This Blue Book Belongs To:

_____

Child Resource File
"BLUE BOOK"
Contents Breakout

Section I: Placement Information

1. CoBRIS Face Sheet (if child is an open KCI Case)
2. Placement Letter
3. Service Agreement
4. Child's Medical Information Quick Reference Sheet
5. Risk Factors Assessment

Section II: Legal Information

1. Shelter Petition
2. Court Order for Placement/Adjudication
3. Supplemental Court Orders (including all orders pertaining to placement and/or medications)

Section III: Contacts/Correspondence

1. Foster Home Visitation Log
2. Medical Visits Log
3. Child's Photos
4. Letters
5. School Contacts/Progress Reports and Report Cards

Section IV: Inventory/Financial

1. Personal Items Inventory Log
2. Board Rate Breakout
3. Allowance Log
4. Clothing Receipt Log

Child Resource File
"BLUE BOOK"
Verification Checklist

Section I: Placement Information

- ☐ CoBRIS Face Sheet (if child is an open KCI Case)
- ☐ Placement Letter
- ☐ Service Agreement
- ☐ Child's Medical Information Quick Reference Sheet
- ☐ Risk Factors Assessment

Section II: Legal Information

- ☐ Shelter Petition
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Section III: Contacts/Correspondence

- ☐ Foster Home Visitation Log
- ☐ Medical Visits Log
- ☐ Child's Photos
- ☐ Letters
- ☐ School Contacts/Progress Reports and Report Cards

Section IV: Inventory/Financial

- ☐ Personal Items Inventory Log
- ☐ Board Rate Breakout
- ☐ Allowance Log
- ☐ Clothing Receipt Log

Items Pending:	Reason:	Date Completed:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signatures:

Family Care Manager: _____ Date: _____

Foster Parent/Facility: _____ Date: _____

FCM Supervisor Review: _____ Date: _____

FCM Supervisor to file original with Data Services and provide a copy to Service Center Coordinator for QA Review.

Rick Scott
Governor

David Wilkins
Secretary

William S. D'Aiuto
Regional Managing Director

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Receipt for Delivery of Child Resource File "Blue Book"

Child's Name: _____ **DOB:** _____

The above minor child has been sheltered by the Department of Children and Families and is placed in a licensed foster or a provider home.

By signing this document, I acknowledge receipt of the Child Resource File "Blue Book" pertaining to the child's name that is listed above.

Provider / Foster Home Information:

Name: _____

Address: _____

_____

Telephone: _____

Signature of CPI or FSW delivering Blue Book to provider / foster home **Date:**

Provider / Foster Parent's Signature **Date:**

Receipt is to be placed inside of the Child Protective Investigation file.

Rick Scott
Governor

David Wilkins
Secretary

William S. D'Aiuto
Regional Managing Director

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Authorization to Consent for Placement

Date:

To Whom It May Concern:

IN THE INTEREST OF:

Child(ren): _____
DOB: _____
Soc. Sec #: _____
Medicaid #: _____

Placement:

Name: _____
Address: _____
Phone: _____

The above minor child has been sheltered by the Department of Children and Families and placed in the licensed foster or approved provider home above. This placement is an authorized agent for the Department of Children and Families for the purposes of providing consent for ordinary and necessary medical and dental examinations for the above child pursuant to sections **39.407 and 743.0645, Florida Statutes**.

The foster parents and/or approved providers are licensed and/or authorized agents of the Department of Children and Families for the purposes of enrolling the children in school, obtaining ordinary and necessary medical and dental care, and acting as temporary parental guardians in day to day activities. This authorization does not include consent for surgery, general anesthesia, provision of psychotropic medications, or other extraordinary procedures for which a separate court order or informed consent is required by law.

If you have any questions or problems regarding this matter, please contact the Child Protective Investigator at (352) 620-7752.

