CHILDREN'S MEDICAL SERVICES (CMS)
Policy #CW-3006

SUBJECT: **Public Health Nurse (PHN) Role for Level of Care/Specialized Increment Rate (LOC/SCI)**

RESPONSIBLE: Child Welfare Public Health Nursing (CWPHN) Program

EFFECTIVE: July 3, 2017

REVISED: December 13, 2022

PURPOSE: The Department of Children and Family Services (DCFS) has established a LOC/SCI as a specialized rate for children/youth with qualifying medical, behavioral, emotional, and developmental conditions. In order to qualify for specialized rate, the caregiver must perform related activities based upon the child's/youth's diagnosed condition and instructions from the child's/youth's medical provider(s).

POLICY: The PHN will conduct an LOC/SCI medical review upon request from the LOC/SCI Team, Children's Social Worker(s) (CSW's), and/or recommendation by the PHN. Examples of LOC/SCI's include: MCMS determination, adoptions, post-adoptions, KinGap, retroactive, and F-rates.

PROCEDURES:

I The PHN receives the request and required documentation from the LOC/SCI Team/CSW for review and completion of the Medical Conditions portion of the LOC/SCI. The documentation needed includes the following:

A 3-or-4 tier DCFS 1696 form.

B A DCFS form149 (Medical Care Assessment Form- see Reference 9) or a medical report from the physician including all elements as listed on DCFS form 149. The following information should be included on the DCFS form 149, or medical report.

1	Child/Youth Name
2	DOB
3	Child/Youth Diagnosis
4	Diagnosis date
5	Date of Examination (must be within the last six months, except for retroactive rate review). All medical documentation must be from a health care provider who has examined the child, within the prior six-months.
6	Frequency
7	Expected duration

8	Any specialized care instructions/activities to be done by the caregiver.
9	The provider's signature, printed name, and address are required for all community-based non-DHS providers. For DHS hub providers an electronic signature is provided.

C The PHN receives the DCFS 149 electronically or directly from the CSW/LOC CSW or any other supporting medical records/documentation.

D Medical file/folder as necessary.

II The PHN shall:

A Review available DCFS 149 and any supporting medical records.

B If further information is needed, the PHN will request in collaboration with the LOC/SCI Team/CSW additional information to provide a thorough assessment of the child/youth's medical condition.

C Review the available information to evaluate LOC/SCI criteria guidelines.

D Consult with the Public Health Nurse Supervisor (PHNS) when there are discrepancies on determining LOC/SCI with CSW.

E Complete the "Medical Conditions" portion of the DCFS 1696 as appropriate (See table below) and attach appropriate documentation.

LOC/SCI category	Foster Care	General Program
Kin-GAP	* N/A	Use form DCFS 1696 provided by CSW (usually 3-tier). If no form is provided, follow-up with CSW. If Legal Guardianship is granted prior to 1/1/2017 use 4-tier.
LOC/SCI	3-tier is used any time on or after 4/1/2021.	3-tier is used any time on or after 4/1/2021.
Open Adoptions	3-tier. If consult is from the AAP LOC CSW a consultation form will be provided. - The time range from the AAP LOC CSW is any time on or after 4/1/2021. -Adoptions CSW time range consults will be prior to 4/1/2021.	* N/A
Post-Adoption Services (PAS)	*N/A	Use form DCFS 1696 provided by CSW (usually 3-tier). If no consultation form is provided, follow-up with CSW. If the initial AAP agreement was signed prior to 1/1/2017, use 4-tier (per AAP LOC/SCI Consultation form also provided by CSW). See attachment C.

Retroactive (court terminated)	*N/A	Use form DCFS 1696 provided by CSW (usually 3-tier). If no form is provided, follow-up with CSW. Consult with the CSW to determine which form to use. For medical records prior to 4/1/2021 use the 4-tier protocol.
Retroactive (open case)	3-tier for any placement date or diagnosis effective on or after 4/1/2021. For placement date or diagnosis ** prior to 4/1/2021 use the 4-tier protocol. ** Please refer to the medical record to assist with determining the correct diagnosis(es) date(s)., 	Use form DCFS 1696 provided by CSW (usually 3-tier). If no form is provided, follow-up with CSW. For medical records prior to 4/1/2021 use the 4-tier protocol.

