PURCHASE OF SERVICE AGREEMENT
CONTACT INFORMATION

1. LCCS Information:

Agency Name: Lucas County Children Services

Address: 301 Adams Street, Toledo, Ohio 43604

Telephone: Fax: 419-327-3582

Agency Representative: Emergency Phone: 419-213-3400

Email Address:

2. Provider Information:

Agency Name:

Address:

Telephone: Fax:

Agency Representative: Emergency Phone:

Email Address:

3. Placement Information: (foster parent)

Name: Phone:

Address:

4. Child's Information

Child's Name: DOB:

Child's Caseworker:
Name *Phone*

Supervisor:
Name *Phone*

Manager:
Name *Phone*

Agency Liaison:
Name *Phone*

Case Plan Goals:

☐ Reunification ☐ Independent Living ☐ Adoption

☐ Permanent Alternative Placement, Excluding Adoption

Family Visits:

Persons who will visit the child: (check all that apply)

☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Grandparents

☐ Other _____

Non-Emergency Medical Needs:

Substitute Caregiver will secure health services following the Provider's instructions. The Substitute Caregiver is responsible for child receiving routine medical care including transportation to medical, dental and optical care and administering prescription medicine to child.

Doctor to be used: _____

Address: _____ Phone: _____

Dentist to be used: _____

Address: _____ Phone: _____

Optometrist to be used: _____

Address: _____ Phone: _____

Emergency Medical Needs:

Substitute Caregiver should transport child to child's physician or if unavailable, the hospital emergency room shall be used and Substitute Caregiver should notify the Provider and Agency as soon as possible. At the time of treatment, please present either medical (Medicaid) card, or a billing authorization letter. If it is after hours, or a number is still not yet available, the practitioner may forward the invoice directly to the Lucas County Children Services, Accounts Payable Department. Upon receipt of the child's Medicaid number from the State of Ohio, our accounting department will return the invoice to the practitioner indicating billing instructions.

Date Purchase of Service Agreement signed: _____

SUBSTITUTE CARE AGREEMENT

Name of Child: _____ DOB _____

A plan for substitute care has been arranged for (child) _____
This plan has been discussed with and approved by the foster care caseworker.

1. Substitute Care Plan:

Name of Provider: _____

Social Security Number: _____

Location: _____

_____

Hours: _____

Days of the Week _____

Have police checks been completed? ☐ Yes ☐ No

2. Backup or Emergency Plan for Substitute Care:

In case of emergency, child care shall be provided by: _____
Child care arrangement shall be made in cooperation with the Agency, Provider and Substitute Caregiver

3. Supervisory Requirements:

_____ may not be left without supervision.

_____ may be left without supervision for up to _____ hours.

This substitute care arrangement meets ODJFS Rule 5101: 2-7-08 D requirements. _____FCW initials

The foster parent agrees to notify their foster care caseworker of any changes in this plan.

_____ _____
Foster Parent, Signature *Date*

_____ _____
Provider Staff Signature *Date*