Sincerely,

_____
Child Protection Investigator

Rick Scott
Governor

David Wilkins
Secretary

William S. D'Aiuto
Regional Managing Director

MYFLFAMILIES.COM

State of Florida
Department of Children and Families

Letter of Authorization for Medical Consent

Date:

To Whom It May Concern:

IN THE INTEREST OF:

Child(ren): _____
DOB: _____
Soc. Sec #: _____
Medicaid #: _____

Placement:

Name: _____
Address: _____
Phone: _____

This placement is a licensed Foster home or court approved provider and is an authorized agent for the Department of Children and Families for the purposes of providing consent for ordinary and necessary medical and dental examinations for the above child pursuant to *sections 39.407 and 743.0645, Florida Statutes.*

The authority of the Foster Parent/Provider to consent to treatment for these children is limited to consent for ordinary and necessary medical and dental examination and treatment. This includes immunizations, tuberculin testing, and well-child care, but does not include consent for surgery, general anesthesia, provision of psychotropic medications, or other extraordinary procedures for which a separate court order or informed consent as provided by law is required.

When treatment is provided pursuant to this authorization, the requirements of section 743.0645(4), Florida Statutes that notice of the treatment be given to the legal custodian of the child shall be satisfied by notification to:

Florida Department of Children & Families, Child Protective Investigation
1515 E Silver Springs Blvd Suite 114 Ocala, Fl 34470-6831
(352) 620-7752 Telephone (352) 620-7774 Fax Number

_____
Child Protective Investigator Date

Circuit 5
1515 E. Silver Springs Blvd., Suite 114 Ocala, FL 34470-6831

All About Me

Name of Child: _____ Age: _____

Grade: _____ My birthday: _____

My favorite things to do:

_____

_____

_____

_____

My favorite books/stories/movies:

_____

_____

_____

_____

I like-favorite foods:

_____

_____

_____

_____

I hate to eat: _____

_____

_____

_____

When I get upset, this helps me feel better:

_____

_____

_____

_____

At night before going to bed my favorite thing to do is:

The thing that scares me most about not being at home is:

The things I like about my family:

More than anything I hope:

I would like to take

with me.

Family Connections Questionnaire

1. Have you spent the night at a friend's house or at a sleep over? Yes [ ] No [ ]

   If yes, who? _____

   Address_____ Phone:_____

2. Where have you stayed when you are not at home?

   Name: _____ Phone:_____

3. Do you attend a church? Yes [ ] No [ ]

   If yes, which one: _____

   Where? _____

4. Have your children gone to daycare? Yes [ ] No [ ]

   If yes, which one? _____

   Where? _____

5. Do you have relatives, family or friends in the area? Yes [ ] No [ ]

   Name: _____ Phone:_____

6. What about relatives outside the area?

   Name: _____ Phone:_____

7. Who do you call in an emergency?

   Name: _____ Phone:_____

8. Who do you call when you have good news to share?

   Name: _____ Phone:_____

Kids Central, Inc.

CHILD SERVICE AGREEMENT
I. CHILD AND FAMILY INFORMATION

Child's Name: _____ ID # _____
Date of Birth: _____ Age: _____
Date child placed in care: _____ Date child placed in your home: _____

Reason(s) child came into care:

_____
_____
_____
_____
_____
_____
_____
_____

Child's Current Goal

☐ Reunification ☐ Long Term Licensed Custody ☐ Long Term Custody
☐ Adoption ☐ Guardianship Pursuant to Chapter 744 ☐ Independent Living

Foster Provider

Foster Parents' Name:

_____

Foster Parents' Address:

_____
_____
_____

Phone Number: _____

_____

Prior Foster Provider
Name: _____
Address: _____
_____
_____
Phone Numbers: _____
_____

Biological Family

Primary Caretaker at time of removal:

_____

If appropriate include the following information:
Address: _____
_____
Phone Number: _____

Include the names and current placement (home, relative, foster) of siblings
Brothers: _____
_____
Sisters: _____
_____