* Does not apply

** Please refer to the medical record to assist with determining the correct diagnosis(es) date(s).

F Complete the 3-tier (**see Reference 10)** vs 4-tier (**see Reference 11)** LOC/SCI as listed in the chart above.

III **Steps for completing the 3-tier DCFS 1696:**

A Review the "Medical Conditions" section and check all the appropriate boxes in each tier that applies on pages 1-2 of the 3-tier DCFS 1696 form.

B Complete the "PHN SCI-Rate Recommendations" box.

C Review the additional PHN Recommendations" and check the appropriate corresponding recommendations.

D Select "Recommend transfer to MCMS" if SCI Tier 2 or 3 for medical conditions is checked or when three or more tier 1 'Medical Condition' categories are checked.

E PHN will check the 6-months, or 12-months re-evaluation box based on the child/youth's diagnosis (i.e. temporary non-chronic conditions- 6months vs. chronic conditions- 12 months).

F Check the box if CSW has not provided documentation/proof of training by caregiver/parent. I.e., medical training confirmation form DCFS 6079. (PHN is not responsible to ensure training confirmation).

G Check the box for, "this child's level of care does not appear to meet the criteria for Specialized Care Increment Rate for medical conditions" if no boxes are checked in medical condition tiers.

H Type PHN name on the Excel version of DCFS 1696 and enter date when LOC/SCI is completed.

I Save the Excel version of the DCFS 1696, then convert document to a PDF file and sign

J Send the signed, completed PDF document with any applicable attachments (ie. DCFS 149 and PHN Progress Note- see attachment A) to LOC/SCI Team or CSW and cc: PHNS.

IV **4-tier DCFS 1696:** See attachment B

A Use the 4-tier DCFS 1696 when the AAP agreement was signed prior to 1/1/2017 or medical diagnosis date is prior to 4/1/2021.
B DCFS 1696 form prior to 1/1/2017 is usually presented as a Word document (See Reference 11).
C Complete the dual agency rate (for client's receiving regional center services under the age of 3). For those over the age of 3, refer the CSW to their supervisor or have them contact the DCFS Regional Center Section.

V Using the PIE format, PHN will copy and paste the PHN progress note in Child Welfare Services/Case Management System (CWS/CMS) contact notebook.

VI Enter LOC/SCI information into a PHN progress note and as a contact note in CWS/CMS. For any closed cases (i.e. PAS or kinGap) the PHN will enter the medical portion of the LOC/SCI as a PHN progress note and provide a copy to the CSW/LOC CSW. The progress note is to be sent via email to the CSW and cc: SCSW and PHNS.

VII Enter the date the PHN completed the LOC/SCI rate into the summary tab of the health notebook. For example: (LOC/SCI completed, 1/20/2022/CD,PHN).

VIII Enter pertinent medical information into CWS/CMS Health Notebook/Health and Education Passport (HEP).

IX **Kin-Gap**

A The CWPHN Kin-Gap referral coordinator and ITC receives the request for LOC-SCI from Kingship Support Services CSW via following email address: CWPHNkinGAP@ph.lacounty.gov
B Assignment is made by the Kin-Gap referral coordinator/ITC using the PHN rotation assignment list.
C PHN will review Kin-Gap request and determines if sufficient information is available to complete the consultation. If the legal guardianship was finalized prior to 1/1/2017 the 4-tier 1696 form should be completed If after 1/1/2017 the 3 Tier form should be completed.
D If sufficient medical information is available PHN will complete the 1696 "SCI Rate Recommendations" and "Additional PHN Recommendations" based on the medical record review on either the 3-tier or 4-tier form and submit the 1696, the nursing note and all other documentation to the Kin-Gap CSW and PHNS.
E If there is missing information, the PHN will notify the Kin-Gap CSW via PHN note and email.

