



***AGREEMENT WITH FOSTER PARENTS  
REGARDING EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT  
POLICIES AND PROCEDURES***

I/we \_\_\_\_\_  
Husband's First Name                      Middle Name                      Last Name

\_\_\_\_\_  
Wife's First Name                      Middle Name                      Last Name

Residing/located at \_\_\_\_\_, County \_\_\_\_\_

Hereby agree to cooperate and assist in the provision of EPSDT services to all foster children placed in my/our care by the Department of Children and Families.

I/we understand that the following medical tests and examinations are provided free of charge through Medicaid screening: health and developmental history; physical assessment; height, weight, growth assessment; developmental assessment; speech assessment; direct referral to a dentist; nutritional assessment; vision assessment; hearing assessment; immunizations; and laboratory tests. EPSDT screening also includes treatment for problems detected during the screening such as the provision of eyeglasses, hearing aids, and dental services.

I/we understand that children must be scheduled for examination according to the following periodicity schedule: 2 months of age, 4 months of age, 6 months of age, 1 year of age, 15 months of age, 18 months of age, once every year from age 2 through 5, and once every 3 years from age 6 through the month the young adult reaches age 21. If required by a child's particular needs, screening may be scheduled more frequently or at different intervals.

Signed: \_\_\_\_\_  
                    Foster Parent  
\_\_\_\_\_  
                    Foster Parent

Date: \_\_\_\_\_  
Date: \_\_\_\_\_