Is the child allowed contact with siblings:
☐ Yes ☐ No

Family Care Manager/CPI

Name: _____
Work Phone: _____
Home Phone: _____
Pager Number: _____

Family Care Management/CPI Emergency Contact

Name: _____
Phone Number: _____
Pager Number: _____

Care Manager/CPI Supervisor

Name: _____ Work Phone: _____

Pager Number: _____

II. MEDICAL /PSYCHOLOGICAL INFORMATION

Child's Medical Doctor: _____

Child's Therapist: _____ Dates of Scheduled Visits: _____

Child's Psychiatrist: _____ Dates of Scheduled Visits: _____

Medication (Name and Dosage): _____

Child's Dentist/Orthodontist _____ Dates of Scheduled Visits: _____

Is Child's Resource Record Attached: ☐ YES ☐ NO

Pertinent Medical Information (allergies, injuries, depression, chronic conditions, asthma, diabetic, etc.) _____

III. SCHOOL INFORMATION

Child's Grade: _____ Surrogate Parent Name: _____

Educational Placement: ☐ Regular ☐ Special Ed _____ (Type)

Date of Last IEP: _____

NEW	FORMER
School:	School:
Phone No.:	Phone No.:
Teacher:	Teacher:
Guidance Counselor:	Guidance Counselor:

Pertinent School Information (activities, organizations, classroom behaviors/concerns, etc.):

IV: CHILD FILE

Child File accompanied child to placement: YES ___ NO ___

Child File Includes: If answered no to any of the below, indicate date to be completed and by whom:

ITEM	YES	NO	WHO	DATE
Medical/Psychological Inf.				
Immunization Records				
Medicaid Card				
School Information/Records				
Recent Photograph				
Family Information				
Care Manager Information				
ESI behavior checklist				
Care Management Visit Log				
Critical Incident Log				

VI. SIGNATURES

All information contained in this document is true to the best of our knowledge.

_____ _____

Foster Parent Signature **Date**

_____ _____

Foster Parent Signature **Date**

_____ _____

Kids Central, Inc. Representative **Date**

The Family Care Manager (FCM)/CPI is to fully complete all information regarding the child and have all parties sign this Service Agreement prior to the child being placed in the foster home. If any information is not completed on this Service Agreement, indicate the date to be completed and by whom. One copy of the Service Agreement is to be given to the Foster provider, one copy given to the child's FCM/CPI and the original placed in the foster parents licensing file.

Kids Central, Inc.
Providing a new system of care for our Children

Child's Medical Information

Known Illnesses/Allergies:

1. _____ 2. _____

3. _____ 4. _____

History of Surgery or Major Illness:

1. _____ **Date Occurred:** _____

2. _____ **Date Occurred:** _____

3. _____ **Date Occurred:** _____

Medication	Dose	Route	Frequency	Prescribing Dr.

The Following Items Must Accompany This Form:

1. **Medicaid Eligibility Printout ---Required at the time of Placement**
2. **Immunization Records (copy) --- within 30 days of Placement for New Shelters only/ At time of Placement if child is moving within licensed care**
3. **Birth Certificate (copy) ---within 30 days of Placement for New Shelters only/ At time of Placement if child is moving within licensed care**

Kids Central, Inc.
Providing a new system of care for our Children

IDENTIFICATION OF RISK FACTORS AND PREVENTION OF SEXUAL ASSAULT IN SUBSTITUTE CARE PLACEMENTS

This checklist is to be utilized when making a shelter placement or moving a child to a new foster or shelter home. This checklist is also to be completed when staffing a case for foster care. This checklist is to be completed within three (3) working days of the placement.

A copy of this form must be maintained (and updated as necessary) in the Child File. A copy must also be sent to the foster/shelter parent, and a copy must be sent to the Intake and Assessment Services Coordinator.