X **Post-Adoption Services (PAS)**

A The CWPHN PAS coordinator and ITC receives the request for PAS via the following email address: CWPHNPAS@ph.lacounty.gov
B Assignment is made to the GP PHN using the PAS rotation assignment list.
C PHN review PAS request and determines if sufficient information is available to complete the consultation.
D If sufficient medical information is available, PHN will review the information to evaluation LOC/SCI criteria guidelines. PHN will complete the "Medical Conditions" portion and "SCI Rate

Recommendations" section of the DCFS form 1696 based on the medical record review on the 3-tier form. If the initial AAP agreement was signed prior to 1/1/2017, the PHN will complete/ use the 4-tier 1696 form. PHN will submit the 1696, PHN Progress note, and any other documentation to the PAS CSW and PHNS.

E If there is missing information, the PHN will notify the PAS CSW via PHN note and email.

Diane Sanchez
_____

Diane M. Sanchez, RN, PHN, MSN/MPH, CNS
CMS Nursing Director

April 4, 2023
_____
Date

DEFINITIONS:

- **Level of Care/Specialized Increment Rate (LOC/SCI):** a rate given to resource parents when they assume additional responsibilities due to child/youth/NMD's needs. For the purpose of the CWPHN Program, assessment is limited to diagnosed medical condition(s) and need(s) obtained on or after 4/1/2021 using a 3-tier 1696 form.
- **Specialized Increment Rate (SCI) F-rate:** A rate paid for the care of children/youth with special needs. For the purpose of the CWPHN Program, assessment is limited to diagnosed medical condition(s) and need(s) prior to 4/1/2021 including developmental conditions (i.e. Early Start-Regional Center Services) for children under the age of 3, using a 4-tier 1696 form.

ATTACHMENT(S):

Attachment A: Public Health Nursing Progress Note: LOC/SCI [3-tier]. Revised 5/2022.
Attachment B: Public Health Nursing Progress Notes: LOC/SCI [4-tier]. Revised 5/2022.
Attachment C: Public Health Nurse AAP LOC/SCI Consultation Request [DCFS 5646-AAP] Form. Revised 1/17/2021.
Attachment D: Public Health Nursing Process Note: Post-Adoption Services (PAS) [3-tier]. Revised 3/14/2022
Attachment E: Public Health Nursing Progress Note: Post-Adoption Services (PAS) [4-tier]. Revised 3/14/2022

REFERENCE(S):

Reference 1: Children's Medical Services: Staff Development and Training Unit (SDTU). Level of Care (LOC) Specialized Care Increment (SCI)Update. [Online training; December 8, 2021].
Reference 2: Medical Training Confirmation [DCFS 6079]. Revised 1/20/2016.
Reference 3: Children's Medical Services (CMS)- CWPHN LOC/SCI Workflow. Revised 4/4/2023.
Reference 4: Children's Medical Services (CMS)- CWPHN Kin-GAP LOC/SCI Workflow. Created 12/1/2021.
Reference 5: Children's Medical Services (CMS)- CWPHN Open Adoptions LOC/SCI Workflow. Created

12/1/2021.

Reference 6: Children's Medical Services (CMS)- CWPHN Post Adoptions Services (PAS) LOC/SCI Workflow. Created 12/16/2001.

Reference 7: Children's Medical Services (CMS)- CWPHN Retroactive (court terminated) LOC/SCI Workflow. Revised 12/1/2021.

Reference 8: Children's Medical Services (CMS)- CWPHN Retroactive (open cases) LOC/SCI Workflow. Created 11/18/2021.

Reference 9: Medical Care Cover Letter and Assessment [DCFS Form 149]; revised 12/21.

Reference 10: Specialized Care Rate Increment (SCI) Indicators- LOC/SCI [DCFS Form 1696; 3-tier]; revised 1/25/2023.

Reference 11: Specialized Care Rate Increment (SCI) Indicators- F-Rate Indicators [DCFS Form 1696; 4-tier]. Revised: 3/2013.

