Connecticut Department of Children and Families

**PERMISSION TO DELIVER OR OBTAIN ROUTINE/SPECIALTY HEALTH CARE AND MULTI-DISCIPLINARY EVALUATION (MDE)**

DCF-460R
01/21 (Rev.)

**TO BE GIVEN TO THE CAREGIVER AT THE TIME OF PLACEMENT**

| Child's LAST Name: | Child's FIRST Name: | Child's DOB: | LINK #: | Child's Gender: |
|---|---|---|---|---|
| Name of Medical Insurance Provider: | Group #: | Policy #: | Child's Legal Status: | |
| Placement Contact Last Name: | Placement Contact First Name: | Placement Contact E-mail: | Placement Contact Phone #: | |
| Placement Address (No. and Street): | City: | State: | Zip: | |
| Social Worker (SW) Last Name: | SW First Name: | SW E-mail: | SW Phone #: | |
| Social Work Supervisor (SWS) Last Name: | SWS First Name: | SWS E-mail: | SWS Phone #: | |
| DCF Office of SW: | Name of Specialty Clinic/MDE Clinic/Provider | | | |

**On behalf of the above named child, permission is given to deliver or obtain health care as follows:**

- EPSDT services, which are age-appropriate periodic screenings and, when indicated, diagnosis and treatment, including comprehensive history and physical examination, laboratory tests, health education and anticipatory guidance, and vision, hearing and dental services
- Follow-up and monitoring of chronic medical conditions by Primary Care Provider and/or Specialty Provider
- Treatment of common childhood diseases
- Completion of camp physicals and forms and completion of school forms
- Specialty Consultation and Evaluation
- Non-Sedated Radiological Studies
- Mental Health Screening and Care (excluding psychotropic medications)
- Multi-Disciplinary Evaluation

**This form expires (1) when a child changes placement or (2) 365 days after the date of the parent's, guardian's. or Social Work Supervisor's signature**

| Parent's or Guardian's Name (if child /youth under an OTC): | Parent's or Guardian's Signature: | Date: |
|---|---|---|

**Authorization for Recommended Immunizations:**

| ☐ **Yes, I authorize:** | ☐ **No, I DO NOT authorize** | |
|---|---|---|
| Parent's or Guardian's Signature: | Parent's or Guardian's Signature: | Date: |
| DCF Social Work Supervisor (or above) name/title: | DCF Social Work Supervisor (or above) Signature: | Date: |