Children's Name	D.O.B	Race/Sex
_____	_____	_____

Placement need/risk factors which must be considered in selecting a placement:
(FOR SUBSTITUTE CARE PLACEMENTS ONLY)

a. BACKGROUND CHECK MUST INCLUDE: FPSS, ARIS, all referrals including delinquency/CINS and all past and present CIS providers is attached.

b. If this is a subsequent placement for the child, what information concerning prior placement history is significant in selecting a new placement? N/A_____
Comments: _____
_____
_____
_____

c. Does the child have any special needs which should be taken into account in selecting a placement? Include any clinical diagnosis.

_____
_____
_____

d. Has the child been a known victim of sexual molestation or assault? (Yes) __ (No) __
If yes, describe when, where, how often and specific circumstances.
_____
_____
_____
_____

Kids Central, Inc.
Providing a new system of care for our Children

Child's Visitation Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Visitor's name, reason for visit, outcomes)**	**Visitor's Signature**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Visitation Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Visitor's name, reason for visit, outcomes)**	**Visitor's Signature**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Visitation Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Visitor's name, reason for visit, outcomes)**	**Visitor's Signature**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Medical Visits Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Dr. seen, reason for visit, outcomes)**	**Noted By**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Medical Visits Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Dr. seen, reason for visit, outcomes)**	**Noted By**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Medical Visits Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Dr. seen, reason for visit, outcomes)**	**Noted By**

Kids Central, Inc.
Providing a new system of care for our Children

Child's Medical Visits Log

Child's Name: Last, First MI		DOB:
Date	**Notes (Dr. seen, reason for visit, outcomes)**	**Noted By**

Kids Central, Inc.
Providing a new system of care for our Children

FPN
Family Partnership Network

Child's Photographs

Affix Envelope for Pictures here

Kids Central, Inc.
Providing a new system of care for our Children

FPN
Family Partnership Network

Letters

Affix Envelope for Letters here

Kids Central, Inc.
Providing a new system of care for our Children

FPN
Family Partnership Network

School Correspondence

Affix Envelope for School Correspondence here

Kids Central, Inc.
Providing a new system of care for our Children

FPN
Family Partnership Network

MONTHLY FOSTER CARE BOARD RATE & BREAKDOWN

	Infant to 5yrs	6yrs to 13yrs	13yrs and Up
Board Rate:	**$369**	**$389**	**$455**

Breakdown:			
Clothing	**$35**	**$36**	**$43**
Allowance	**$10**	**$10**	**$12**
Incidentals	**$8**	**$9**	**$11**

Kids Central, Inc.
Providing a new system of care for our Children

Children's Inventory Checklist

Child's Name:	Age	Sex	Race	Fiscal Year

Ages 1-18

ITEM	HAS	NEEDS	PURCHASED	COST
Bathing Suit(s)				
Bathrobe				
Blouses				
Boots				
Bra				
Dress				
Jackets				
Jeans				
Pajamas				
Pants				
Shoes				
Skirts				
Slippers				
Socks				
Sweater				
Tennis Shoes				
Underpants				
Undershirts				
T-Shirts				
Dress Shirts				
Child Specific Item	*(Items such as toys, keep sakes, family belongings, atheletic equipment, school supplies, and jewerly that are specific to this child)*			

Infants

ITEM	HAS	NEEDS	PURCHASED	COST
Playsuits				
Dresses				
Booties				
Pants				
Undershirts				
Outerwear Shirts				
Hats				
Sleepwear				
Socks				
Shoes				
Blankets				
Jacket				
Mittens				
Sweater				
Miscellaneous				
Child Specific Item	*(Items such as toys, keep sakes, family belongings that are specific to this child)*			

Comments:	Date Prepared:			
	Prepared By:			

If leaving a Foster Home/Facility, indicate that all items are present

Kids Central, Inc.
Providing a new system of care for our Children

Child's Allowance Log

Child's Name: Last, First MI		DOB:	FCM:
Date	**Allowance Given**	**Child's Signature**	**Caregiver's Signature**