PUBLIC HEALTH NURSING
PROGRESS NOTES

NAME		DATE OF BIRTH:	
CASE		CASE NUMBER:	

DATE:	CT CODE	NOTES: LOC/SCI Assessment (3-tier)
		PROBLEM: CSW requested PHN to review medical documentation to assess if child meets the criteria for a Specialized Care Increment Rate. **INTERVENTIONS:** PHN reviewed and entered the available documentation into the CWS/CMS. **MEDICAL CARE ASSESSMENT** performed on _____ **by** _____ as follows: **CHILD'S DIAGNOSIS(ES):** **DATE of Dx:** **CHILD'S PROGNOSIS:** **MEDICATION/TREATMENT REQUIRED/FREQUENCY/EXPECTED DURATION:** **How often is medical followup needed?** **SPECIALIZED CARE INSTRUCTIONS/ACTIVITIES TO BE DONE BY CAREGIVER:**

CT CODES: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____, Ext. _____ CSW: _____, Ext. _____ Page 1

		<u>LOC/SCI CRITERIA GUIDELINES</u>: (*list all that applies from DCFS 1696)* **Medical Conditions:** **Tier level asessed:** **EVALUATION/SUMMARY/RECOMMENDATION:** "According to all the available medical documentation this child's level of care Choose an item. the criteria for a Specialized Care Increment Tier/Rate of Choose an item. for medical concerns." • The duration of the LOC/SCI is subject to review Choose an item.. The review may result in a change in the LOC/SCI status for the child, i.e., increase, decrease, and/or termination of payment. • Per DCFS Policy caregiver must have participated in the initial 16 hours F-rate certification training and 6 hours yearly thereafter to be certified. PHN's will review certification of caregivers training if provided by CSW but are not responsible for obtaining or verifying that training has been completed.
		Signature: xxx/xx,PHN—xx/xx/20xx

CT CODES: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____, Ext. _____ CSW: _____, Ext. _____ Page 2

Attachment B

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES

PUBLIC HEALTH NURSING
PROGRESS NOTES

NAME		DATE OF BIRTH:	
CASE		CASE NUMBER:	

DATE:	CT CODE	NOTES: F-rate (4-tier)
		PROBLEM: CSW requested PHN to review medical documentation to determine if child meets the criteria for a Specialized Care Rate. **INTERVENTIONS:** PHN reviewed and entered the available documentation into the CWS/CMS. **MEDICAL CARE ASSESSMENT** performed on _____ **by** _____as follows: **CHILD'S DIAGNOSIS(ES):** **DATE of Dx:** **CHILD'S PROGNOSIS:** **MEDICATION/TREATMENT REQUIRED/FREQUENCY/EXPECTED DURATION:** **How often is medical followup needed?** **SPECIALIZED CARE INSTRUCTIONS/ACTIVITIES TO BE DONE BY CAREGIVER:**

CT CODES: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ CSW: _____ Page 1

* CONFIDENTIAL CASE RECORDS PURSUANT TO WIC SECTION 827 AND ORDERS OF THE LOS ANGELES JUVENILE COURT

		F-RATE CRITERIA GUIDELINES: 1. ASSISTING WITH DAILY LIVING TASKS BEYOND LEVEL EXPECTED FOR CHILD'S AGE DUE TO SERIOUS MEDICAL PROBLEMS **LEVEL ASSESSED**: 2. ADMINISTERING MEDICAL OR DEVELOPMENTAL REGIMENS **LEVEL ASSESSED**: 3. MONITORING HEALTH STATUS OF CHILD **LEVEL ASSESSED**: 4.CARING FOR INFANT/CHILD PRENATALLY EXPOSED TO DRUGS OR ALCOHOL (MUST BE REFERRED TO REGIONAL CENTER) **LEVEL ASSESSED**: 5.CARING FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES WHO HAVE BEEN DIAGNOSED/SERVED BY REGIONAL CENTER **LEVEL ASSESSED**: 6A. WORKING WITH CHILD'S EMOTIONAL PROBLEMS IN CONJUCTION WITH MEDICAL PROBLEMS [Medical problems plus documented emotional problems. Children age 3 or over must be in a treatment program for the emotional problem. Raise the rate one level above highest medically related caregiver activity up to level four.] **LEVEL ASSESSED**: 6B.WORKING WITH A CHILD WITH MULTIPLE MEDICAL PROBLEMS (ADDED 8/18/09) **LEVEL ASSESSED**: 7.OTHER: N/A

