



**Tennessee Department of Health  
HUGS Medical Verification (CHILD)**

Dear Provider,

Date:

Your patient \_\_\_\_\_ is participating in HUGS, a statewide home visiting program. Home visitors work to coordinate care and help families achieve wellness.

Please **verify this patient is receiving recommended medical care**. We welcome additional comments or suggestions for education/ resources that would benefit this family. Thank you for your cooperation and participation as a member of the care team for this patient.

**STEP 1: HIPPA Release of Information (Filled out by CLIENT GUARDIAN)**

My child \_\_\_\_\_, born \_\_\_/\_\_\_/\_\_\_, is a client of the TN Health Department. I am requesting that you verify whether or not my child is keeping medical appointments.

*Mi hijo/a \_\_\_\_\_, nacido/a en, \_\_\_\_\_ es un cliente del TN Departamento de Salud. Solicito verificación de la asistencia de mi hijo/a a todas las citas medicas.*

\_\_\_\_\_  
*Client Signature/Firma del cliente* \_\_\_\_\_  
*Date/Fecha*

**STEP 2: (Filled out by PROVIDER)**

1) Has this child been seen in your clinical setting?  Yes  No

2) Date of most recent well child check-up/ EPSDT: Date (mm/dd/yy): [ ][ ] [ ][ ] [ ][ ]

3) Please complete about the most recent components of a well child check:

VISION Screen: Date: [ ][ ] [ ][ ] [ ][ ]	HEARING Screen: Date: [ ][ ] [ ][ ] [ ][ ]
<input type="checkbox"/> Passed	<input type="checkbox"/> Passed
<input type="checkbox"/> Did Not Pass	<input type="checkbox"/> Did Not Pass
<input type="checkbox"/> Not applicable, did not perform	<input type="checkbox"/> Not applicable, did not perform

**STEP 3: (PROVIDER)**

**\*\*\*\*\*Please attach a copy of the child's immunization record to this form\*\*\*\*\***

**STEP 4: (PROVIDER)**

4) Education or resources that would benefit this client?

Safety/ Environment:  
 Physical Health Topics:  
 Mental Health/ Development Topics:  
 Nutrition:  
 Psychosocial:

**Additional Comments:**

**PROVIDER:**

**HOME VISITOR:**

\_\_\_\_\_  
printed name

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
printed name

\_\_\_\_\_  
phone

**Please mail this form to:**

PH-4147  
(rev. 3/12)

**Or Fax to:**

RDA 150

## **HUGS MEDICAL VERIFICATION (CHILD) INSTRUCTIONS**

**PURPOSE:** To provide pertinent information from the medical provider to the HUGS Program. The medical verification form may be generated from within the health department or from an outside agency or entity (i.e. Hospital, Doctor's Office, Clinics, Health Centers or any medical provider, etc.). This information will assist the home visitor with information related to the compliance of well child checks.

The Medical Verification Form is self-explanatory.