Kids Central, Inc.
Providing a new system of care for our Children

Children's Monthly Clothing Receipt Log

Child's FCM:________________

Child's Name:	Age	Sex	Race	Fiscal Year

Month:	Month:	Month:	Month:
Items Purchased:	Items Purchased:	Items Purchased:	Items Purchased:
Amount Spent:	Amount Spent:	Amount Spent:	Amount Spent:
Store items purchased at:	Store items purchased at:	Store items purchased at:	Store items purchased at:
Month:	Month:	Month:	Month:
Items Purchased:	Items Purchased:	Items Purchased:	Items Purchased:
Amount Spent:	Amount Spent:	Amount Spent:	Amount Spent:
Store items purchased at:	Store items purchased at:	Store items purchased at:	Store items purchased at:
Month:	Month:	Month:	Month:
Items Purchased:	Items Purchased:	Items Purchased:	Items Purchased:
Amount Spent:	Amount Spent:	Amount Spent:	Amount Spent:
Store items purchased at:	Store items purchased at:	Store items purchased at:	Store items purchased at:

OP175-79

Attention Caregivers:
Please have the child(ren) seen by a licensed physician within 72 hours of their placement in your care.

Brevard County Health Departments
Titusville (321) 383-2795
Rockledge (321) 634-6305
Melbourne (321) 726-2920

Marion County Health Department
(352) 629-0137

Citrus County Health Department
(352) 527-0068 ext 261

Lake County Health Department
(352) 483-7926 (Eustis)
(352) 394-4399 ext 113 (Clermont)

Sumter County Health Department
(352) 793-6979 (Bushnell)
(352) 330-1313 ext 245 (Wildwood)

Hernando County Health Department
(352) 504-6800

Highlands County Health Department
(863) 386-6040

Hardee County Health Department
(863) 773-4161

Polk County Health Department
(863) 519-7900 ext 1002

Okeechobee County Health Department
(863) 462-5819

Martin County Health Department
(772) 221-4002

Indian River County Health Department
(772) 794-7460

St. Lucie County Health Department
(772) 462-3800

Orange County Health Department
(407) 836-7155
(407) 249-6232 ext 249

Osceola County Health Department
(407) 343-2009

Child Health Physical Examination

(Child Health Check Up/ EPSDT)

Name: _____

ID#: _____

Date of Birth: _____

Reason for Visit: _____

Date: _____ Age: _____ Sex: _____ Temp: _____ Pulse: _____ B.P. _____

Height _____ Percentile/Age _____ Weight _____ Wt/Ht Percentile _____

Head Circ _____ Percentile/Age _____ Chest Circ _____

O=Normal Check=Abnormal	NA=Not Applicable	Comment: Abnormal only, by number
1. Appearance		
2. Alertness		
3. Skin/ Nodes		
4. Head/ Scalp		
5. Fontanels (if applicable)		
6. Eyes		
7. Visual acuity (R/L)	/	
8. Ears		
9. Auditory Acuity (R/L)	/	
10. Nose/ Throat		
11. Mouth, Teeth, Gums		
12. Chest/ Lungs		
13. Heart (including rate)		
14. Abdomen		
15. Genital and anus		
16. Musculo-skeletal		
17. Neurological		
18. Other		

Initial Laboratory

Hgb (gm)/ HCt(%) _____ Stool (O&P) _____ Urine _____

Lead _____ Sickle Cell _____ Other _____

Tuberculin Test (type) _____ Date Read _____ Neg _____ Pos _____

Assessment/Diagnosis:

Plan/ Treatment:

Counseling/ Education:

Fingerprint Contacts by County, NCIC

Circuit 18:

Brevard County
North- 321-264-4062 x 237
Central- 321-634-6047 x2057
South- 321-837-7500 x204

Seminole County
(407) 268-9238

Circuit 9:

Orange and Osceola County
(407) 897-5932

Circuit 19:

Indian River, Martin, Okeechobee, and St. Lucie County
(772) 778-5008

Circuit 5:

Hernando County
(352) 754-6640

Marion County
(352) 620-7779

Lake County
(352) 742-6193
(352)742-6330

Citrus County
Citrus County Sheriff's Office
(352) 726-4488

Circuit 10:

Polk County
(863) 534-7100

Highlands County
(863) 773-2155

Sumter County
(352)330-1355

Attention Caregivers:
Please contact your local police department or local county designee to complete your fingerprints within 7 days.