CT CODES: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ CSW: _____ Page 2

		EVALUATION/SUMMARY/RECOMMENDATION: **"According to all the available medical documentation this child's level of care** Choose an item. **the criteria for a Specialized Care Increment Rate of** Choose an item. **for medical concerns."** The recommended due to criteria requiring the caregiver to supervise and/or to perform medical treatment as prescribed by a licensed medical provider to promote and maintain health and to prevent deterioration of health care condition • The duration of the F-rate is subject to review every six months. The review may result in a change in the F-rate status for the child, i.e., increase, and decrease, termination of payment. • Per Policy caregiver must have participated in the initial 16 hours F-rate certification training and 6 hours yearly thereafter to be certified. Signature:

CT CODES: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ CSW: _____ Page 3

Attachment C

PUBLIC HEALTH NURSE
AAP LOC SCI CONSULTATION REQUEST

Date:

To: ☐ PHN Name:

From:	☐ AAP LOC CSW ☐ PAS CSW ☐ Adoption CSW
Email:	Phone:

Child's Birth Name:		DOB:	
Child's Adoptive Name:		Case # (or AAP#)	
Case Type:	☐ Adoption (Open Case) ☐ Finalized Adoption (PAS) ☐ Other:		

Caregiver's Name:			
Caregiver's Address:		Telephone:	
Relationship to Child:	☐ Prospective Adoptive Parent ☐ Adoptive Parent (PAS) ☐ Foster Parent ☐ Relative ☐ Legal Guardian		

Request:

☐ AAP LOC Special Care Increment (SCI) Assessment ☐ Pre 1/1/2017 (4-Tier) ☐ After 1/1/2017 (3 Tier)

☐ Medical Folder Review ☐ Input Medical Info to CWS/CMS

☐ Other Assistance Needed (Explain Below) ☐ Joint CSW/PHN Visit

The following field must be completed by the referring CSW. (List the child's known or suspected medical problems and/or what your concerns are.)

Primary CSW's Name:	Office:	Primary SCSW:

Adoption CSW's Name:	Office:	Adoption SCSW:

Attachment D

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES

PUBLIC HEALTH NURSING
PROGRESS NOTES
POST ADOPTION SERVICES (Adoption finalized after 01/01/2017)
3 Tier LOC-SCI Protocol

CHILD: _____ DATE OF BIRTH: _____

CASE NAME: _____ CASE NUMBER: _____

DATE	CT CODES	NOTES
Date: xxxx		**PROBLEM:** CSW requested PHN to review medical documentation to determine if child meets the criteria for an AAP LOC/SCI (Level of Care/Specialized Care Increment). Per CSW, adoption finalized after 01/01/2017.
		INTERVENTIONS: PHN reviewed and entered the available documentation into the CWS/CMS. **MEDICAL CARE ASSESSMENT** performed on _____ **by Dr.** _____as follows: **CHILD'S DIAGNOSIS(ES):** **DATE of Dx:** **CHILD'S PROGNOSIS:** **MEDICATION/TREATMENT REQUIRED/FREQUENCY/EXPECTED DURATION:** **How often is medical followup needed?** **SPECIALIZED CARE INSTRUCTIONS/ACTIVITIES TO BE DONE BY CAREGIVER:**

***CT CODES**: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ **CSW:** _____

PUBLIC HEALTH NURSING
PROGRESS NOTES
POST ADOPTION SERVICES (Adoption finalized after 01/01/2017)
3 Tier LOC-SCI Protocol

CHILD: _____ DATE OF BIRTH: _____

CASE NAME: _____ CASE NUMBER: _____

DATE	CT CODES	NOTES
		<u>LOC/SCI CRITERIA GUIDELINES</u>: (*list all that applies from DCFS 1696)* **Medical Conditions:** **Tier level asessed:**
		EVALUATION/SUMMARY/RECOMMENDATION: "According to all the available medical documentation this child's level of care Choose an item. the criteria for a Specialized Care Increment Tier/Rate of Choose an item. for medical concerns." **PHN portion of the DCFS 1696 completed and attached.** **Signature: xxx**/xx,PHN—xx/xx/20xx

