**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.

|  |  |
| --- | --- |
| 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 GuardianshipDate Granted:       Date Expires:      Rationale for why Guardianship was granted:       |
| [ ]  Temporary GuardianshipDate Granted:       Date Expires:       |
| [ ]  Limited GuardianshipDate Granted:       Date Expires:      Rationale for why Guardianship was granted:       |
| [ ]  Full GuardianshipDate Granted:       |
| [ ]  TPR GrantedDate Issued:       |
| **Type of Consent** |
| [ ]  Non-Medical ConsentsDMCPS has approved this type of request in the past: [ ]  Yes [ ]  No [ ]  UnknownDate 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 [ ]  UnknownDate 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      |