Relative Caregiver Program

This program provides monthly financial support to relatives who meet eligibility requirements and have custody of a child under age 18 who has been adjudicated dependent by a Florida court and placed in their home by the Department of Children and Families Child Welfare/Community Based Care (CW/CBC) contracted provider. The monthly payment is more than the Temporary Cash Assistance for one child, but less than the amount paid for a foster care child.

Only the needs, income, and assets of the child(ren) are considered when determining eligibility and payment amounts. Payments are based on the child's age and any countable income. Monthly payments for children with no countable income are as follows:

Age 0 through 5 - $242 per child
Age 6 through 12 - $249 per child
Age 13 through 17 - $298 per child

To obtain for Medicaid or additional assistance for the child(ren) in your care, please visit the following website:

http://www.myflorida.com/accessflorida/

or call:

1-866-76ACCES (1-866-762-2237).

To access the Florida Telecommunication Relay Service toll free TDD/TTY phone numbers for the hearing or speech impaired:

Toll-free Access Numbers

Dial 711 to use the Relay or continue using

1-800-955-8770 (Voice)
1-877-955-8260 (VCO)
1-800-955-1339 (ASCII)
1-800-955-8771 (TTY)
1-877-955-5334 (STS)
1-877-955-8773 (Spanish)
1-877-955-8707 (French Creole) 8 a.m. - 2 a.m. daily

OP175-79

CAREGIVER HOME STUDY

Central Region Non-Licensed Relative/Non-Relative Placement
Fingerprint Based Criminal History Check Form

☐ Emergency Placement
In Urgent Circumstances
With a Relative or Non-Relative
And with an NCIC Name Check
(FL9xxxx4Z)

☐ Non-Emergency Placement
With a Relative or Non-Relative
And no NCIC Name Check
(FL9xxxx3Z)

A fingerprint check is requested from adult persons who have not been licensed and thoroughly screened by the Department of Children and Families. This is to safeguard that a child is not left in the care of someone who may have criminal charges found in Florida Statute 39.0138 or any other charges which may indicate a potential risk to a child.

By signing this form and being fingerprinted, you understand that your criminal history will be checked with the Federal Bureau of Investigation (FBI) and you are certifying that the information below is correct.

*If fingerprints are not provided to the Department by the next business day, the child may be removed from your care.

FOR COUNSELOR'S USE ONLY

☐ **Non-Rush (Fingerprint card attached)** ☐ **RUSH (Fingerprint card to follow)**

Requestor: _____ **Phone:** _____ **Case ID:** _____

Unit: _____ **Date:** _____ **Supervisor Signature:** _____

Placement Made? ☐ **NO** ☐ **YES (If YES, Date:** _____)

Date Fingerprint Card Given to Individual: _____

FOR DISTRICT/REGION POINT OF CONTACT USE ONLY

Date Fingerprint Card Returned to DCF or Live Scan Prints Taken: _____

Date Fingerprint Card Sent to FDLE or Live Scan Prints Transmitted: _____

Date Results Received from FDLE: _____ FBI: _____

ID Verified? ☐ No Additional Record – Placement May be Made/Continued.
☐ NO (If NO, Date Placement Notified: _____)
☐ Record Under Other ID (e.g.: Maiden Name): _____

Child Removed Due to Fingerprints NOT submitted within 10 Calendar Days of NCIC Check? ☐ YES ☐ NO

PLEASE PRINT

Name: _____ AKA: _____

Nickname/Maiden Name: _____

Date of Birth: _____ Social Security #: _____

Race: _____ Sex: _____

Attention Caregivers:
Please contact your local police department or local county designee to complete your fingerprints within 7 days.