***CT CODES**: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ **CSW:** _____

Attachment E

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES

PUBLIC HEALTH NURSING
PROGRESS NOTES
POST ADOPTION SERVICES (Adoption finalized before 01/01/2017)
4 Tier F-rate/SCI Protocol

CHILD: _____ DATE OF BIRTH: _____

CASE NAME: _____ CASE NUMBER: _____

DATE	CT*	NOTES
Date: xxxx		**PROBLEM:** CSW requested PHN to review medical documentation to determine if child meets the criteria for an AAP SCI/F-rate. Per CSW, adoption finalized before 01/01/2017.
		INTERVENTIONS: PHN reviewed and entered the available documentation into the CWS/CMS. **MEDICAL CARE ASSESSMENT** performed on _____ **by Dr.** _____as follows: **CHILD'S DIAGNOSIS(ES):** **DATE of Dx:** **CHILD'S PROGNOSIS:** **MEDICATION/TREATMENT REQUIRED/FREQUENCY/EXPECTED DURATION:** **How often is medical followup needed?** **SPECIALIZED CARE INSTRUCTIONS/ACTIVITIES TO BE DONE BY CAREGIVER:**

***CT CODES**: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ **CSW:** _____ **Page** 1

PUBLIC HEALTH NURSING
PROGRESS NOTES
POST ADOPTION SERVICES (Adoption finalized before 01/01/2017)
4 Tier F-rate/SCI Protocol

CHILD: _____ DATE OF BIRTH: _____

CASE NAME: _____ CASE NUMBER: _____

DATE	CT*	NOTES
		<u>F-RATE/SCI CRITERIA GUIDELINES</u>: 1. ASSISTING WITH DAILY LIVING TASKS BEYOND LEVEL EXPECTED FOR CHILD'S AGE DUE TO SERIOUS MEDICAL PROBLEMS **LEVEL ASSESSED:** 2. ADMINISTERING MEDICAL OR DEVELOPMENTAL REGIMENS **LEVEL ASSESSED:** 3. MONITORING HEALTH STATUS OF CHILD **LEVEL ASSESSED:** 4. CARING FOR INFANT/CHILD PRENATALLY EXPOSED TO DRUGS OR ALCOHOL (MUST BE REFERRED TO REGIONAL CENTER) **LEVEL ASSESSED:** 5. CARING FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES WHO HAVE BEEN DIAGNOSED/SERVED BY REGIONAL CENTER **LEVEL ASSESSED:** 6A. WORKING WITH CHILD'S EMOTIONAL PROBLEMS IN CONJUCTION WITH MEDICAL PROBLEMS **[**Medical problems plus documented emotional problems. Children age 3 or over must be in a treatment program for the emotional problem. Raise the rate one level above highest medically related caregiver activity up to level four.**]** **LEVEL ASSESSED:** 6B. WORKING WITH A CHILD WITH MULTIPLE MEDICAL PROBLMES **LEVEL ASSESSED:**

***CT CODES**: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ **CSW:** _____

PUBLIC HEALTH NURSING
PROGRESS NOTES
POST ADOPTION SERVICES (Adoption finalized before 01/01/2017)
4 Tier F-rate/SCI Protocol

CHILD: _____ DATE OF BIRTH: _____

CASE NAME: _____ CASE NUMBER: _____

DATE	CT*	NOTES
		EVALUATION/SUMMARY/RECOMMENDATION: "According to all the available medical documentation this child's level of care Choose an item. the criteria for an F-Rate of Choose an item. for medical concerns." **Signature: xxx**/xx,PHN—xx/xx/20xx

***CT CODES**: **T/C/T** for a telephone call made by PHN; **T/C/F** for a telephone call received by PHN; **LTR** for a letter; **HV** for a home visit made by PHN with CSW; and OV for an in office contact.

PHN Signature: _____ **CSW:** _____ **Page** 3