HAMILTON COUNTY JOB & FAMILY SERVICES

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December 10, 2015

HCJFS REQUEST FOR PROPOSAL
PLACEMENT MEDICAL SCREENINGS

ADDENDUM 2

Providers in attendance at RFP Conference:

Access for Youth
Cincinnati Children's Hospital Medical Center
Comprehensive Health Care
Focus on Youth
Foundations for Living
Lighthouse Youth Services

Questions asked during RFP Conference:

Q1. Can we complete the placement medical screenings just on the children sent to us by you and still bill for it? We do not have a team that can travel.

A. You can propose to complete medical screenings for that specific segment of the population, provided that it is not contrary to any prior contractual arrangement you have with us.

Q2. The form that will need to be completed; do you have a sample of it?

A: The form is attached with this addendum. Other alternatives are acceptable upon collaboration with HCJFS.

Q3. Would HCJFS be open to other funding options besides a per unit base?

B. There is a new section chief over this program. She will provide input to answer this question. The answer will be provided in an upcoming addendum.

Q4. Section 1.2 – Scope of Services states “HCJFS also reserves the right to agree to contracted placement provider networks or facilities utilizing their own licensed or contracted medical staff to provide placement medical screenings for children placed in their care. These factors may reduce the number of referrals.” What exactly does this mean? Is this statement in regard to placement preferences in the future?

A: This is in reference to a placement provider’s ability to use other medical providers or pre-existing business relationships to meet the needs of the children. It is not guaranteed.

Q5. The population on page 6 seems to indicate that this would be larger than the agency selected clients.

C. These are guidelines, inferred by historical data and potential trends. This data is provided for planning purposes.

Q6. Page 5 of the RFP indicates “HCJFS’ goal is to work with providers who are able to meet the entire continuum of services.” Does this mean that referrals for placement will be based upon the ability to conduct placement medical screenings?

A: No, this is in reference to the spectrum, if any, of placement medical screenings (i.e. in a clinical setting; done by field staff). Referrals for placement should not be specifically impacted by contract or lack thereof for placement medical screenings.

Hamilton County Children's Protective Services

Nursing Examination Report

Child's Name:			Date of Exam:
Birth Date:	Age:	Sex:	Race:
Children's Services Worker's Name:			Phone: 946-
Parent Name:		F&C Case #:	Recipient #:
Foster Parent/Caregiver name:		Was Foster Parent/Caregiver present during exam? ☐ Yes; ☐ No	
Signature:		Caregiver phone:	
Address of Exam Site:			

Temp _____ Pulse _____ Resp. _____ Head Circumference _____ Weight _____ Height _____

Medications _____ Allergies _____

Immunization Status _____

Growth & Development:

☐ ***Infant (B –12 mo)***	☐ ***Toddler (1-3 yr)***	☐ ***Preschool (4-5)***	☐ ***School Age (6 & up)***
☐ Follows objects w/eyes	☐ Uses I, me, you	☐ Understands commands	☐ Grade in school _____
☐ Reflexes _____	☐ Picks up small objects	☐ Verbal using 2-3 words	☐ Age appropriate
☐ Crawls	☐ Builds 6 block tower	☐ Answers appropriately	☐ Answers appropriately

☐ Other: _____

Posture:

☐ appropriate for age ☐ erect ☐ steady gait ☐ scoliosis screen neg (12 +)

☐ Other: _____

Nutrition:

☐ well developed ☐ thin ☐ obese ☐ formula amt. _____ freq. _____

☐ Other: _____

Skin:

☐ lesions _____ ☐ warm & dry ☐ intact ☐ rashes

☐ bruising ☐ good turgor ☐ see body figure (pg 2)

☐ Other: _____

Neck:

☐ supple ☐ supports head ☐ palpable nodes

☐ Other: _____

Head/Hair:

☐ normocephalic ☐ fontanel soft & flat ☐ hair clean ☐ hair free of infestation

☐ Other: _____

Eyes:

☐ can see objects ☐ wears glasses ☐ sclera white ☐ cornea clear

☐ PERRLA ☐ drainage ☐ follows objects ☐ coordinates eye/hand

☐ Other: _____

Ears:

☐ symmetrical ☐ drainage ☐ redness ☐ responds to voice

☐ Other: _____

Nose:

☐ nares patent ☐ with drainage ☐ with crusting ☐ sneezing frequently

☐ Other: _____

Mouth/Throat/Tonsils/Teeth:

☐ membranes pink/moist ☐ throat w/inflammation ☐ intact palate ☐ uvula midline

☐ good dental hygiene ☐ gums pink ☐ frenum upper lip intact ☐ frenum tongue intact

☐ strong suck/swallow ☐ teeth present ☐ tonsils present ☐ tonsils edematous

☐ Other: _____

Chest:

☐ symmetrical ☐ good excursion w/resp ☐ free from abrasions ☐ sternal retractions

☐ Other: _____

Distribution: **White:** Hamilton County **Yellow:** Foster Parent

Hamilton County Children's Protective Services

Nursing Examination Report

Child's Name:	Date of Exam:

Heart:

☐ AP strong & regular ☐ murmurs/rubs ☐ brisk capillary refill
☐ Other:_____

Lungs:

☐ BBS clear ☐ cough/congestion ☐ resp easy & even ☐ hx of breathing problem
☐ Other:_____

Abdomen:

☐ soft & flat ☐ rounded ☐ no palpable masses ☐ bowel sounds present ☐ non-tender
☐ Other:_____

Behavioral Health Observations:

_____

_____

Extremities:

☐ symmetrical ROM: ☐ full ☐ limited ☐ nail beds pink ☐ 10 fingers/toes
☐ bilateral peripheral pulses ☐ deformity present ☐ equal muscle tone
☐ Other:_____

Infant Reflexes:

☐ Babinski ☐ startle ☐ palmer ☐ plantar ☐ rooting ☐ sucking
☐ Other:_____

Genitalia:

☐ sexually active ☐ use protection ☐ exposure to STD ☐ use birth control
☐ drainage/discharge/lesions ☐ pain/burning urination ☐ periods regular ☐ method of birth control
☐ circumcised
☐ Other:_____

Recommendations for further medical care: (lab work, ophthalmologist, immunizations, dental, prenatal & etc.) _____

_____

_____

Recommendations requiring immediate action called to HCJFS Caseworker? ☐ **Yes;** ☐ **No** ***And*** PDN Case Manager on call? ☐ **Yes;** ☐ **No**
Name of PDN Case Manager Notified:_____

Reminded foster parent of follow-up visit with physician within thirty (30) days? ☐ **Yes;** ☐ **No** _____

Known exposure to communicable disease? ☐ **Yes;** ☐ **No** _____

Is the child free of contagious disease per nursing assessment? ☐ **Yes;** ☐ **No** _____

Nurse's signature:	Date:

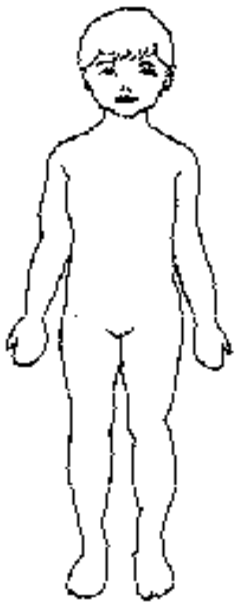
A. Use code to indicate locations and size of area on figure:

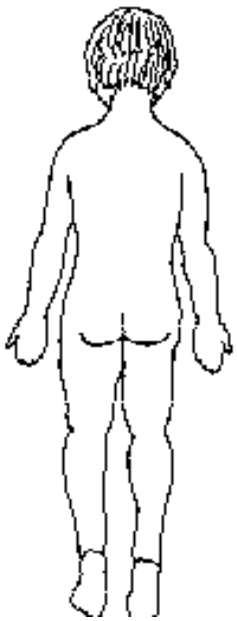
R - Rashes **S** - Scars
L - Lesions **E** - Ecchymosis
D - Decubitus **B** - Burns

B. Please note presence and location of:

1. In-dwelling catheters,
2. Ports,
3. Enteral tubes,
4. Shunt
5. Trach,
6. Other _____

Comments:





Distribution: **White:** Hamilton County **Yellow:** Foster Parent