

**NOTICE TO PROVIDER - EDUCATIONAL AND MEDICAL**

CHILD'S NAME <i>(Last, First, M.I.)</i>	BIRTHDATE	CHILD'S ID NO.
CPS SPECIALIST'S NAME <i>(Print Name)</i>	CPS SPECIALIST'S SIGNATURE	DATE
SUPERVISOR'S NAME	PHONE NO. (      )	
CPS SPECIALIST'S OFFICE ADDRESS <i>(No., Street, City, State, ZIP)</i>		

This notice serves to confirm that this child is in the care, custody and control of the Arizona Department of Economic Security. The child has been placed with the following authorized out-of-home care provider. 1) The whereabouts and information about this child is confidential. *(El paradero e información sobre este niño(a) es confidencial.)* 2) This notice confirms that the child is eligible for health coverage through CMDP. *(Este aviso convalida que el niño(a) es elegible por seguro de salud mediante CMDP.)* **The school and medical provider need to make a copy of this form. (La escuela y proveedor deben hacer una copia de este formulario.)**

OUT-OF-HOME CARE PROVIDER'S NAME <i>(Last, First, M.I.)</i>	PHONE NO. (      )
OUT-OF-HOME CARE PROVIDER'S ADDRESS <i>(No., Street, City, State, ZIP)</i>	

NAME OF SCHOOL CHILD PREVIOUSLY ATTENDED	CURRENT GRADE
NAME OF SCHOOL DISTRICT WHERE THE PARENT(S) OF THE CHILD LIVED AT THE TIME THE CHILD WAS PLACED IN OUT-OF-HOME CARE	

**THIS INDIVIDUAL IS:**

- Not permitted to have contact with the child.
- Not permitted to remove the child from school.
- Not permitted to have access to the child's medical records.

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*

**THIS INDIVIDUAL IS:**

- Not permitted to have contact with the child.
- Not permitted to remove the child from school.
- Not permitted to have access to the child's medical records.

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*

**THIS INDIVIDUAL IS:**

- Not permitted to have contact with the child.
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\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*

Concerns and notices of meetings regarding the special educational needs of the child should be addressed with the CPS specialist and IDEA parent. When the IDEA parent is not the foster parent, also include the foster parent.

SURROGATE PARENT(S) NAME <i>(Last, First, M.I.)</i>	<input type="checkbox"/> NA	PHONE NO. (      )
SURROGATE PARENT(S) ADDRESS <i>(No., Street, City, State, ZIP)</i>		

**See reverse side for CMDP information**

PRIOR MEDICAL PROVIDER'S NAME	PHONE NO. (      )
PRIOR MEDICAL PROVIDER'S ADDRESS <i>(No., Street, City, State, ZIP)</i>	

ROUTING: Original – Out-of-Home Care Provider; Copy – Permanent file

**ARS § 8-514.05 effective April 13, 2003, requires a health care provider, health plan or health care institution to provide the child's medical and behavioral health records, information relating to the child's condition and treatment, and prescription and non-prescription drugs, medications, durable medical equipment, devices and related information to the out-of-home care provider in whose care the child is currently placed.** Further, this law authorizes out-of-home care providers to consent to evaluation and treatment for emergency conditions that are not life threatening and routine medical and dental treatment and procedures, including early periodic screening diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions. It also states that an out-of-home provider is not authorized to consent to general anesthesia, surgery, testing for the presence of the human immunodeficiency virus, blood transfusions, and abortions.

A health care service provider must be registered with the Comprehensive Medical and Dental Program (CMDP) before the claims can be paid for services rendered to the child. The Provider Registration form (CMD-050) can be obtained by calling the CMDP's Provider Services AT 602-351-2245 OR toll-free at 1-800-201-1795.

It is necessary for you to submit your claim for medical services, with the required information, on one of the following forms: UB-92 or HCFA-1500; and for dental services, forms approved by the American Dental Association (ADA) or an Arizona Foster Children Program Dental Claim form (CMD-1003AFORNA). All authorized medical/dental services are based on eligibility at the time of service. The health care provider is responsible for verifying eligibility. Eligibility questions can be directed to the CMDP's member services. Send claims to CMDP, 942C • P.O. Box 29202 • Phoenix, Arizona 85038-9202.

NOTE: Many services require prior authorization. The CMDP Provider Manual (HPM-069) offers instruction on prior authorization. EPSDT well-child screening, billing information, covered and non-covered services, as well as many other topics. If you need more information or would like to request a CMDP Provider Manual, please call:

**(602) 351-2245 or 1-800-201-1795 (8 am to 5 pm – Monday through Friday)**

**FOR SERVICES WHICH REQUIRE THE CONSENT OF A LEGAL GUARDIAN, INCLUDING SURGERIES AND HIV TESTING, CONTACT THE CHILD'S CPS SPECIALIST FOR POLICY GUIDELINES AND ASSISTANCE IN OBTAINING CONSENT.**

**THANK YOU FOR CARING FOR ARIZONA'S FOSTER CHILDREN!**

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-3598; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.

Empleador/Programa con Igualdad de Oportunidades ♦ Bajo los Títulos VI y VII de la Ley de Derechos Civiles del año 1964 (Título VI y VII) y la Ley de Estadounidenses con Incapacidades del año 1990 (Americans with Disabilities Act: ADA), Sección 504 de la Ley de Rehabilitación de 1973, y la Ley de Discriminación a Edad de 1975, el Departamento prohíbe discriminar en los programas, entradas, servicios, actividades o el empleo basado en raza, color de piel, religión, sexo, origen nacional, edad, e incapacidad. El Departamento tiene que hacer arreglos razonables para permitir a una persona con una incapacidad participar en un programa, servicio o actividad. Esto significa, por ejemplo, que si es necesario el Departamento debe proporcionar intérpretes de lenguaje en señas para personas sordas, un establecimiento accesible para sillas de ruedas, o materiales con letras grandes. También significa que el Departamento tomará cualquier otra medida razonable que le permita a usted entender y participar en un programa o una actividad, incluso efectuar cambios razonables en la actividad. Si usted cree que su incapacidad le impedirá entender o participar en un programa o actividad, por favor infórmenos lo antes posible qué necesita para acomodar su incapacidad. Para obtener este documento en otro formato u obtener información adicional sobre esta política, comuníquese 602-542-3598; Servicios de TTY/TDD: 7-1-1. • Ayuda gratuita con traducciones relacionadas a los servicios de DES está disponible a solicitud del cliente.