CONSENT/AUTHORIZATION FOR MEDICAL/MENTAL HEALTH EVALUATION
CHILD MEDICAL EVALUATION PROGRAM

I. A. Name of Child _____ Date of Birth _____
(First) (Middle) (Last)

B. The evaluation is a component of child protective services investigations and is used in making decisions regarding allegations of child abuse or neglect. The referral is made by authority of (check one):

( ) Parent
( ) Legal Guardian
( ) DSS Director - when acting as temporary guardian of child found abandoned or without natural guardian or when having been vested with parental rights by the adoption or termination of parental rights laws (G.S. 35A-1220).
( ) Judge's Order - in accordance with G.S. 7A-647(3) when a court order authorized this evaluation(court order attached).

C. I hereby authorize _____ to perform:
(Name of Examiner)

( ) A medical evaluation, including diagnostic studies and photographs, on the above named child.
( ) A mental health evaluation, including diagnostic studies, on the above named child.

Furthermore, I understand that the findings of the evaluation(s) will be released to the county department of social services and the Child Medical Evaluation Program.

_____

Signature of parent/guardian | Date | Nature of authority to consent (i.e., parent, guardian, custodian)

II. The provider is authorized to claim reimbursement in accordance with the Purchase of Service Contract for the following services provided to the child named above:

A. Date Case Opened for Service Code 212 :_____
B. Open for Medicaid? yes___ no___ Medicaid #-_____
C. SIS I.D. # _____
D. County Case #: _____
E. Purchase Program I.D. #: 00161

III. A. _____ County Department of Social Services

B. Social Worker: _____ Telephone #:_____

C. Signature of authorized county representative: _____

D. Date: _____

Purpose of the form: This form is to be used to refer a child for a child medical/mental health evaluation through the Child Medical Evaluation Program and for the DSS to transmit to providers the authorization and the data necessary to claim reimbursement.

Section I:

A. Enter the name of the child for whom the service is being provided.

B. Check the source of authority for consent of the evaluation (See Vol. I, Chapter III, Child Welfare Services and Use of the Juvenile Court Appendix XII for clarification of consent).

C. Enter the authorized examiner's name and the type of evaluation requested (Examiner must be subcontracted through the CMEP by "letter of agreement" for provision of direct client services).

Obtain signature from the authorized individual for consent to the evaluation and the date signature obtained. **Note: Consent must be signed prior to or on the date of the examination**.

Section II:

A. Service Code 212 is specific to medical, psychological, and medico-legal diagnostic studies and evaluations where needed to substantiate and assess the circumstances of abuse or neglect of children.

The effective date must be entered. This date is the same as the beginning date of the period of authorization on the DSS-5027. The case must be open for Service Code 212.

B. Determine if the child is eligible for Medicaid. If so, enter the Medicaid # of the child for whom this service is authorized.

C. Enter the SIS ID # of the child for whom this service is authorized.

D. Enter the county case record number.

E. No additional entry required. The purchase program ID # remains constant for the Child Medical Evaluation Program.

Section III:

A. Enter the name of the county authorizing the service.

B. Enter the name and telephone # of the social worker completing the form.

C. The form is to be signed by an authorized representative of the director of the county department of social services. Enter the date on which the form was signed.

DISTRIBUTION: Complete in duplicate. One copy for services record and one copy for provider; attached to the Evaluation Report Form.