | |
|  | Diagnosis/target symptoms | | | | |
| c. | Medication and Prescribing Doctor | | | | | Status of Medication  Current Medication  New Medication  Change to Current Medication. Explain the medication change and include the previous dose: | | | |
|  | Prescribing Dosage | | | | |
|  | Diagnosis/target symptoms | | | | |
| d. | Medication and Prescribing Doctor | | | | | Status of Medication  Current Medication  New Medication  Change to Current Medication. Explain the medication change and include the previous dose: | | | |
|  | Prescribing Dosage | | | | |
|  | Diagnosis/target symptoms | | | | |
| e. | Medication and Prescribing Doctor | | | | | Status of Medication  Current Medication  New Medication  Change to Current Medication. Explain the medication change and include the previous dose: | | | |
|  | Prescribing Dosage | | | | |
|  | Diagnosis/target symptoms | | | | |
| **Pertinent Information/Case Updates that are important to the need of the consent**  *(Change in placement, new diagnosis, new services/supports, case transfer, hospitalization within the last 6 months, etc. For new services/supports, detail if the providers are added or replacing current services/supports.)* | | | | | | | | | |
| If a case transfer happened within 90 days, put date of case transfer: | | | | | | | | | |
| **DMCPS Internal Use Only** | | | | | | | | | |
| Date Received | | | Date Completed | | | | Uploaded to eWiSACWIS  Yes  No | | |
| Completed by | | | | Uploaded by | | | | | |