AGREEMENT WITH FOSTER PARENTS REGARDING EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT POLICIES AND PROCEDURES

DATE: ___________________

I, ____(and)
Print FOSTER PARENT # 1's full name (first, middle, last)

I, ____ with
Print FOSTER PARENT # 1's full name (first, middle, last)

KIDS CENTRAL, INC.

Residing at ____
Foster parent's street address, city, state and zip

In the county of _______________ do hereby agree to cooperate and assist in the provision of EPSDT services to all foster children placed in our care by the Department of Children and Families.

We understand that the following medical tests and examinations are provided free of charge through Medicaid screening; health and developmental history; unclothed physical assessment; nutrition assessment; developmental assessment; dental screening with direct referral to a dentist by age 3 or earlier if indicated: vision screening; hearing screening: immunizations; and laboratory tests and health education. EPSDT screening also includes treatment problems detected during the screening such as the provision of eyeglasses, hearing aids, and dental services.

We understand that children must be scheduled for examination according to the following periodicity schedule: Birth, 2 months of age, 4 months of age, 6 months of age, 9 months of age, 12 months of age, 15 months of age 18 months of age, once every year after an initial screening for ages 2 through 6 and once every 2 years after an initial screening for ages 7 through the month the young adult reaches age 21. A child may be screened more frequently based on medical necessity.

SIGNED ________________________________
Foster Parent # 1

SIGNED ________________________________
Foster Parent # 2

DATE ________________________________

WITNESS: _________________________

DATE: _________________________